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Bioethical Decisions and Today's Christian

Finding Your Way Through

The Morass of Today's Overwhelming

Medical Ethical Dilemmas

A 13-Lesson Overview
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Soli Deo Gloria.

Robert E. Cranston, M.D.

Introduction

The end of the 20th century has brought unusual technological advances to our society. Christians today face dilemmas that were completely beyond imagination just a few years ago. Abortion became legal in the U.S. in 1973. Organ transplantation came into its own in the latter half of the century. When I attended medical school in the late 1970s, AIDS was not a part of standard medical school curriculum. Since then, the AIDS epidemic has exploded in America and around the world.

New diseases, technologies, and health treatment options raise many complicated questions. When does life begin? When does death transpire? What is “Quality of Life”, “Sanctity of Life”, and how do they differ from each other? When is care futile? Who owns the life that we each live?

Christians are to be light in a dark world and a seasoning salt in a corrupt society. If we are to serve God in these roles, we must engage the prickly issues of the day. To do this John Wesley used four tools to make decisions that have since been labeled the Wesleyan Quadrilateral. These are: Scripture, Reason, Tradition—including the wisdom of the Church through the ages, and Experience—including God’s work in our lives and the inner witness of the Holy Spirit. We will always observe and respect these same four signposts as we travel through this process. We will reason together around scripture and pray for the Holy Spirit’s illumination as we do so. Since many of the bioethical dilemmas we will engage were not extant in ages past, we will tap not only into the great creeds of the church and the wisdom tradition within our own churches, but also into the new tradition of Christian bioethical thought.

It is my belief that our ethics must be, in the words of John Kilner, (See Lesson Twelve), “God-Centered... Reality-Bounded...(and) Love-Impelled.” As I work through ethical dilemmas, using Wesley’s quadrilateral, I am always guided by these three parameters.

This is a brief introduction for the committed Christian to the world of bioethics. An evening fellowship and discussion group might be its most appropriate setting, but a Sunday School class study group may also prove effective. I hope that it will whet your appetite, and stimulate further learning so that as Christians we will be a part of the discussion, keeping God in the public forum.

God Bless you as you read and study together.

Notes for Discussion Leaders

This curriculum is designed for use in one of several settings. It may be used in a standard Sunday School class, or perhaps more effectively in a longer class format, such as an evening adult Bible study group. It is important to emphasize that much of the learning in this endeavor will occur as your discussants prepare for the classes ahead of time and then process the information afterward, either singly or in groups. If your group's participants cannot make the commitment to read the entire lesson ahead of time, I suggest that you ask as a minimal effort that they agree to carefully read the scripture passages prior to class.

I would recommend in your group discussions each week that you limit your group size to no more than ten. Larger groups may be split into smaller cells, but for effective discussion, maximum cell size optimally should not exceed ten. Each group should be isolated enough from the other groups that they do not distract each other.

As you prepare for your classes, I would suggest that in addition to the week's reading and scripture passages, you try to read some of the background information contained in "For Further Reading". If your group's funds are limited, I would recommend that you purchase Scott Rae's book *An Introduction to Ethics*, as a helpful single reference book. The Bio Basics series booklets are also quite good for the topics they cover, and are relatively inexpensive.

This is probably not the kind of study for which you can easily delegate weekly teaching responsibilities. I would anticipate best results from leaders with strong interest or background in the subject matter. The dynamics of your particular group may prove this suggestion unnecessary.

Your group may discover that each chapter merits two weeks of study and discussion. If you try and cover each lesson in one week you will probably find that there is too much material to answer all the questions. As a leader, you may wish, the week before, to designate specific questions for discussion the next week. Some of these suggestions will be more or less necessary, depending on the composition of your group. I recommend that you read the notes for the upcoming lesson early in the week. By doing this, the concepts can percolate in your mind throughout the week. You may then choose to focus the discussion on one of the areas covered in the lesson, as opposed to trying to cover all the questions.

Finally, in an effort to continually focus on the process with which we address these complicated questions, I might suggest that on the blackboard or on a poster in your discussion room, you place in large letters the four guideposts that will help you through this complicated discussion. These are Scripture, Reason, Tradition and Experience. Each week as you process your discussion, make an effort to direct your thoughts along these lines. This is more fully explained in the introduction and in the first two lessons.

May the Lord direct your words and thoughts.

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Chapter One

What is Bioethics?

Samantha Jones is a seventeen-year-old speed skater. Her father disappeared long ago. Sam has no idea where he is. Her mother has worked two full-time jobs to earn the money to pay for the rink time and skating instruction that she needed to achieve her cherished dreams. She has won many regional and state competitions, and recently was offered a chance of a lifetime. Samantha has been asked to join the U.S. Olympic speed skating team for the upcoming international races to be held in nine months in Oslo, Norway. She is ecstatic, and her mother is so proud she literally glows.

Samantha has also been sharing her life and dreams with Loren Kelly, another Olympic hopeful. They have spent hours at the rink together. With Sam's mother gone so much of the time at her two jobs, with her loneliness, and with her growing affection for Loren, Sam has begun to sleep with Loren. They plan to marry some day, after they both achieve some of their high aspirations.

Six months before the races, Sam misses her menstrual period. Perhaps it is just her body adjusting to the new birth control pills she received at Planned Parenthood. When she misses her second period, however, she schedules an appointment to meet with the nurse clinician at the local Planned Parenthood clinic. She is stunned to learn she is pregnant. Not to worry, though, says the nurse. A minor procedure, performed for a small fee, will allow her to go forward with her plans and make her mother happy. All her hard work will still pay off.

Joe and Ellen Pound are deeply in love. They have an ideal marriage in almost every respect. They have wonderful jobs that provide excellent financial security, are active in their church, and come from supportive warm families. Their deep heartache, however, is their childlessness. They would love to have children, but after six years without contraception, and thousands of out-of-pocket dollars spent on infertility treatments, they still have empty arms.

Then Dr. Faith tells them about an option they hadn't considered. Since Joe's sperm count is normal, and his sperm motility is excellent, would Joe and Ellen considered using Joe's sperm to fertilize a donor egg? This could be grown in vitro and then surgically placed into Ellen's uterus. The donor egg could be from an anonymous donor, from a family member—such as Ellen's sister, or even purchased via the internet from a beautiful, highly educated young woman. While the cost would be significant, and the success rate only fair, the danger to Ellen would be limited. If this were to be successful, Joe and Ellen would provide a Godly, loving home for a long-awaited child.

Thousands of children die every day in Bombay because their starving families have no way to feed them. A dollar per day will feed, clothe, house and educate a child.

Tom and Mary Gomez have been driving their Ford Taurus for seven years. It has over 90,000 miles on the odometer. While Tom is channel surfing on Saturday afternoon, he sees the "Child Care Ministries" infomercial fund drive, and actually stops

and watches the show for about ten minutes. He changes back to the football game, and flips open the Consumer Reports issue on new mid-size sedans. Should they move on up to a Buick this year?

What do these scenarios have in common? They all involve bioethical decision-making. Bioethics have been a part of human concerns from the time that Cain decided to kill Abel in hopes of improving his own quality of life. Hippocrates specifically discussed abortion, infanticide, euthanasia, suicide and sexual relations between physicians and patients. But while the broad field of bioethics is ancient, some of today's questions are brand new.

Abortion was legalized in the U. S. in 1973 with *Roe v. Wade*. By the 1980s artificial respirators had become common even in community hospitals. The federal government began discussions to approve federal funding of embryo research in the late 1990s. We may not realize it, but on a frequent, almost daily basis bioethical questions confront us.

As we study together for the next 13 lessons, we will use four guides. John Wesley, the great English reformer and founder of the Methodist movement summarized these in what has become known as the Wesleyan Quadrilateral. We will employ ***Reason***, God's gift uniquely given to humankind, to explore ***Scripture***, his Holy Word. ***Experience***, the inner witness of the Holy Spirit in our lives over many years, and particularly God's wisdom given when we seek his assistance in prayer, will be our third guide. Fourthly, the ***Tradition*** that we will employ will include the thoughts and actions of the Protestant and Roman Catholic churches through the ages, as well as the wisdom of a new group: Christian bioethicists. These modern clinicians, theologians, scholars and lawyers will help us understand the cumulative wisdom of the ages, and then apply this wisdom to the burgeoning discipline of Christian bioethics. Each lesson contains references from Christian scholars that I highly recommend for review.

We have already been applying Reason to this effort, and I have already been directing our thoughts to address some of the age old Traditions, particularly as applied by our new Christian bioethicist thought leaders. With each lesson I will highlight and reference these Christian bioethicists, and try to tie these new thinkers back to their deep church roots. Every lesson should begin and end with a request for the Holy Spirit to illuminate our minds, reminding us of his work in our lives over the years (Experience) and actively leading us into deeper Scriptural truths together. With this in mind, what does the Bible have to say about bioethics? A lot more than you might first think. Let us examine some passages together as we begin to survey this broad field.

Scripture and Discussion Questions

Exodus 20:1-17

Leviticus 18:1-23

Leviticus 19:9-10, 14-18

James 1:5-8

Romans 1:18-31

- 1) As you review the “Ten Commandments” is there an obvious division between categories of command? Is there any significance to the order in which the commandments occur?
- 2) Leviticus 18 delineates a number of unusual sexual relationships. Have you heard of any of these occurring lately? If so, have these sins been limited to “worldly” settings? What bearing does this have on any of this bioethical discussion?
- 3) Leviticus 19 discusses rules for general social welfare? Do we respect these guidelines today? If not, what happens in our society? Are these rules characterized by principles not present in today’s welfare or international diplomacy laws?
- 4) James 1 is specifically referring to trials and temptations. What temptations are inherent in today’s bioethical debates?
- 5) What does Romans 1 have to do with this whole discussion?
- 6) Why are Americans so willing to spend great sums of money on infertility work-ups but less willing to adopt? What are the moral and cultural implications of cross-cultural adoptions?
- 7) Is capitalism Biblical?
- 8) Many Christians would feel comfortable selling their hair to a wig-maker, or the blood to a plasma program. What is the difference between this and selling sperm or eggs to the highest bidder? Remember neither sperm nor eggs are live, and each contains only 23 chromosomes.
- 9) What role does television play in forming public opinion regarding bioethical issues? Give examples.
- 10) Is there a moral difference between adoption and surrogate motherhood?
- 11) Do you know what percent of your gift goes to overhead when you give to the charities that you support? Should you?

Comments

- 1) Samantha’s mother’s decision to work two jobs may have contributed to Samantha’s situation. Time may be the most important thing we can give our children.
- 2) Contraceptives are available for our children through organizations like Planned Parenthood, with no parental notification. Abortion is legal in many states without parental notification.
- 3) Every abortion has multiple victims. Abortion involves the baby, the mother, the father, the extended family, and all of society.
- 4) Justice is a term often applied to situations within our own national or regional borders. Many Christians in emerging nations find America’s hoarding of natural resources and wealth incomprehensible. Many Christians in America feel that even on a national level there are great injustices in allocation of goods and services.
- 5) “A minor procedure”—from the first vignette emphasizes the power of terminology. Advocates of abortion are never called Pro-abortion. Interestingly, however, the press often refers to “sanctity of life” or Pro-life forces as “anti-abortionists”.
- 6) There is an old adage “He is so heavenly-minded that he is no earthly good.” Jesus spent much of his ministry addressing pain, disease, suffering and interpersonal discord. We cannot abandon these issues to those who do not honor Christ.

PRAYER REQUESTS: As you close today's lesson together, pray that God will illuminate your mind and heart in the upcoming weeks. Pray that the Holy Spirit will show you areas in society and in your own life that require more thoughtful deliberation and wisdom from God.

For Further Reading:

Scott B. Rae, *Moral Choices, an Introduction to Ethics* (Grand Rapids, Michigan: Zondervan Publishing, 1995). Dr. Rae is a professor at BIOLA University in Los Angeles. His text is a very readable introduction to bioethics, from a Christian perspective. While giving reasonable perspectives from various schools of thought he does not leave the reader wondering what he believes on various difficult issues. If one has limited time and desires a broad Christian overview of the field, this text is well worth reading and keeping for your reference library.

John S. Feinberg and Paul D. Feinberg, *Ethics for a Brave New World* (Wheaton, Illinois: Crossway Books, 1993). The Drs. Feinberg serve on faculty at Trinity Evangelical Divinity School in Deerfield, Illinois. These brothers individually write alternating chapters of an engaging, stimulating nature, that each deal with one of the major issues of the day. This is an excellent resource for Christians seeking a broad introduction to the field of bioethics. A list of abbreviations and a Scriptural index are helpful for the inquiring believer.

Stephen E. Lammers and Allen Verhey, eds., *On Moral Medicine*, 2d ed. (Grand Rapids, Michigan: Eerdmans Publishing Company, 1998) offers a series of scholarly essays for those who wish to dig a little deeper. Parts I and II focus on the relationship between religion and medicine and specific concepts within this domain. Part III has nine chapters addressing specific issues within medical ethics. Chapter essays are authored by a "Who's Who" of Christian thought leaders such as Pope John Paul II, William May, Karl Barth, Paul Ramsey, Nicholas Wolterstorff and many others. While not designed to be a general reference, it may well provide thought-provoking reading for several years if taken an essay per week, chewed thoughtfully, and digested slowly.

In what many people feel is a classic, Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York, New York: Oxford University Press, 1994), provide a broad-based foundation for a secular approach to bioethics. The inquiring Christian desiring a scriptural foundation for their pursuit of bioethical knowledge might do best with Rae's or the Feinbergs' book, but this would certainly help to round out one's limited library.

Much discussion and debate in ethics devolves eventually to the question of authority. Are we to fall back to our basic native intellect to sort through this marshland, or will we

rely primarily on scripture and religious tradition? Nicholas Wolterstorff, *Reason Within the Bounds of Religion*, 2d ed., (Grand Rapids, Michigan: Eerdmans Publishing Company, 1984), answers the latter, resoundingly. However, he challenges the reader to be very careful to establish exactly what a sound interpretation of Scripture really does tell us before we become too dogmatic about our moral positions.

Co-founding editor of the *Journal of Biblical Ethics in Medicine*, Franklin E. Payne, Jr., M. D., *Biblical Healing for Modern Medicine* (Augusta, Georgia: Covenant Books, 1993), offers an insightful insider's tour through medicine as seen from the perspective of a conservative Biblical worldview. This should probably be read after one of the basic texts. While one may not agree with everything Dr. Payne writes, this book will certainly challenge to deeper thought.

A lively debate, not within the scope of this curriculum, focuses on scripture itself, and our ability to understand what scripture is saying. Hermeneutics is the discipline that concerns itself with interpretation. Deconstructionism and associated patterns of reinterpreting texts of all sorts and particularly scripture, is a widespread phenomenon on secular and Christian campuses throughout the world. For a full discussion see Kevin J. Vanhoozer, *Is There a Meaning in This Text?* (Grand Rapids, Michigan: Zondervan Publishing House, 1998). Pages 9-35 set the stage for the debate.

Chapter Two

Why Do Bioethics?

Loretta and Bill are generous people. Every December, as they approach the New Year, they budget several thousand dollars to give to various charities, on top of tithing to their local church. The United Way campaign is underway at Loretta's office. Every year her supervisor at work strongly suggests that the entire department contribute. "This is a way we can give back to our community," she says, "and besides, if we get 100% participation we get off work at 3:00 p.m. one Friday, to have an ice cream party sponsored by the company."

Loretta and Bill designate \$50.00 for the United Way. As Loretta seals the envelope she wonders "What organizations are covered by contributions to UW?" As she is running late for church choir practice, she drops the check in the mail, and hurries on. She will check on that later.

Joey Heatherton, being a good citizen, arrives early at the voting booth. She has voted in every election since 1972. This past week has been extremely hectic, with the church social, the school play, the PTA meeting, and a full-time job. Joey examines the ballot carefully. Bo Brown, Kim Hunter, and John Lee are running for the state senate seat. Joey thinks that the senate needs more minority representation. She decides to vote for John Lee, a Korean-American. As she drops her ballot in the box, she wonders, "Where does John stand on school health clinics, the new "Right to Die" initiative and affirmative action for medical and law schools?" No time to think about that now, though, as she is late for the "Earth First" business meeting.

"I am sick of people telling me what to do," screamed Martha Jenkins at her mother. "No one should tell another person what to think. And besides, who are you to act like you know what is right or wrong? If it's right for me, then it's right!" Martha's mother, Judy stood in stunned silence as Martha slammed the door. She squealed her tires in the driveway as she sped off to her "Catholics for Choice" meeting. Was Martha right?

The title of this chapter is really a trick question. We all make bioethical decisions frequently, perhaps even on a daily basis. The sad truth is, though, that we make many of these decisions without realizing that we are deciding at all. Given this fact, we should examine these choices carefully from a Christian perspective.

Should we support charities if we do not understand what they stand for? Should we be involved in the political process? If so, how? While as Christians we are called to stewardship of God's earth, what are the underlying assumptions of Animal Rights groups in your state? How can we know right from wrong? When we disagree with someone based on Judeo-Christian scripture is this an example of Eurocentric, white male arrogance? What reliable guidelines do we have for making difficult decisions that involve people, their choices, and their lives?

Several major methods of decision-making are used in formal and informal bioethics. Perhaps the easiest method for Christians to employ is deontological, or rule-based, principle-based decision-making. Immanuel Kant was among the first to formally describe this process, but as Jews and Christians, we come from a long line of rule-based thinkers. We believe that God actually spoke to Moses, giving him the Ten Commandments. We also believe that he revealed himself to humankind through scripture, the prophets, the apostles, and most completely through the person of Jesus Christ. We believe that we will be held accountable for the manner in which we live by these rules and principles. While there is a long history of dynamic tension between Grace—but not having license to sin, or living by God’s laws—but not being slaves to legalism, Judeo-Christian tradition has always subscribed to the strong reference of Scripture to adjudicate our difficult questions. We should maintain this respect for Scripture.

Teleologists, or utilitarians, another major group, subscribe to the motto “The end justifies the means.” The goal of utilitarianism is to “provide the most benefit for the greatest number of persons.” The definition of “benefit” is a bit slippery. In addition, the underlying assumption is that this “most benefit...” is the only rule that applies. All other concepts, such as loyalty, integrity, respect for God, fidelity, etc., are only to be adhered to if they help meet the goal of “benefit”. Peter Singer, who holds an endowed chair in ethics at Princeton University, is probably the most widely known utilitarian today. He takes this one step further by questioning the definition of “person”. According to Singer mentally handicapped and demented humans *are not* persons, while baboons and chimpanzees, having capacity to learn, grow, and establish meaningful social ties, *are* persons. Thus, the seemingly simple concept of “most benefit for the greatest number of persons” may not always mean precisely what one might think. While Singer represents only one arm of utilitarian philosophy today, he does clearly employ the use of its primary tenet “most benefit to most persons.”

A third contingent of bioethicists today employs a form of reasoning that utilizes four broad principles. These principles are 1) autonomy of the patient, client, or decision-maker, 2) beneficence, 3) non-maleficence, and 4) justice. This approach has been labeled “Principlism.” Principlism has actually helped advance the discipline of clinical bioethical decision-making a great deal, but has, nonetheless, some obvious drawbacks. These principles are not always easy to apply. The complexities of a given dilemma may not easily be captured in these four principles. Over time other major schools have arisen, including casuistry (deciding each complex case by the particular merits of the case), virtue-based ethics (trusting in the virtue of the given decision-maker), and others.

I believe that we as Christians should always refer back to our four guideposts: Scripture, Reason, Experience and Tradition. As Christians entering the public bioethics debate, no one can stop us from using these guides as we formulate our positions. However, as we engage our world we must anticipate that they will roundly reject Scripture as a basis for authority and will scoff at our religious Experiences and Traditions. We must therefore be able to articulate reasoned, essentially religion-neutral arguments if we hope to persuade persons antagonistic to our faith. Paul said that we must use various means to win sinners to Christ. While we must never abandon our guides in forming our position, we may need to create our public discourse based more on reasonable tenets that will immediately have purchasing power in the secular arena.

What does the Bible say about making bioethical decisions? Let's look and see.

Scripture and Discussion Questions

Genesis 1:1

John 1:1

Genesis 11:1-8

Romans 3:10-12

Psalm 37:5,6

Proverbs 2:6

- 1) Genesis 1 and 2 talk about God creating the earth. Does this have any bearing on our bioethical thinking and discussions today? Does evolutionary theory (Darwinism), which is primarily a biological theory have any bearing on the philosophical theory of relativism?
- 2) John 1 begins the whole story with God in Christ, followed by creation. What kind of statement does this make about humanism? Pantheism?
- 3) What is Genesis 11 really talking about? Is this important today? This is a difficult passage to understand, but some people believe that humans were attempting to "play God" in this passage. Are we "playing God" when we get involved in genetic engineering, for instance?
- 4) Many people speak about the basic goodness of humankind. What does the Holy Spirit, through Paul, say about this? (We live in a fallen world.)
- 5) Psalm 37 discusses truly committing our way to God. How might this passage effect the way that you carry forth bioethical discourse?
- 6) Think about Proverbs 2:6. If a person begins his or her thought process with the presupposition that there is no god, how will this effect their thinking, and the answers they get?
- 7) Scripture tells us that our right hand should not know the good deed that our left hand is doing. Does this apply to public charities (should you refuse to have your name listed as a benefactor for the community theater?) or gifts to Christian organizations?
- 8) What principles does scripture give us on "affirmative action"? Might godly believers end up on both sides of this question?
- 9) Is socialism Biblical? Defend your answer from scripture.
- 10) Is the concept of "separation of church and state" a Biblical pattern?
- 11) Is there any scriptural warrant for the concept of a "right to die"?

Comments

- 1) Some Christians feel that giving to organizations like United Way, which includes groups like Planned Parenthood, is evil. Others feel that if Christians abandon philanthropic efforts of a secular nature they are failing to engage society, and that if so, society is right in condemning us. This controversy might be worth exploring.

- 2) We should be good stewards of all that we are or have: time, energy and money. Explore how this statement applies to the study of bioethics.
- 3) Challenge your group to become more informed voters. Discuss the importance or possible shortcomings of political groups that print up candidate “report cards”.
- 4) Some environmental groups base much of their action on a pantheistic “world view”. People for the Ethical Treatment of Animals believe that the worth of any given animal is equal to that of any given human. This is not a scriptural pattern.
- 5) Martha Jenkins’s position is relativistic, humanistic, and post-modern. These terms are worth exploring with your group.
- 6) Many Christians say that they base their decisions on scripture, but when we closely examine their decisions, we discover they are often based on potential consequences. This is a type of utilitarianism. This whole issue is worth exploring.
- 7) Justice means different things to different people. To many in emerging nations and in less affluent segments of American society it refers to distribution of land and material goods.
- 8) Some Christians feel that if we abandon a prophetic role in proclaiming that God’s word as the basis for our decision-making that we are denying God. Others feel that it is our duty to reach anyone by any ethical means. Godly people may end up in either camp. Discuss historical examples from each camp.

PRAYER REQUESTS: As you close today’s lesson together, pray that God will help you realize the many times that you are, in fact, doing bioethics. Pray that God will give you wisdom to recognize the dilemmas as ethical, and that you will have the humility to continually seek God’s wisdom and knowledge in difficult decisions.

For Further Reading:

Robert Audi and Nicholas Wolterstorff, *Religion in the Public Square—The Place of Religious Convictions in Political Debate* (New York: Rowman and Littlefield Publishers, 1997). These two highly respected philosophers, while both coming from Christian roots, offer surprisingly different perspectives on where religious convictions and discourse belong in the political arena. If you wish to prayerfully reflect on your personal role in the public dialogue, this book will provide valuable food for thought.

Charles Colson and Nancy Pearcey, in *How Now Shall we Live?* (Wheaton, Illinois: Tyndale House Publishers, 1999), offer many vivid examples of Christians engaging the secular world, without the use of peculiarly Christian rhetoric in the debate. One of the primary tools Colson encourages us to use is the appeal to Natural Law. Colson, founding director of Prison Ministries and author of several best-selling books says that he considers this his “magnum opus.”

C. S. Lewis, in *Mere Christianity* (London, England: Simon and Schuster, 1952), offers perhaps one of the best examples of this century of tightly-reasoned, logical, persuasive arguments for the existence of God and his work in the lives of human beings. In their original form, the chapters of these three brief books in one volume were aired between

1943-45 over British radio. The original title of this combined work, as published in England, was *Broadcast Talks*.

G. K. Chesterton, in *Saint Thomas Aquinas "The Dumb Ox"* (New York, New York: an Image Book, by Doubleday, 1933), explores the life and thought of a great Roman Catholic thinker and leader who brought the concept of Natural Law to life in the Catholic church. Aquinas knew more scripture than almost anyone of his day, but solidly argued that God and the eternal truths of scripture can be proven through reason, apart from the use of Scripture. Martin Luther, a few years later, reportedly burned Aquinas's works in public.

Nicholas Wolterstorff, *Reason Within the Bounds of Religion* (Grand Rapids, Michigan: Eerdmans Publishing Company, 1984) addresses mainly the two concepts of Reason and Religion. A careful reading of this work, however, reveals that his concept of Religion includes Scripture, Tradition and Experience. Thus, while a firm believer in the power of Reason, he relegates it to a position bounded by the other three elements of Wesley's quadrilateral.

Donald A. D. Thorsen, *The Wesleyan Quadrilateral* (Indianapolis, Indiana: Light and Life Communications, 1997). Dr. Thorsen, of Azusa Pacific University, offers an excellent treatment of the four sides of the quadrilateral. Most Christians are aware of the essential elements contained in the areas of Scripture, Reason, and Tradition. This work has an illuminating review of Wesley's thoughts on Experience including "introspection, self-analysis, private conscious states and other means." While a firm believer in faith's reliance on both "evidence of religious experience...and not ...reason alone" he seemed to fear the overvaluation of feelings, mysticism and "enthusiasm." While the entire book is worth reading, his chapter on Experience is particularly worth exploring.

Chapter Three

Abortion and Our Response

As Lydia Hsu walked to her car in the darkened parking lot she had a vague uneasiness. She should have waited for the security guard escort, but if she had she undoubtedly would have been late for her meeting at the Garden Club. Hastily she unlocked the door, yanked the car door open, jumped in and was trying to shove the key in the ignition when a hand from the back seat covered her mouth and jerked her head viciously into the head rest. “One sound out of you, and you are dead”, he said.

The next ten minutes would be seared into her brain forever. With a knife at her throat, he sexually assaulted her in the back seat of the car, beat her savagely, and left her for dead.

When she finally came to her senses she drove herself to the nearest Emergency Room. Over the next few weeks the physical wounds would heal. The emotional healing would take much longer. The nightmare continued. Four weeks after the assault, the clinic confirmed her worst fears. She was pregnant.

Surely God wouldn't demand that she carry this criminal's spawn to term. The rape was terrible enough, but there was no way she could endure the pregnancy. Her mind was numb but her heart felt untold anguish as she drove herself to the abortion clinic.

Gary and Karen Goldberg were ecstatic. After four years of marriage, Karen was pregnant. Gary would finish law school in six months. The timing could not have been better. Karen had always wanted a big family, but they had delayed till Gary would have a regular paying job.

After her third prenatal visit Dr. Abrams called her at home. Could she and Gary come to the office tomorrow at three to review her recent test results? He would explain everything then.

Over the next few weeks ultrasound tests confirmed what the blood tests had suggested. Their baby, if allowed to come to term, would have severe neural tube defects. In layman's terms the child would have an open spinal cord, hydrocephalus, mental retardation and probably never walk in a normal manner. The burden that this child would experience, and the pain the family would suffer would be unbearable. The best thing would be to have an abortion. Dr. Abrams gave them the names of two competent gynecologists. It would be best for everyone.

Tom Frasier would never hurt anyone. He was not the kind to picket abortion clinics. He felt saddened by the violence against abortion providers. But he adamantly believed that abortion under any circumstance was wrong.

Sally Jay was stunning. She had a vibrant personality, great looks, and was smart as a whip, to boot. Within a week of her first Sunday at church, she and Tom had spent three evenings together.

Things progressed rapidly, and Tom thanked God that he had sent him this angelic woman as a friend and potential wife. He thought about Sally constantly, and dreamed of their life together, perhaps serving God overseas as missionaries.

When Tom proposed to Sally, she cried tears of joy and hugged him tightly to herself. “Oh Tom,” she exclaimed! “I love you so much I could burst! But there is so much about me you still don’t know...”

The next few minutes changed everything for Tom. Sally? An abortion? As Sally poured out the story of her life before Christ, Tom felt heartsick. How could he ever forgive her? Why had God allowed him to fall in love with a woman who had killed her own baby, a woman he could never marry?

Two watershed Supreme Court cases in 1973 changed abortion from a criminal act to a right protected by the constitution. The more famous case was *Roe v. Wade*. Norma McCovey claimed she had been raped (a statement she later revealed was a pure concoction), and was pregnant. Texas law at that time allowed abortion only to save the mother’s life. Her suit, decided at the Supreme Court, established that a woman had an unquestioned right to an abortion during the first trimester, and after that, with possible restrictions by the state.

Doe v. Bolton, decided the same day, blew the cracked door wide open. Essentially, the court ruled that whenever the “life and health” of the mother was in danger, abortion was legal. And, they broadly defined “health” to include emotional health, undue worry, stress or hardship. With these two decisions, abortion essentially became legal, on demand, for almost any reason, throughout the whole United States. Since that time over thirty million abortions have been performed in the U. S.

A number of court cases followed over the years, alternately restricting or liberalizing abortion parameters. State legislatures have mandated minor guideline changes on a state-by-state basis, but the broad general protection of abortion on demand has been upheld many times.

Thousands of books, articles, laws, and opinions have been published on abortion since *Roe* and *Doe*. Many have taken a fairly firm “Life begins at conception”, pro-life stance. [This is where I believe Scripture directs us.] Others, Christians and non-Christians, have worked hard to “keep abortion legal”, and protect women’s “right to choose”. Even among conservatives, however, many find cause to consider particular exceptions.

What about the fetus conceived by incest? What of the woman impregnated through rape? Are there not some legitimate instances when the life and health of the woman should receive preference to that of the fetus? What about children who are doomed to severely limited and painful lives? Is there no place for consideration of the quality of life of the fetus/baby and the mother?

The Roman Catholic Church has stood firmly as one of the staunchest proponents of the “life begins at conception” point of view. Many main line protestant denominations, on the other hand, have taken pro-choice positions. How can Christians come to such divergent opinions, and what does the Bible say about this?

The word “abortion” is never used in the Bible. In fact, the specific concept as used in this century is never discussed. There are underlying Bible principles, however, that do help us begin to frame our thoughts. Let’s look at them together.

Scripture and Discussion Questions

Exodus 20:13
Jeremiah 1:5
Isaiah 49:1
Psalm 139:13-16
Psalm 51:5
Luke 7:36-50
John 4:7-26
John 8:1-11

- 1) Look at the first three references above. Does this make a compelling argument against abortion? Why or why not?
- 2) Read the Psalm 139 passage. What does this tell you about the beginning of life? Does this make things clearer or more confusing for you?
- 3) Jesus went out of his ways to get to know and show love to sinners. As you read the Luke passage, above, imagine the sinful woman as a woman who has had an abortion, or more powerfully, imagine her as a doctor who performs abortions. Do you sometimes find yourself feeling judgmental and angry with the sinners, as opposed to the sins? How can you love the sinner, but hate the sin of abortion?
- 4) Jesus again is reaching to a sinful woman in John 4. Many Christians find it easy to feel moved for the dying babies, and rightly so, but do you feel moved for the women who are contemplating an abortion or who have had an abortion? Are you involved in helping the women who have had abortions?
- 5) How many victims are there in an abortion?
- 6) John 8:1-11 describes a poignant scene. Does this have any bearing on the abortion debate?
- 7) What other scriptural passages do you think of that need to be considered here?
- 8) God has not only given us 1) Scripture, but 2) the Holy Spirit, included under the heading of Experience, 3) Tradition, including the creeds and counsel of other believers, and 4) Reason to decide difficult issues. Do any of these other sources of wisdom help you in addressing abortion?
- 9) Is autonomy a Biblical concept? Why do Americans value it so highly? Is this true of people from every part of the world? We must be careful to not confuse American cultural values with scriptural principles. They are not always the same.
- 10) The Tom and Sally vignette is aimed at our self-righteousness. A corollary Biblical passage is that of the prodigal son and his self-righteous brother. As you read the parable of the prodigal, do you identify with him or his older brother?
- 11) Does your church sponsor participants in Walk for Life or other fund- and consciousness-raising events to aid centers for young pregnant women?

Comments

- 1) The first vignette is intentionally graphic. While I certainly do not advocate abortion I wanted everyone to feel the pain of this victim, and perhaps have a little more empathy for her in making this terrible choice.
- 2) Many rape victims feel ashamed and alone. Note that no mention is made of Lydia's discussing her crisis with anyone. As there are many victims of an abortion, there are also many victims of a rape.
- 3) The doctor tells Joe and Ellen that the pain the family would face "would be unbearable". This is a value judgment. God will never ask us to bear a burden too heavy for us. On the other hand, if our brother or sister is in pain and we don't help them bear their burden then we are part of that burden.
- 4) Dr. Abrams is fairly directive. Most Americans prefer their doctors to be less assertive. These dissenters are often asserting their own desire for autonomy. This may be an important good, or may be essentially selfish, depending on motivation.
- 5) In armed conflicts throughout the ages, conquerors have raped women. Women who have been raped are then often treated as "damaged goods". We may find this abominable, yet we do the same thing when we stereotype people based on their former life styles?
- 6) Scripture is very clear regarding murder, but is not as clear regarding some of the possible exceptions to the abortion rule. It is important to be clear on issues where you believe God has given you convictions, but it is also important to be open to the possibility that other Godly people may feel led in different ways.
- 7) Many Christians correctly fight abortion as evil destruction of life. This chapter is not meant to downgrade this effort. But, we can address abortion in a number of other Godly ways: mentoring programs for young girls and young boys, post-abortion counseling, adoption efforts, Christian pregnancy centers, and in-home care for pregnant women to name a few.
- 8) One church planted hundreds of small white crosses on its front lawn to commemorate the anniversary of Roe v. Wade. This gets back to the earlier discussion about being the voice of the prophet versus "all things to all men, so that we might win some". Discuss the role of confrontation in social redemption.

PRAYER REQUESTS: As you close today's lesson, pray that God will always help you to love sinners even as you hate sin. Pray that God will give you wisdom as you think about significant ways that you can impact your world for Christ when you are faced with the many complicated issues surrounding abortion.

For Further Reading:

Francis J. Beckwith, *Politically Correct Death—Answering Arguments for Abortion Rights* (Grand Rapids, Michigan: Baker Books, 1993.) Dr. Beckwith is an engaging author with a witty but well-reasoned style. He methodically answers major Abortion Rights arguments and then presents his own positive case for the Pro-Life position. He includes useful appendices including a list of arguments for abortion, followed by references from within the text in response.

J. P. Moreland and Scott B. Rae, *Body & Soul—Human Nature & The Crisis in Ethics* (Downer's Grove, Illinois: Intervarsity Press, 2000.) While this work is not as easily read as Rae's earlier book, *Moral Choices*, this will offer a deeper philosophical structure for the Christian ethical thinker. Chapter seven addresses abortion and its related topic, fetal research.

Harold O. J. Brown, *The Sensate Culture—Western Civilization Between Chaos and Transformation* (Dallas, Texas: Word Publishing, 1996). Dr. Brown looks reflectively at the twentieth century, and calls all Christians to renewed prayer and hope. In chapter ten he discusses the decline of medicine, and particularly its drift away from absolutes, including Hippocrates' oath against abortion.

John F. Kilner, Nigel M. de S. Cameron, and David L. Schiedermayer, eds., *Bioethics and the Future of Medicine—a Christian Appraisal* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1995). In this collection of enlightening essays, Part III has five essays covering the post-abortion syndrome, abortifacient vaccines, legal arguments regarding autonomy, and Biblical and moral thoughts on abortion.

Francis J. Beckwith and Gregory Koukl, *Relativism—Feet Firmly Planted in Mid-Air* (Grand Rapids, Michigan: Baker Books, 1998). This book, dedicated to the impact that relativism has on present day thought, is both easily read and informative. Chapter thirteen focuses particularly on how relativism impacts bioethical decision-making, particularly abortion and euthanasia.

Scott B. Rae and Paul M. Cox, *Bioethics—A Christian Approach in a Pluralistic Age* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1999). Offers a solid Biblical foundation for bioethical thinking. Chapter four, "The Image of God and the Sacredness of Human Life" focuses on abortion and its flip-side, euthanasia.

Infertility and Assisted Reproduction

Thomas and Betty Muldoon were heartbroken. After eight years of marriage and high hopes for a large, loving family, the Muldoons were still childless. Six pregnancies were followed by six miscarriages. And then the bleeding began. A tumor the size of a grapefruit was removed from Betty's uterus. In the process, however, Betty ended up receiving a complete hysterectomy, leaving only her ovaries. Now they never would have children together.

But wait—an opportunity to make everything right again had been dropped into their laps. Betty's favorite cousin, Kim, had offered them the chance of a life-time. Using Tom's sperm and Betty's hyperovulated eggs, fertilization could be achieved in a petri dish. The six to eight embryos could be quick-frozen, and stored in the lab. Then two or three of the embryos could be implanted, at just the right time of the cycle, in Kim's uterus. The fetuses would grow, and later on, if more than one was viable, the extra fetus(es) would be removed. The remaining healthy fetus would grow to term in Kim's body, and then would be given back to the Muldoons at delivery.

What a great opportunity to realize our dreams, thought Betty, and how relatively simple. How sweet Kim was to offer her help in this way. "Let's do it!" she urged Tom.

In the Easy Life Fertility Clinic the freezers were becoming full. Todd Jenkins's job as lab supervisor was to find a way to store more frozen embryos without raising clinic overhead. As he began sorting through the stacks of records, he was surprised to note how long some of the embryos had been in their custody.

Letters, phone calls, emails, telegrams, and even personal ads in the city newspapers failed to locate many of the "parents". Not to worry; the laboratory service agreement contracts were quite explicit. Unclaimed embryos with rental fees more than two months post-due were to be disposed of at the discretion of the clinic.

Todd looked up the telephone number for the local crematorium. Business was business, and there was just no more room. Tomorrow he would ship out the oldest thousand embryos for incineration. With more coming in everyday, freezer space was at a premium.

Duchenne Muscular Dystrophy is an X-linked recessive inherited disease. Joni Reinhard had watched her two brothers die before the age of twenty-five. Genetic testing performed on Joni showed that Joni was a carrier of the gene marker.

The doctor described a technique whereby the DMD status of the fetus could be determined by ten weeks gestational age. Thus, if the fetus was positive for the abnormal gene, Joni could choose to abort, and not bring a Duchenne baby boy into the world. But Joni was ambivalent about abortion. Wasn't there some other simpler way?

Yes, the doctor explained. Dick Reinhard's sperm, obtained either by masturbation, or captured in a condom during intercourse, could be centrifuged. Using a special technique, the sperm with his X chromosomes could be separated from those with his Y chromosomes. His Y sperm could all be discarded, and only his Xs retained. These

X chromosome sperm, artificially inseminated into Joni, fertilizing her eggs would produce only girls, who could be carriers but not Duchenne children.

Thus, no one gets hurt, no fertilized eggs are discarded, and no child will have to suffer with Duchenne Dystrophy.

In the last twenty years or so, reproductive medical science has made astounding leaps forward. Some of these advances have been primarily medical interventions, such as improved care for mothers with diabetes, hypertension, and primary ovulatory failure. But many of the advances involve what might be labeled “reproductive technologies”. These include: 1) artificial insemination from husband or donor, 2) ova donation, 3) transfer techniques where eggs are placed with sperm inside or outside the body, grown briefly and then assisted to implant, 4) cloning—thus far (March, 2001), successful only in animals, 5) surrogate motherhood, and 6) prenatal genetic screening. Each of these areas would further include several variations on each of these themes. (See reference.)

Historically, Protestant churches have had little to say about any of this. The Roman Catholic Church, on the other hand, has had a great deal to say. The Catholic Church has based much of their teaching on “natural law”, which is law based on careful observation and reflection on creation, as opposed to revealed law, seen in scripture. Thomas Aquinas, an influential natural law thinker, summarized this position relative to procreation by stating that every individual marital sexual act must be open to the idea of creating new life. This, then, would forbid any form of contraception.

In 1968, Pope Paul VI clarified this in *Humanae Vitae: On the Regulation of Birth*, an official Vatican encyclical. In 1987, “*Instruction of Respect for Human Life in Its Origin and on the Dignity of Procreation*,” further clarified the Vatican position. Any form of sexual expression that separated the sexual union of the couple from the direct possibility of pregnancy was to be shunned.

To illustrate, any form of permanent sterilization would be sinful, as would any form of contraception, including the use of condoms—even if the aim was to capture sperm for fertilization. (Some Catholics fulfill the letter of the law by using a condom with a tiny pinhole in it. This technically meets the Pope’s dictum.) Sperm or egg donation would be sinful. Surrogate motherhood was forbidden, as was cloning and any type of prenatal genetic testing. There is some controversy as to whether all forms of transfer would be wrong, but all agree there would be very limited, if any, place for this.

Even within the Catholic Church, however, many feel that these parameters are too strict. Certainly within Protestant Christianity, the idea that all sexual activity must be open to creating new life is not held to be true. While Protestants in general revere the processes of procreation and sexual marital union, few would claim that the two processes must always be linked.

Most conservative Protestants agree on the Christian’s right, and perhaps even obligation to plan one’s family. Permanent sterilization is a non-issue for most Protestants. Many would condone artificial insemination with husband’s sperm, or manipulations involving the couple’s own eggs and own sperm. The use of donor sperm or donor eggs is more controversial. Surrogate motherhood would be deemed highly problematic and general unacceptable.

Surrogate motherhood may include use of the surrogate's eggs and uterus, or solely her uterus. In the case of the former, one can easily see how she might come to see herself as the true mother, and be unwilling or unable to give the child back to the biological father and his wife. Even in the case of the latter, when a woman carries a live human in her body for nine months, regardless of where the genes come from, it may be extremely hard to surrender the child on delivery. A number of ugly lawsuits have resulted from surrogate arrangements, and most states now have laws that prohibit or strictly regulate this process.

What does the Bible say about assisted reproduction? Let's look and see.

Scripture and Discussion Questions

Genesis 1:27,28

Genesis 2:24

Matthew 19:3-9

Deuteronomy 25:5-10

Genesis 16:1-4a

1 Samuel 1:3-10, 27, 28

Luke 1:5-25

- 1) Some have quoted Genesis 1:27 as a command to all Christians today to have as many children as possible. What does this passage say to you?
- 2) Genesis 2:24 says that a man will leave his family to start a new one. This was generally not the pattern of family life in the Middle East. Do you see this as relevant to today? Please elaborate. Does this verse apply to this lesson?
- 3) Jesus quotes Genesis in Matthew 19, and then explains this more completely. How does the Genesis passage or Christ's explanation bear on today's discussion?
- 4) Deuteronomy 25 describes a concept called Levirate marriage. Does this concept have any bearing on today's discussion? Why or why not? Do Old Testament laws have any purpose for our lives today? (Note: there was no form of Social Security in Israel and many scholars feel that this was a way of protecting the widow from destitution.)
- 5) Genesis 16 relates a story about a common practice of that day. Genesis 30 relates a similar story. What do you think about these events, and should we use these passages as templates for relationships today? Why or Why not?
- 6) Hannah suffered the pain of childlessness. God chose to answer her prayers. Are we to make promises to God to manipulate him into giving us what we want? Is this an example of how we should act? If not, why did God answer her prayers? Why does he choose not to answer the prayers of many other childless couples?
- 7) Luke 1 tells Elizabeth's story. She says that God has "taken away her disgrace" of childlessness. Is this a disgrace? Do we treat this as if it was a disgrace? How can we be more sensitive to those around us who may be feeling as if they are disgraced?
- 8) Can you think of other scriptures that would guide your thoughts and actions through this complex discussion? Traditions? Experience?

- 9) How is the destruction of fertilized zygotes any different than extermination of Jews and Gypsies in Nazi Germany?
- 10) Does the concept of polygamy have any bearing on discussion of infertility and assisted reproduction? Does the Bible speak against polygamy?
- 11) If you knew that your family carried a recessive trait for a potentially painful, disability syndrome, would you feel morally obligated to not conceive children? Discuss and role-play.

Comments

- 1) “Selective reduction” is a euphemism for the abortion of the extra fetuses in utero, whose continued existence might decrease the likelihood that the chosen fetus would survive and flourish. The term “selective reduction” sounds benign, but is clearly another form of abortion. Terminology is important in framing our thoughts.
- 2) Many quick-frozen fertilized embryos exist throughout the world in fertility clinics. Dr. James Dobson has aired several radio shows emphasizing the plight of the stranded embryos. The Center of Bioethics and Human Dignity and other groups have issued a call to prevent the creation of more fertilized zygotes. (This could be a full day’s discussion all by itself.)
- 3) The name “Easy Life Fertility Clinic” is used to remind readers that infertility is a source of untold hidden pain and suffering throughout America and the world. Research efforts to relieve this problem, however, may result in death and destruction of fertilized embryos. Discuss an appropriate Christian response to these two tough issues.
- 4) The Catholic Church, historically, has decried any separation of the sexual act from the possibility of procreation. Thus, even the act of masturbation to obtain sperm for in-vitro fertilization would be deemed wrong, as would the use of a standard condom, even when used by a married couple.
- 5) Contraceptive options have moral implications. Discuss the most commonly used options and their bioethical implications. You may need to obtain assistance from a Christian physician or scientist to facilitate this discussion.
- 6) A number of bizarre legal cases have arisen from surrogate litigation. See if you can find some examples to bring to class from articles at your local library or from off the internet.
- 7) If you have time, role-play a surrogate agreement, and see if you can capture all the possible emotions the surrogate mother, the legal mother and the legal father might feel.
- 8) In today’s first vignette, Betty thought that Kim’s offer was sweet and relatively simple. These types of arrangements are never simple, and the long-term ramifications of this arrangement might be even more complicated by keeping it within the family.

PRAYER REQUESTS: As you close today’s lesson together, pray that God will help you to be more sensitive to the pain of the childless in your midst. Pray that God will give you wisdom to address these tough issues, and the love and humility to support persons, if not

their acts, who may interpret scriptural principles differently that you do where scripture does not clarify God's will completely.

For Further Reading:

Much of the information for this lesson comes from Scott B. Rae, *Brave New Families—Biblical Ethics and Reproductive Technologies* (Grand Rapids, Michigan: Baker Books, 1996). Dr. Rae scores again with a readable, informative text—this one dedicated to reproductive ethics.

John F. Kilner, Paige C. Cunningham, and W. David Hager, eds., *The Reproduction Revolution—A Christian Appraisal of Sexuality, Reproductive Technologies, and the Family* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2000). This is a delightful collection of essays focusing on foundational issues, specific technologies and difficult bioethical cases from a Christian perspective. Chapters five through eight specifically address technologies and will prove helpful to group leaders looking for a more in-depth coverage of this week's topics.

Gary P. Stewart, D. Min., William R. Cutrer, M.D., Timothy J. Demy, Th.D., Donal P. O'Mathuna, Ph.D., Paige C. Cunningham, J.D., John F. Kilner, Ph.D., and Linda K. Bevington, M.A. *Basic Questions on Sexuality and Reproductive Technology—When is it Right to Intervene?* (Grand Rapids, Michigan: Kregel Publications, 1998). This is another of the BioBasics Series, produced by The Center for Bioethics and Human Dignity, in Bannockburn, Illinois. An easy evening's reading, this booklet gives one a quick overview of a complicated field.

Robert D. Orr, MD, A Clinical Ethics Perspective on Assisted Reproductive Technology, *Ethics and Medicine—An International Christian Perspective on Bioethics*, (2000) 16: 2, 51-54. Dr. Orr, of Loma Linda University Medical School, offers a concise Christian look at Assisted Reproductive Technology.

Ronald Munson, *Intervention and Reflection—Basic Issues in Medical Ethics*, 5th ed., (New York: Wadsworth Publishing Company, 1996). Chapter eight provides a secular look at in vitro fertilization, artificial insemination, and surrogate pregnancy. Dr. Munson tells his stories through interesting historic case presentations, selected readings and decision scenarios.

Stephen E. Lammers and Allen Verhey, eds., *On Moral Medicine—Theological Perspectives in Medical Ethics*, 2d ed., (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1998). Chapter eleven, "Technological Reproduction," offers six essays on this complicated topic.

Chapter Five

Genetics Dilemmas

Juan Ramirez met Angelica Ruiz at the Spanish House on the campus of a major mid-western university. He was drawn to her instantly, and soon they were planning marriage. Juan had grown up in Chicago, and Angelica in Gurnee, Illinois. Juan's family had originally come from Puerto Rico, and Angie's from Lake Maracaibo in Venezuela. Juan had always dreamed of a large family. As he and Angelica began discussing their hopes and dreams, however, Juan got a big surprise.

Several of Angelica's relatives had died from Huntington's Disease. HD is an autosomal dominant disease that has no effective treatment. It begins in one's late thirties or early forties with peculiar behaviors and limb movements and proceeds through a progressive dementing process and worsening bizarre limb movements to inevitable death after fifteen to twenty years. She did not know if she was a carrier for HD. If she was, it was only a matter of time till she was affected, and she had a fifty per cent chance of passing this illness on to each of her children.

Juan did not know what to think. As he checked the HD website on the internet that night, he learned more. There now was a DNA blood test that could prove long before any symptoms occurred if a person had Huntington's. All they had to do was obtain the appropriate testing, and they would know if Angie had HD. If she didn't they could happily proceed with their wedding plans. If she was positive, however, Juan was shocked at what he read next. 10-12% of all HD victims kill themselves, and 30% of those at risk, in one study, said they would kill themselves if they discovered they had the disease. Did Juan really want to have to deal with these problems? Perhaps he was wisest just to break it off with Angelica and walk away before he got in any deeper.

Michelle McKenzie's mother and grandmother and two of her maternal aunts all had had breast cancer. She always knew she carried a higher risk than most women for this disease. Now she sat in her internist's office. Dr. Healy was completing her yearly physical examination, and as she reviewed Michelle's chart her brows were furrowed.

"Most of your lab tests are completely normal," she said. "Your physical exam, Pap smear, and mammogram are also just fine. There is one other test that we could order, though, and we probably should talk about it. A new genetic marker test has come out for breast cancer risk. If you test positive for BRCA1 on Chromosome 17, we will confirm your much higher risk of breast cancer, and will be fore-warned to follow your mammograms and breast exams that much closer."

"Unfortunately, there is a down side. Should you ever need to change insurance carriers, they will know that you tested positive for BRCA1 and they might deny you health coverage for breast disease."

"That sounds unconscionable! That's immoral! Can they do that?" stammered Michelle.

"I can't say that they would," said Dr. Healy, "but stranger things have happened."

At the age of 42, Jennifer Talwin was caught completely by surprise. As a mother of three, with the youngest age 12, Jennifer had certainly not planned on becoming pregnant. After David's chemotherapy, the doctor had told them that there was little to no chance of her becoming pregnant again, so she had never obtained the tubal ligation that she had previously planned on getting. Now at her obstetrician's office, she had more unusual news to process.

"We will follow your pregnancy closely," said Dr. Nguyen, "and of course we will get serial alpha-fetoproteins and ultrasounds. That way, if your baby turns out to have Down Syndrome, we could electively terminate."

The words slowly sunk in. "You're talking about killing my baby, aren't you," whispered Jennifer. "I thought you were a Christian."

"I am a Christian, certainly," said Dr. Nguyen. "And that is exactly why I offer you this option. This was all a mistake, and modern science has provided us a way to ensure that you and your dying husband are not saddled with the added pain of dealing with a child who has an incurable illness. Genetic testing is a gift from God. Please let me help you in this way."

In 1988 the National Research Council endorsed a mind-boggling research project that had been discussed for several years. The Human Genome Project is an ambitious plan to map out the entire human DNA blueprint. This project is spread over nine major research centers, will probably cost upwards of \$5 billion, and was originally projected to take close to 20 years to complete. During this same time period, a parallel project, privately funded, is taking place in England under the direction of J. Craig Venter. In June 2000, Dr. Francis S. Collins, an avowed Christian and Human Genome project director, along with Dr. Venter announced the essential completion of this monumental undertaking. (Continued research is ongoing.)

The benefits of these two projects are hard to fully fathom. Foremost in most people's minds, however, is that we will soon gain a vastly improved understanding of genetically inherited diseases. With this understanding we could prevent and treat many diseases that currently are unpredictable, inescapable and untreatable. This could completely alter the way we do medicine.

So what is the cause for concern? There actually are a number of concerns:

- 1) Could this information be used to discriminate against those who have serious diseases in their gene pool?
- 2) Who would be responsible for maintaining confidentiality regarding this sensitive information?
- 3) Would the information provided cause some people to give up on life before their lives were over based on the negative predictions inherent in their genes?
- 4) Would knowledge of future risks relegate some people to lower class status, opportunities and perhaps health care? Who would want to pour scarce monies into funding the education of people who are not destined to learn much?
- 5) If important decisions are going to be based on this blueprint, what are the false positive and false negative confidence intervals for the test results?
- 6) Even if the testing is absolutely correct, many diseases are caused by a combination of genetic and environmental factors. These cannot always be controlled for. Thus, important decisions might be made based on very incomplete information.

- 7) Even if one has the most gifted gene pool in the universe, doesn't the free will and personality of the person in question often play the decisive role in achievement? Don't we all know people with little natural talent, who through sheer effort and determination have accomplished great things?

Throughout history pessimists have warned that different technological advances would create various foreseen and unforeseen dire consequences. "If God wanted us to fly he would have given us wings. We'll be burnt up if we fly into the air." "If God had wanted us to ride automobiles, why did he give us horses? Those loud new machines will spook all the livestock." The unknown effects of electricity were thought to cause cancer and dementia.

Yet, some technologies *have* caused previously unforeseen problems. Industrial pollution has killed many animals. DDT, an insecticide, helped almost bring about the extinction of several species of birds. The warm, unpolluted effluent from some factories caused the death of fish that lived best in colder waters. The dam built as part of the Tennessee Valley Authority nearly brought about the extinction of a species of darter fish.

Where will all the new genetics knowledge lead us? Only God knows for sure.

What does the Bible teach us about principles related to the genetics debates?

Scripture and Discussion Questions

Genesis 11:1-9

Genesis 30:31-43

Genesis 4:6-12

Leviticus 19:9, 10, 13-15, 33, 34

1 Kings 3:3-14; 11:31-34

John 3:16

- 1) Genesis 11 discusses the Tower of Babel. Does this have any bearing on the discussion of genetics today? What was the sin of the people at the tower? Think together, again, about the concept of "playing God".
- 2) Jacob, the schemer, relied on some interesting genetic principles in this passage. Is there any basis for his theories? If not, why did Jacob's flock increase?
- 3) How can we know if we should embrace a given evolving technology? Are there any biblical guidelines for discerning this?
- 4) Cain had an unmatched genetic make-up. All his genes came directly from Adam and Eve, the direct creations of God. Yet, he killed his brother Abel. Was the evil in Cain a product of his genes, his environment, or something else? Elaborate.
- 5) The passages in Leviticus, above, all deal with aspects of social welfare. God clearly has an interest in the welfare of all his people. Does this make you more or less interested in genetic intervention? List arguments for and against intervention, from scripture if possible.

- 6) Solomon, directly descended from David, “a man after God’s own heart”, received the best education money could buy. God also granted him the gift of unusual, profound wisdom. Yet, in 1 Kings 11 we see that these were not enough to keep him from ruining his life and destroying the combined Kingdom of Israel/Judah. To what do you attribute his demise? How does this affect our discussion?
- 7) John 3:16 seems to indicate that eternal life, the only ultimately meaningful possession, is unrelated to anything we could engineer genetically. Does this fact change your thoughts any on funding for genetic research? If you were a U. S. senator would this affect your resource allocation decisions?
- 8) Role-play Angelica and Juan’s vignette. Does Juan have an obligation to go ahead and marry Angelica? Does Angelica have an obligation to not bear children? Discuss as a group and defend your positions from scripture if possible.
- 9) Is a doctor who wants to practice good medicine morally culpable if he or she works for a managed-care organization? What are the potential conflicts of interest in working as a managed care doctor, versus those in working as a fee-for-service physician?
- 10) Should insurance companies be forced to pay for all the new genetic susceptibility testing? If not for all, then where should the line be drawn between covered and non-covered testing?
- 11) Some scientists refuse to carefully consider the ethical implications of their new research. Who should decide if scientific inquiry should be allowed to go forward in any given new direction?
- 12) If our bodies are to be temples for the Holy Spirit, is it immoral for a woman to have prophylactic mastectomies performed if she is at high risk for breast cancer?
- 13) Some HMOs set standards for frequency of mammograms that differ from American Cancer Society guidelines. If they claim that the ACS cannot prove the necessity of the more frequent breast screening is this good business, or is this immoral? Discuss.

Comments

- 1) Some Christian thinkers believe that all managed-care arrangements are inherently unethical, as they remove the patient’s physician from his or her primary role as patient advocate. Financial considerations for the whole group come into play. On the other hand, if a physician only considers the interests of the patient in front of them, there is the possibility that he or she may do things that are clearly not in the interest of society as a whole. This is not a simple issue. In the traditional fee-for-service model of medicine, the incentives are aligned to encourage more testing, more interventions, and more medication use.
- 2) Most Americans agree that medical costs are rocketing out of control, and that actions need to be taken to limit expensive forms of care. On the other hand, most Americans want the very best care available for their family. Discuss the obvious conflict inherent in these two statements.
- 3) The problem of medical-record confidentiality is vastly compounded by the use of electronic medical records. The federal government is enacting major legislation to protect patient confidentiality. These regulations will cost doctors and hospitals millions of dollars to implement.

- 4) Blacklisting patients for insurance for their medical problems seems immoral. Conversely, insurance companies are businesses and need to make a profit. If they do not raise the costs for people who are high risks, then low-risk individuals will pay more to pick up the difference. This is called cost-shifting, and is done all the time. Discuss fairness versus justice in this setting.
- 5) A major Christian publication profiled a woman who refused to have an abortion or to receive chemotherapy when she was pregnant and cancer was found in her body. Her choice to refuse abortion cost her her life. The tone of the article was that she was behaving in a Godly, principled fashion. It might be interesting for your group to discuss other Godly answers this couple might have come to.

PRAYER REQUESTS: As you close today's lesson together, pray that God will give you wisdom as you think about these difficult questions. Pray that God will raise up Christian voices to enter this complicated debate, and that you will be "wise as serpents and innocent as doves" when it comes to thinking about, discussing, and voting on public policy issues that involve genetics.

For Further Reading:

Ronald Munson, *Intervention and Reflection—Basic Issues in Medical Ethics*, 5th ed., (New York: Wadsworth Publishing Company, 1996). Munson's text is used on a number of secular university campuses. It is not written from a Christian perspective. Nonetheless, for the inquiring Christian, this book is loaded with classic essays, case presentations and decision scenarios. It may stretch your horizons. Chapter seven is devoted to genetics, and includes four thought-provoking readings, and decision scenarios.

Between the time that I write this and the time that you use this material with your class, much will have been written on the Genome projects. Nonetheless, sometimes to best savor the flavor of a momentous event it is helpful to review its initial public announcements. For a nice concise overview of the DNA projects and an initial national newspaper account see: Tim Friend, "Genome projects complete sequence—Unraveling of DNA code is a blueprint for the future of medicine" *USA Today*, 23 June 2000, page 1.

Another example of an initial review is an article from Wire Services, "Researchers decipher riddle of human genome" *The Indianapolis Star*, 27 June 2000, page 1. Several related articles covering this monumental breakthrough accompany the lead article.

John F. Kilner, Rebecca D. Pentz, and Frank E. Young, ed., *Genetic Ethics—Do the Ends Justify the Genes?* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1997). A Horizon in Bioethics Series Book, produced through The Center for Bioethics and Human Dignity, this series of essays provides an extensive overview of bioethical concerns in genetics.

H. Richard Beresford, Chair, Genetics Testing Task Force, *Practice Parameter: Genetic Testing Alert—Statement of the Practice Committee Genetics Testing Task Force of the American Academy of Neurology*. *Neurology* 1996;47: 1343-1344. The American Academy of Neurology Practice Committee establishes ad hoc committees to speak to new and developing concerns in the practice of neurology.

American Medical Association, *Code of Medical Ethics—Current Opinions with Annotations*, (Chicago, Illinois: American Medical Association Press, 1996). This edition has separate topics of gene therapy, genetic counseling, genetic engineering, genetic screening and genetic testing a) by employers, b) by health insurers, and c) of children.

Chapter Six

Quality of Life vs. Sanctity of Life

Joe Brady was drunk the night he crashed his car at 80 mph into the large Oak tree in front of the high school. Now, ten days later, in the Intensive Care Unit at Bridgeport Memorial Hospital, he was still on the ventilator. He was not clinically brain dead. In a few more days he would be able to be weaned off the ventilator. He almost certainly would live. However, it was unlikely that he would ever leave the nursing home where he would soon be sent.

He had never completed advanced directives, and his family was all gone. Drs. Brown and Jenkins discussed what to do next.

“He certainly will have no quality of life in the nursing home, even if he does regain some ground,” said Dr. Brown. “I think that given the fact that he will have such a poor quality of life, we should take him off the ventilator today, allowing him to die peacefully. If we hesitate, and he goes into persistent vegetative state, we will all be sorry.”

“I agree,” said Dr. Jenkins. “Let’s just let him go peacefully.”

It was obvious that Melinda Tompkins was never going to smile, talk, or interact socially again. She required frequent turning, constant care, and thrice-daily tube feedings just to keep on breathing. Her eyes opened from time to time, but she did not look directly at faces or follow activities in the room. It had been six months since she was transferred to the long-term care facility, and she had never once said a word or obeyed any single command.

“She is just a burden on society,” said Lucinda Hardy, RN, to Debby Rak, the Health Care Tech. “Someone should put her out of her misery.”

“I don’t know,” said Debby. “She isn’t really in any pain, and I think we should let God decide when it's time for someone to die.”

“You and your religious nonsense. If you had to pay her bills yourself, I doubt that you would be so high-minded. Did you know it costs \$500/day to keep her in that bed? What a waste of tax-payer money.”

Tim Johnson had shot himself in the head with a pistol. At least that is probably what happened. No one had seen him do it, and he had not been particularly depressed. He lay now, in the Intensive Care Unit, clinically not brain dead, but never likely again to talk, walk, think, or eat on his own. His family members had converged on the hospital, and unanimously were demanding that he be removed from the ventilator.

He had not completed a Living Will, or Health Care Power of Attorney, and he was no in imminent danger of dying if he was carried safely through the next few days.

Were the doctors completely certain that Tim would never function independently? No one can be absolutely certain, but they felt quite confident of their predictions.

Given the poor quality of life that Tim would likely experience the family demanded discontinuation of all life-prolonging measures. After a bedside Ethics

Consultation the wishes of the family were acceded to. Five hours later, off the ventilator and blood pressure maintaining medications, Tim expired.

What is “quality of life”? This fairly nebulous term applies to situations in which decisions about withholding or withdrawing care are made based on the likely low levels of self-awareness, reasoning, communication and activity that the patient will have and the low probability of improvement. Quality of life decisions are usually not made by the person in question, but by their physicians, their families, or at times, the courts. Thus, there is inherently an element of uncertainty and guesswork involved. There are a number of reports of people who were seriously injured, made only limited recovery, but when they reached their final new baseline, seemed to be relatively happy. If they had been asked to predict what the response to their new life would be, families and doctors would have underestimated what the patients would rate their happiness and adjustment to be. Stated another way, the observers would think that the patients would have a low quality of life, but the patients themselves would rate their quality of life fairly high.

This concept may also be employed in health care rationing discussions. “After all, we shouldn’t waste any more money on this person because their quality of life will be so low, anyway.” Utilitarianism, with its goal of providing “the most good for the most number of people” would espouse this type of decision-making.

Another concern in thinking along these lines is: “Whose definition of quality do we use?” This was the way that Nazi Germany rationalized killing mentally ill and handicapped patients. They essentially maintained that the quality of life that these people led was not worth saving. It would be an act of mercy to kill them. Eventually, it became almost an obligation to the remainder of the Aryan race to dispose of these subhuman elements. Eventually the Nazis killed millions of Jews and Gypsies for similar reasons. These undesirables were polluting the overall quality of life for the great Aryan race.

“Sanctity of life” advocates usually find themselves on the opposite end of a choice/free will spectrum from quality of life proponents. Quality supporters usually also support abortion on demand and a patient’s “right to die.” Sanctity supporters usually seek to support the patient regardless of likely outcome. The extreme sanctity position is that everything possible must be done for every patient regardless of expense in time, money or personal sacrifice. This position is called “vitalism” (supporters are called vitalists), and very few Christian bioethicists would hold to this.

Even among sanctity of life advocates, for instance, many would support removing feeding tubes from patients in persistent vegetative state, if certain conditions apply. Scott Rae, in *Moral Choices*, see below, suggests that under certain conditions removal of the feeding tube is justifiable for a patient in persistent vegetative state. If 1) the patient cannot absorb nutrients, 2) feeding is a burden greater than a benefit, 3) there is no reasonable hope of benefit or 4) if written advance directives dictate, removal may be considered.

Finally, on a metaphysical level, what is the purpose of our lives? Is it only to be happy, or is it primarily to glorify God and serve him in whatever means he puts at our disposal? If we answer the former, then we are hedonists, humanists, or utilitarians. If we answer the latter, then we align ourselves with the great Christian creeds of the ages.

God is eternal and sacred, so his life is sacred. We are fallen creatures, and our time-locked lives are a gift from God. Our lives are sacred because God has made us in his image, sacred. The phrase “sanctity of life” reminds us that life is God’s precious gift and cannot be toyed with, or wasted. This gift of life that he has given others, likewise, cannot be exploited. God’s laws break down primarily into two commands: 1) to love God, and 2) to love others. This phrase is employed to emphasize the great respect that we are to show for all human life including the newly conceived up to the aged and infirm. No lack of intelligence, creativity, or beauty on the part of the humans in question should diminish the deep respect that we owe these persons simply because they are God’s creations, made in his image.

What does the Bible have to say about quality of life and sanctity of life? Let’s look and see.

Scripture and Discussion Questions

Job 2:9,10; 42:12-17
Psalm 22:1-8
Daniel 3:16-18
Matthew 5:3-12; 28:20
Mark 5:35-43
Luke 7:11-16
1 Corinthians 13:13
Philippians 1:19-25

- 1) What was Job’s quality of life after he lost everything? What became of Job?
- 2) Jesus had a poor quality of life in many ways, yet he brought salvation to the whole world through his suffering? Have you witnessed redemptive suffering?
- 3) Shadrach, Meshach, and Abednego placed their lives and their futures completely in God’s hands. He honored their faith. Have you been faced with a situation where you had to choose between trusting in the face of uncertainty or taking things into your own hands? Were you able to say: as in Daniel 3:18 that even if God did not choose to save you in the way you thought best that you would continue to serve him? How does any of this fit into the issue of quality of life?
- 4) What place do the beatitudes have to do in a quality of life discussion? What does Matthew 28:20 impinge on this discussion?
- 5) In Mark 5, Jesus chose to heal the little girl. He does not always choose to heal, and sometimes his chosen servants suffer the most, as Paul did. How can you trust a God who does not always answer your prayers in the way you see best? Perhaps a member of your class might share how God ministered to them through a situation where he did not answer prayer the way they would have liked.
- 6) When Jesus resurrected the widow’s son the people said, “God has come to help his people.” Relate an event where God did not immediately grant your prayer request, yet worked events out to his glory and your good. What does that have to do with quality of life or sanctity of life?

- 7) 1 Corinthians 13:13 ranks hope as one of the three cardinal virtues. We often expound on faith and love, but do not often talk about hope. Are you hopeful? What do you put your hope in? How is hope different than faith?
- 8) Philippians 1:19-25 was written from prison. What quality of life do you think that Paul had, by human standards? A wasted life? See also Acts 9:15,16.
- 9) The decision made in the Joe Brady vignette is made many times a day throughout this country. Is this wrong? Should doctors make these decisions at the bedside or should special committees be set up to deal with these questions? Are there other alternatives?
- 10) Do we as citizens have a right to make these complicated life maintenance issues based on financial concerns? Do we have a right to ignore financial concerns?
- 11) Some Christians never ask for God's healing for physical ailments. In other congregations if a person has any physical ailment it is felt to reflect a lack of faith on the person's part. What is the Biblical position on healing and miracles today? How will your answer to this question impact your position on strategic bioethical questions?

Comments

- 1) Medical futility, to be discussed further in chapter nine, has an important bearing on the finances of long-term care. If we could accurately predict when further intervention is truly futile, it would simplify decision-making. At present, this is not really possible.
- 2) Some Christian thinkers talk about the redemptive merit of suffering. God remains in control, and we remain in subjection to his will. This might prompt some animated discussion in your group.
- 3) The "quality of life" argument raises the specter of possible future "obligation to die". If one cannot demonstrate that one has a high quality of life (after a severe stroke, after severe burns or injuries, etc.) then perhaps one has the obligation to die so that valuable resources may be shifted to those who have a good life quality—or so the argument goes. I believe this is absolutely wrong.
- 4) The phrase "Imago Dei" implies that our worth is based on the fact that we are made in God's image, and that it is not based on our abilities, talents or potential. This runs directly counter to the basic tenets of utilitarianism.
- 5) Job is a complicated, fascinating book, and it underscores the fact that God does not always make his thoughts or intentions clear to us. Not knowing the exact reason something is happening often serves to either pull us toward God or push us away from Him, depending on our response to the uncertainty.
- 6) Some secular thinkers state that Faith and Reason are mutually exclusive. I would contend, however, that rationalists begin all their syllogisms with several steps of faith. These are: 1) that there really are some answers as to how the universe began, what is the meaning of life, etc., and 2) that their finite reasoning is capable of discerning those answers without the help of God.
- 7) Evolutionary theory impinges directly on the "Quality vs. Sanctity" discussion. "Natural selection" and "survival of the fittest" as applied to social evolution are

inherently anti-scriptural. The idea of a soul is unnecessary and insupportable in this model.

- 8) In almost every state at present, the Ethics Consultation carries no binding authority. Many consultations focus on intra-family communications or communications between the medical team and the family. In my experience, most consultations are not particularly dramatic or fascinating, but may be helpful in sorting out complicated situations.

PRAYER REQUESTS: As you close today's lesson together, pray that God will speak to you about the way that you are using your own life. Are you hoarding it to preserve your quality of life, or are you acknowledging your life as a gift from a holy God, and as a sacred trust? Pray that God will remind you frequently of his love and gifts to you.

For Further Reading:

Much of the background for this chapter comes from Dr. John F. Kilner, *Life on the Line—Ethics, Aging, Ending Patients' Lives, and Allocating Vital Resources* (Grand Rapids, Michigan: Eerdmans Publishing Company, 1992). Dr. Kilner is Director of The Center of Bioethics and Human Dignity, in Bannockburn, Illinois. A truly compassionate, Christian intellectual, he is an author whose works any Christian bioethicist should know well. His treatment of allocation of resources is exceptional.

Scott B. Rae, *Moral Choices—An Introduction to Ethics* (Grand Rapids, Michigan: Zondervan Publishing, 1995). See page 179 for a discussion of removing feeding tubes from patients in persistent vegetative states.

See chapter three in Paul Ramsey's *The Patient as Person* (New Haven, Connecticut: Yale University Press, 1970). Dr. Ramsey presents a thoughtful discussion on caring for the dying patient. This may be available through inter-library loan if your library does not carry this classic work.

Jean Bethke Elshtain, *Who Are We?—Critical Reflections and Hopeful Possibilities* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2000). Dr. Elshtain is a fascinatingly insightful social critic, with strong Christian roots, who is a professor at University of Chicago. In Chapter two she discusses a pervasive consumerist-commodifiable ideology in America. This has obvious implications in "quality of life" discussions.

James Dobson, *Solid Answers* (Wheaton, Illinois: Tyndale Publishers, 1998). Dr. James Dobson is revered in many Christian homes as "America's foremost family counselor." In this 575-page book, Dr. Dobson answers all manner of child-rearing, marriage, and general family questions. Chapter twenty-four is entitled "The Sanctity of Life."

Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed., (New York: Oxford University Press, 1994). To many secular bioethicists, this is

considered the “bible” of bioethical discourse. It contains numerous references to the “quality of life” discussion.

The Christian Response to AIDS

David Candy was a fantastic singer, pianist and composer. The Mt. Zion Missionary Baptist Church band, choir, and touring ensemble owed their existence and high quality of music to David and his unceasing efforts. David had a full-time job at the hospital, but he was also taking correspondence Bible study to become ordained in his church. His official title was Minister of Music.

But David had not always been such a model Christian. He had never used street drugs, but did go through a period, while serving in the military, where he was a fairly heavy binge drinker and was promiscuous sexually.

In his job as a nursing assistant, David had always been known as a hard worker. He always found work to do, even when it would have been easier to relax. Lately, however his supervising nurse noted that David complained frequently of not feeling well, having sore feet, and being tired. He had called in sick on more occasions in the last year than he had in the previous ten.

Then the secret was out. David had AIDS—Acquired Immune Deficiency Syndrome. His malaise and fatigue were due to this, and his sore feet were due to a painful neuropathy associated with this. His frequent sick days were due to his recurrent infections.

David left work soon after the news was out, and died in less than a year. His friends and co-worker had confused thoughts. Did he recklessly expose sick patients to his virus? Did he take advantage of them by staying on at work as long as he did? If he as such a holy preacher type how did he come down with this sexually transmitted disease? Finally, were they as compassionate as they might have been?

Hemophilia A ran in the Brown family. Jeremy Brown had several male ancestors with the disease. He had been a relatively health, happy baby, but as he became more active he began bleeding into his muscles and joints. By the time he was eight he had received hundreds of transfusions and home infusions of Factor VIII. By the time he was ten, he tested positive for HIV.

When the principal at Southside Elementary learned of Jeremy's disease he arranged a meeting with the family. He had already spoken with the Health Policy Coordinator for Jessamine County, and knew that Jeremy was not particularly contagious. Jeremy's teacher was in on the conference as well, and Mr. Simms and Mrs. Lasher assured the Browns that Jeremy could continue to attend Southside with very minor restrictions.

The educators had not counted on the public reaction. As the word got out, the gossip mill churned. Phones were ringing and emails flew back and forth. A week later an organized protest of angry parents barred the entrance to school. If the administrators were not going to protect their children, they would take things into their own hands. Jeremy was not wanted here, and the demonstrators made no bones about it. If the principal did not remove Jeremy from Southside, none of their children would be attending.

After the judge ordered the parents to cease and desist, Jeremy returned to classes. Everywhere he went in the building, however, children whispered, pointed and stared. Jeremy sat alone in the lunchroom. Students gave him wide berth in the hallway. "He's probably a faggot," one whispered, loud enough for Jeremy to hear. "My mom says that all this talk about 'Hemophobia' is just a smoke screen."

"Don't let him breathe on you," said another. "You never know when one of those virus bugs might jump out and get you."

Jeremy sat alone day after day in the lunchroom. He cried himself to sleep at night. What had he done to deserve this? He prayed daily that God would give him a friend, but in the two years at Southside no one ever walked him home from school, invited him to their parties, or played with him on the playground.

"Them homosexuals deserve what they get!" shouted Robert Jones. "This is God's curse raining down on them for their evil ways."

Daniel Boorman nodded. The Bible said to let the damned go to hell. They knew better than to abuse nature. "I'll help you put up those posters around town," he said. The bright red posters with white letters said: "Let Them Die...Don't Waste County Funds on Gays with AIDS."

When Dan got home that night he was surprised to find a letter from his son John in the mailbox. He had not heard from John in several years. The last time John and Dan had spoken would be seared in his memory forever. John screamed at his father: "Your 'Holy Roller' fundamental would-be church wouldn't love a sinner if they met one. But they never will, because they're too busy patting their own backs and hiding from the Evil World. Well I have had enough. I ain't putting up with it no more!" And with that he slammed the front door. The windows shook in their frames as he stomped off the porch.

John left town that night, and Dan heard nothing from his son for the next eleven years. Now Dan held his letter, post-marked from San Francisco. "Dear Dad" it began. "I would not be writing you, except with Mom and Sarah dead, you are all the family I have left. I thought I was doing okay out here in California, but the last few months I haven't been feeling well. The doctor confirmed my worst fears yesterday. After ten years in the Gay community here, I have come down with that virus that attacks the immune system. Could I come home and talk to you about things? He says I am pretty far along and may not have long to live..."

Dan's whole body convulsed with sobs, and he dropped the letter from his hands as he fell to the floor. How could he have been so wrong?

Before 1982 AIDS was virtually unknown. There were a few scattered reports about homosexual Haitian immigrants with unusual tumors on their legs that died fairly acutely due to overwhelming infections. It seemed that their bodies just couldn't fight off the bacteria. The epidemic initially grew slowly, but yearly more patients were diagnosed with Human Immunodeficiency Virus (HIV), which in its full-blown clinical expression was Acquired Immune Deficiency Syndrome (AIDS). Most common among homosexual men, and initially seen almost exclusively in this setting, it soon was also diagnosed in women who were sexually active with bisexual men, children born to such women, hemophiliacs, and persons who were infected via shared needles in intravenous drug use.

Some doctors, nurses, and health care workers even contracted the disease through contact with contaminated blood products.

In 1985 the total cost of AIDS was \$380 million. It is estimated that by 2000, the cost will rise to nearly \$20 billion. (John K. Iglehart, "Financing the Struggle against AIDS," NEJM, July 16, 1987, 317:180-184.) While new medicines seemed to prolong the time from original diagnosis to death, nothing seemed to offer a cure for the disease.

Some pastors saw this disease as a just judgment of God against sinful sexual activity, and preached this philosophy from their pulpits. The media were quick to publicize this harsh judgmental message and typify all Christians like this. Other groups, however worked hard to be the healing Body of Christ to these poor and dying.

The homosexual community was active in spreading the news of the dire need of those with AIDS, and with proclaiming the hypocrisy they saw in the Christians who refused to help care for the dying. In the process, the Gay community, over less than two decades became much more of a mainstream, legitimate force in the minds of many Americans, and the term "Religious Right" came to stand for harsh judgmentalism. What had become of the followers of Jesus—known for his love of lepers, Samaritans, beggars and prostitutes?

What does the Bible say about situations like this? Let's look and see.

Scripture and Discussion Questions

Deuteronomy 24:14,15,19-22

Leviticus 20:13

Romans 1:24-27

Matthew 5:43-48

Luke 6:37,38

Luke 10:25-37

Luke 17:11-19

John 4:1-42

- 1) Does the Deuteronomy passage, above, shed any light on what our attitude toward the sick and dying should be? Does this apply even if these persons are unrepentant of their sinful lifestyle?
- 2) Leviticus 20:13 is sometimes quoted as proof that God hates homosexuality. Does the context of this verse make any other important point?
- 3) Romans 1 and its apparent condemnation of homosexuality is explained by some in the Gay community as an indictment against promiscuous behavior, and not homosexuality, per se. Does this follow from the passage?
- 4) The Gay community, by and large, have been very critical and hateful toward people in evangelical circles. Are they appropriate in feeling the way that they do? Whether they are or are not appropriate, what is our response supposed to be toward them?
- 5) Luke 6:37 is quoted as a reprimand against any Christians who speak against the Gay lifestyle. Is that what this passage is saying? Defend your answer.

- 6) The “Good Samaritan” probably reached across class, ethnic and religious lines to serve the man traveling from Jerusalem to Jericho. When was the last time you reached across similar lines? Do you think that you ever act like the Levite or the priest in this parable?
- 7) Many people in the first century felt that lepers were afflicted with their disease due to their own sin. Miriam was punished with leprosy in Numbers 12:9-16. Do you believe that persons with AIDS are being justly punished for their evil ways? Do we generally receive punishment in this world for our sins?
- 8) The Samaritan woman that Jesus spoke with was clearly immoral. Jewish men were not to speak with unknown women. How is it that Jesus could break this taboo, and do so with this immoral person? Does this prompt you to any action?
- 9) What other scripture passages pertain to this discussion?
- 10) Should your church be heading up fund drives to assist people with AIDS in your community? Are there any volunteer or hospice opportunities for helping people with AIDS in your town?

Comments

- 1) The David Candy vignette raises some interesting questions. There are situations when a person’s desire for privacy conflicts with the public’s need for safety. There are some situations where the courts have already decided that physician-patient confidentiality should be broken if direct danger is posed to another person.
- 2) Many Homosexual activists state that because the Christian community does not believe that homosexual relationships are God-ordained, we are “homophobic” and hateful. A bumper sticker reads: “Hate is Not a Family Value”, implying that Family Values people, Christians, who do not approve of them, are hateful.
- 3) It might prove interesting and helpful for your group to discuss ways that your church can love persons while still maintaining Godly standards of life style.
- 4) It might prove stimulating to discuss ways that we can encourage our children to reach to other children who are on the social fringe at their schools. Christ always showed special concern for the socially and economically disenfranchised.
- 5) Many secular leaders espouse condom distribution and needle exchange programs a way to combat AIDS. There is no convincing proof that condom availability has cut down on venereal disease or pregnancy.
- 6) AIDS in Africa makes the U. S. problem seem minor. Some evangelistic groups are beginning major initiatives to rescue the continent of Africa. See if you can find any information regarding efforts that your denomination is making in this cause.
- 7) Tony Campolo and Chuck Colson have both written some good things about helping people with AIDS. Homosexual activists consider Campolo a compassionate person even while he never approves of their life style. It is often extremely difficult to hate the sin while still loving the sinner.
- 8) Mother Teresa is another example of a Godly person known for her concern for the unlovable. Yet, at a White House breakfast she looked President and Mrs. Clinton in the eye and condemned abortion. She was able to love sinful persons while hating sin.
- 9) There are some strong Biblical parallels between leprosy in Christ’s time and AIDS today.

PRAYER REQUESTS: As you close today's lesson together, pray that God will help you find the discernment to love all sinners while you still resist sinful behavior. Pray that God will speak to you about needy persons that you should be ministering to, even if this may mean crossing ethnic, cultural or religious lines.

For Further Reading:

The financial impact statistic and some of the background information for this chapter is taken from Robert Orr, M.D., David Biebel, D.Min., and David Schiedermayer, M.D., *Life and Death Decisions* (Grand Rapids, Michigan: Baker Books, 1990). This relatively short book gives a brief overview of Christian bioethical decision-making, and then tackles several of the most compelling dilemmas. An easy evening's reading, this book is entertaining yet informative.

American Academy of Neurology. Report of the American Academy of Neurology on the ethical role of neurologists in the AIDS epidemic. *Neurology* 1992;42:1116-1117. The chair of this committee, Dr. Ronald Cranford, is known for his liberal, relativistic approach to neurologically oriented ethical issues. This position paper, however, is full of good ideas. (It does encourage the use of condoms, but so did C. Everett Koop, M.D.)

Stephen E. Lammers, *AIDS and the Professions of Healing: A Brief Inquiry*, in *On Moral Medicine*, edited by Stephen E. Lammers and Allen Verhey, 2d ed., (Grand Rapids Michigan: William B. Eerdmans Publishing Company, 1998).

Edmund D. Pellegrino and David C. Thomasma (with the editorial assistance of David G. Miller), *The Christian Virtues in Medical Practice* (Washington, D. C.: Georgetown University Press, 1996). Drs. Pellegrino and Thomasma are revered and read not only by Roman Catholic scholars and clinicians, but by the wider Christian and humanist audience as well. Chapter six, "Charity in Action: Compassion and Caring" reminds us that Christ has called us to have compassion on all humanity, and particularly on those who are ill. We cannot escape our calling to care for the ill, even those with self-inflicted illness.

David L. Schiedermayer, M.D., *House Calls, Rounds, and Healings* (Tucson, Arizona: Galen Press, Ltd., 1996). Dr. Schiedermayer reflects poetically on his long clinical career. "Christmas on the AIDS Ward," pg. 63, reminds us of Christ's love for all.

HIV/AIDS offers some unusual concerns for doctors and patient confidentiality. When, if ever, is it appropriate for a physician to break confidentiality in regard to highly communicable and lethal diseases? Scott B. Rae and Paul M. Cox, *Bioethics—A Christian Approach in a Pluralistic Age*, (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1999), discuss this thorny issue.

Brain Death, Organ Transplants and Non-Heart Beating Organ Donor Protocols

Sally Suntori found her mother, Betty Lou Gibson, face downward and unresponsive, in her apartment bathroom. Sally activated 911, and the paramedics arrived in six minutes to transport her to Samaritan Medical Center. She was breathing shallowly, and had a thready pulse. By the time Sally arrived at the hospital, her mother was already on a ventilator in the Intensive Care Unit, still unresponsive. Her pupils did not react, she had no spontaneous movements or other “brainstem signs”, but as long as the ventilator functioned her blood gases were okay, and her pulse and blood pressure stayed stable.

The neurologist, Dr. Sue Kline, examined Betty Lou, and performed several tests, including one where she turned off the ventilator for several minutes. Betty Lou did not begin breathing. Dr. Kline and the intensive care doctors met with Sally Suntori and her husband Bill.

Dr. Kline began the family conference by saying gently, “I am sorry, Mr. and Mrs. Suntori, but your mother is “brain dead”. There is no point in doing anything further, and we will be turning off the ventilator.” They continued to talk for another five minutes answering the family’s questions.

The family joined hands around Betty’s bed, and Dr. Kline sat with them as the ventilator was turned off. Betty took a few inefficient breaths after the machine was stopped, but never really woke up. The blood pressure and pulse both were unobtainable at five minutes.

John Jones hovered at death’s door. In the last three months he had had six major heart attacks. Due to his age and his Alzheimer’s disease he was not considered an appropriate candidate for a heart transplant. Yet, here he was in the Intensive Care Unit once more, again on a ventilator.

The cardiologist, Dr. Dirk Jensen had asked to meet with the family. “Your father is only being maintained with these fancy machines. As soon as we turn them off, he will stop breathing and die. Based on the things that he told me before his dementia got so bad, I would like to offer you an opportunity. If we just stop the machines he will die now, and his organs will not be usable for anyone else. But, if we coordinate our efforts carefully with the regional organ bank, we can keep him going till we can take him to the operating room. There we will turn off everything and wait for five minutes. If he makes no attempt to breathe, a separate team of doctors will immediately begin surgery to recover his liver, kidneys, and corneas so that these will help other persons to live. We of course will not be able to harvest his heart, as this is so damaged.”

“So would you be killing our Dad to get his organs for those other people?” asked Billy Jo, the daughter.

“I prefer to think that in fact we are unnecessarily prolonging the inevitable, and given his dementia, it would not do him any good to keep him around in this state. Besides, before his dementia came on you know how concerned he was for people who use the dialysis unit in Middle Fork. I think this is what he would want.”

“I am so sorry,” said Dr. Silcox to Tom and Sarah Waterford. “Your daughter’s heart disease is very serious and will only get worse over time. I wish there was something else we could do to help, but none of our medicines will really turn this thing around. Our only hope is that we can find a suitable heart donor. With your permission we will place her on the waiting list for heart transplant right away.”

Tom and Sarah were stunned. They somehow had not realized exactly how severe Belinda’s heart disease was. “You mean that the only way Belinda can live is if someone else dies?” asked Sarah. “We would be praying to our loving God that he would choose to kill someone else so that Sarah would not have to die. And what about the children further down the list? Would one of them die because Belinda took a heart that might have been used to save them?”

Skin grafting, as a form of partial transplantation, probably dates back to sixth century India, though it was not introduced to Western medicine until the sixteenth century. Organ transplantation, on the other hand, did not really come into practice till the 1950s. Initially performed in a few select sites, it has now become commonplace throughout the free world, and in many places in the developing world. Dr. James Dobson has encouraged his listeners on Focus on the Family to volunteer to donate their organs in the event of their death.

In 1968, Harvard Medical School published a report from a committee chaired by Dr. H. K. Beecher, in the *Journal of the American Medical Association*, defining brain death. This report was largely prompted by the growing need for organs for transplantation and the feeling that many usable organs were being lost for this purpose because death was so vaguely defined. They defined brain death to be “permanent non-functioning of the brain”, and then spent the rest of their report elaborating exactly what they meant by this.

Little major change has occurred in this definition in the past thirty years. If no evidence of higher brain function is seen, and if no evidence of cranial nerve function or brain stem activity is discerned the patient is deemed “brain dead”. Once these criteria are satisfied, no further care is deemed necessary or appropriate. Artificial ventilation may be discontinued at this point without permission of the family, as the medical system is not compelled to artificially ventilate a corpse.

The newer twist is the non-heart beating organ donor protocol (NHBODP), which carries the transplant team a little further. In this scenario, if death is imminent, the patient may be transported to the surgical suite on life-sustaining machinery. The machines are then turned off. When all signs of life cease, a five-minute waiting period begins. If after the five minutes the organs are deemed salvageable, the harvest of usable organs is performed.

A number of safeguards are built into the NHBODP to squelch overzealous organ procurement, and to protect the donor and donor families from unnecessary pain or invasion of privacy. Interestingly, while “Living Will” and “Durable Power of Attorney for Health Care” laws are in effect in most states, NHBODP rules are presently made mainly on a local basis. Be that as it may, a question is raised: “Do we actually know when death has occurred, and can it occur in the presence of a yet-beating heart?”

The Bible does not directly say anything about these issues, but perhaps some Biblical principles might apply to this discussion. Let's look and see.

Scripture and Discussion Questions

Genesis 1:26,27; 2:21-23

Hebrews 9:27,28

Matthew 9:18-26

Matthew 22:23-33

John 20:1-8b

Acts 1:7-11

James 4:17

- 1) Does the fact that God created us, (as seen in Genesis chapters 1 and 2) have any bearing on our discussion of end-of-life issues? Explain. If we took a naturalistic, evolutionary approach to human life would this change our approach to end-of-life issues?
- 2) Hebrews chapter 9 talks about man dying once. Does this mean that we are not to perform cardio-pulmonary resuscitation? Does this mean that we are not to pursue organ transplantation to stave off eventual inevitable death in those persons with diseased lungs, kidneys or hearts?
- 3) In Matthew 9 Jesus intervenes and raises a dead child back to life. Lazarus, the widow's son in Luke 7, and the widow's son in 1 Kings 17 are other examples of God's intervention to resurrect from the dead. Does this mean that we should never "pull the plug" because God may choose to intervene again?
- 4) If you were Dr. Kline in the first scenario, and Sally Suntori told you that she was certain that God was going to intervene like he did in the three stories above, how would you respond to her? If she had no money to pay for the extended hospital stay would this change your approach?
- 5) Scripture does not tell us a lot about our lives after the resurrection, but it does clearly support the concept of a resurrection. Does this have any bearing on your attitude about "brain death" or NHBODP?
- 6) All four gospels discuss Christ's resurrection from the dead. Many liberal scholars attempt to do away with the resurrection. Does this really matter, since Jesus was such a great moral example to us anyway? Does it have any impact on end-of-life discussions?
- 7) Acts 1 discusses Christ's ascension and his promised return. Who cares? Why?
- 8) Read James 4:17 again. Does this imply that we are morally compelled to give our bodies and the bodies of our loved ones for potential organ donation? Why or why not? Have you signed an organ donor card? Why or why not?
- 9) Why haven't Christian churches supported organ donor cards as a way to help save lives and decrease pain and suffering for other waiting on organ donor lists?
- 10) Christopher Reeves, the movie actor, would die quickly if anyone were to turn his ventilator off. Does this mean his death is imminent? If so, how does he differ from the persons discussed in the NHBODP?

- 11) How can we justify expensive intensive care in this country when thousands die daily throughout the world from lack of food and water?
- 12) Does the concept of not being yoked together with unbelievers imply that a Christian should not designate an unbeliever as their DPAHC?

Comments

- 1) “Vitalism” is the position that as long as there is any sign of life we are morally obligated to do everything possible to maintain life. Most Christian bioethicists do not hold to this position. The Christian’s view of eternal life differs markedly from the rational secularist, and this difference does impinge on this perspective.
- 2) Proper etiquette dictates that we let other have their serving of cake first. If Tom and Sarah leave Belinda on the list someone else may not get a heart, and die. On the other hand, do not Tom and Sarah have primary responsibility to care for Belinda’s needs? Discuss.
- 3) The Non-Heart Beating Organ Donor Protocol discussed in today’s lesson is not a universal policy, but is developed on a local basis. Check with your local hospital to see if they have a NHBODP, and see if you can get a copy to review prior to the lesson.
- 4) Prior to the artificial ventilator, the issues raised in this week’s lesson did not exist. Many other issues are present now that were not present fifty years ago. Discuss the importance of attempting to base decision-making on biblical principles even when there are no direct Bible passages to direct us.
- 5) Survey your class. How many have completed Durable Power of Attorney for Healthcare documents or Living Will? How many have specifically discussed end-of-life decisions with their spouse or families? Ask all people present to consider these possibilities.
- 6) Simple Durable Power of Attorney for Healthcare and Living Will documents can be downloaded from the internet, or obtained from your neighborhood library, or from your local hospital. See if you can find an example to bring to class.
- 7) Dr. Jensen, in the second vignette, actually approached the family about the specifics of obtaining Mr. Jones’s organs. Usually hospital protocols are set up to keep the treating physician’s role completely separate from that of the procuring physician, so there will be no conflict of interest and the patient will always receive the doctor’s undivided attention.
- 8) In the United Kingdom age is used as a strict criteria for allocation of resources. In the U. S. A. we are extending expensive health services to older and older people. There are pros and cons to both positions. This might prompt an active discussion.

PRAYER REQUESTS: As you close today’s lesson together, pray that God will help you continue to think about these difficult questions in the week ahead. Do you need to sign an organ donor card as an act of Godly generosity to those you leave behind? Ask God to help you prayerfully consider this issue this week.

For Further Reading:

An excellent resource on these issues may be obtained through a special request at your library—probably through an inter-library loan. This out-of-print book, considered a bioethics classic is by Paul Ramsey, *The Patient as Person—Explorations in Medical Ethics* (New Haven, Connecticut: Yale University Press, 1970). Chapter two deals with redefining death, and chapters four, five and six deal with specific aspects of organ transplantation.

American Medical Association updates its *Code of Medical Ethics—Current Opinion with Annotations* (Chicago, Illinois: American Medical Association, 1997) every year or two. Chapter 2.00 covers opinions on social policy issues, including each of the ten chapter issues covered in this curriculum. In addition to its policy statements, it contains the AMA Principles of Medical Ethics, and Fundamental Elements of the Patient-Physician Relationship.

Judith C. Ahronheim, Jonathan Moreno and Connie Zuckerman, *Ethics in Clinical Practice* (Boston, Massachusetts: Little Brown and Company, 1994). Written collaboratively by a physician, a philosopher and an attorney, the bulk of this volume is case studies. Case 11 “A religious objection to the determination of brain death” discusses conservative Jewish religious objections to the concept of brain death. (Several states now recognize the right for a family to claim this religious exemption.)

Terrence F. Ackerman and Carson Strong, *A Casebook of Medical Ethics*, (New York: Oxford University Press, 1989). Casuistry is the discipline of analyzing deriving ethical principles from the throes of actual cases. This is a good example of a secular casuistry model for exploring bioethics. Case 2.8 is entitled “Conflict about Maintaining a Brain-Dead Woman for the Sake of her Fetus.”

Robert Orr, M.D., David Biebel, D. Min., and David Schiedermayer, M.D., *More Life and Death Decisions*, (Grand Rapids, Michigan: Baker Books, 1990). Several chapters in this book deal with tough end-of-life decisions. Pages 102-103, “Definition of Death” discusses brain death in an easily understandable fashion.

Franklin E. Payne, Jr., M.D., *Biblical Healing for Modern Medicine*, (Augusta, Georgia: Covenant Books, 1993). Dr. Payne often has a slightly different angle on issues that other thinkers. Pages 97-99, “Brain Death and Organ Transplantation,” provide an example of his unique perspective.

Chapter Nine

Futility of Care

David Simpson never knew what hit him. Jogging along the sidewalk in his suburban neighborhood, he thought nothing of the blue sedan that drove slowly past him. Neighbors, sitting on their porches heard a muffled gunshot and the sound of the car as it sped away. When they looked up, David was lying in a pool of blood.

By the time Janet got to the hospital, David was intubated, and in the Surgical Intensive Care Unit Dr. Braun, the neurosurgeon had already examined David, and told her there was nothing he could do. The bullet fragments had exploded inside his head, and the brain was a swollen, bloody mass. Much of it had been extruded through the exit wound of the bullet.

“Can’t you do something?” wailed Janet. “He can’t die like this. We have three children, and I am six months pregnant again. Do something! Take him to surgery! Transfer him to a bigger hospital!”

“I wish we could help,” said Dr. Braun, “but all further intervention at this point would be useless. We could call your pastor or your family for you, but there is nothing else to be done medically.”

Felipe Jimenez was eighty-two years old, moderately demented, and had widely-spread metastatic lung cancer. The oncologists told him and his family that he likely had less than six months to live. He also had heart disease. On Thursday evening he was admitted to St. Luke’s hospital with crushing mid-sternal chest pain.

As Dr. Jim Garcia filled out the admitting paperwork, he paused and spoke with Felipe’s daughter Juanita. “Since Felipe has the widely-spread cancer, we need to discuss some treatment decisions. If your Dad should go into an acute cardiac arrest, we should probably not intervene and do Cardio-Pulmonary Resuscitation, electrical shock, or put him on artificial respiration. Don’t you think this is what he would want?”

“I thought that everyone was entitled to those basic things,” said Juanita. “Are you giving us bad treatment just because he is on Medicare and can’t pay as much as those other people?”

“No, of course not,” said Dr. Garcia. “If we thought that this would help your dad in the long run we would not hesitate to do everything. But in light of his cancer and his Alzheimer’s disease I just don’t think it would be helpful for him.”

“I thought that since you were ‘Mexicano’ we could trust you! But now I see, us poor folks don’t get the regular care all the rich people get!” seethed Juanita. “We want everything done for my father, and we want another doctor, too. Don’t you touch him again or we will sue you!”

“I know this is tough to hear,” said Lucinda White, advanced nurse practitioner, “but the test results, your exam, and your complaints all seem to indicate that despite our best efforts the Lou Gehrig’s disease has continued to progress. We have tried all the available medications, and nothing seems to be slowing things down like we had hoped.”

Danny Ferguson snorted. “Well, I read on the internet that there is a great new treatment that they are using in Kentucky that has worked wonders on three patients. I know it would work for me too, if you would just try it.”

Lucinda refused to take offense at Danny’s tone of voice, and stayed calm as she gently continued. “If you mean the chelation therapy that the Jonesboro group have touted lately, I hate to tell you, but two major trials proved that chelation is of no use in Amyotrophic Lateral Sclerosis. If I thought it would help I would be glad to arrange for the therapy.”

Luella, Danny’s wife cut in: “If he were your husband you would do everything that you could to help. Since he’s just another patient to you, you are too lazy to fill out the paperwork to arrange for the second opinion! You probably get some kickback from the HMO for not sending patients off to outside doctors.”

Dr. William May, in his book *Testing the Medical Covenant*, states “The concept of ‘medical futility’ has emerged in the middle 1990s as a way of placing a limit on the physician’s and the health care organization’s medical covenant with a gravely ill patient.” He then goes on to elaborate that since the providers receive fixed annual payments from the insurer, instead of the older model of fee for service, it is in the provider’s best interest to deny full service to patients in need of care. They then disguise this fact by describing full service as unnecessary and futile. Godly physicians involved in the delivery of medical care via organized medicine may find Dr. May unnecessarily cynical.

While the term “medical futility” may be relatively new, the concept itself was conceived long before managed care. Triage, established just after World War I, is the placement of wounded soldiers into three classes: 1) salvageable if acute care is given, 2) salvageable even if treatment is delayed, and 3) unsalvageable despite any efforts. This third group was not to be treated. If time and resources were wasted on these patients, they would still die, and so would the patients from the first category. Thus, a functional definition of futility has been employed for over seventy years.

Even though futility may be hard to define absolutely, the idea is rather straightforward. Physicians are not ethically obligated to provide care that in their best judgment will not have a reasonable chance of benefiting their patient. The sticking points are: 1) In whose best judgment? 2) What is a reasonable chance? And 3) What does “benefiting the patient” mean? As one may readily see, each of these benchmarks is somewhat open to interpretation.

While futility has been variably defined over the years, Dr. May highlights several points that should be employed in addressing this question: “Would the proposed course of treatment provide a reasonable chance of benefiting the patient?” These are:

- 1) The process should involve medical and patient or proxy input.
- 2) Unreasonable requests need not be uncritically fulfilled, and no doctor need provide care contrary to conscience.
- 3) Consensus should be achieved, if possible.
- 4) Fidelity to the doctor-patient relationship is paramount, but concurrent responsibilities to all persons involved may be considered.

- 5) In situations of insurmountable disagreement between the medical team and the patient or proxy, assistance in process may be sought from independent sources, such as an ethics consult team, an arbitration panel, or as a last resort, the judiciary system.

The Bible addresses medical futility only indirectly. Let's look and see.

Scripture and Discussion Questions

Genesis 18:20-33

2 Samuel 12:13-23

Joshua 7:1-15; 8:1,2

Deuteronomy 34:1-6

Hebrews 6:4-6

Acts 18:5,6 and 19:8,9

Romans 1:24,26,28

Luke 19:11-27

- 1) In Genesis 18, God tells Abraham of his plans to destroy Sodom and Gomorrah. Abraham postulates that there might be a few righteous people left. God seems to be saying that further postponement of punishment for these evil cities is futile. God, infinitely wise, is in a position to make these judgments. Does this underscore one of our problems in establishing futility?
- 2) Nathan predicts the baby's demise, but David fasts and prays for his salvation. God decides not to affirmatively answer David's prayers. When David realizes that the child is dead, he gets up, bathes, and eats. He has realized that God has answered his prayers "No." Have there been any times in your life, when you realized that further prayers or efforts were futile? How did you respond to this realization?
- 3) Achan disobeyed God and Joshua. As a result of his sin, the efforts of the Israelites were futile. Can you think of times in your life or the lives of loved ones when further actions were futile because of previous irrevocable sins?
- 4) Though Moses was a powerful prophet and leader of Israel, he disobeyed God in the wilderness, and God refused to allow him to enter Canaan. Can you think of times in your life when irrevocable acts reaped painful consequences? Was God still able to work things out to his glory and your growth?
- 5) Hebrews 6:4-6 talks about believers who knowingly step away from God. While there has always been some debate about "eternal security" versus the ongoing work of the Holy Spirit in the life of the believer, this passage would seem to indicate that we can choose to irrevocably distance ourselves from God. In this case further preaching to us would appear to be futile. How would you interpret this passage? What bearing does that have on this discussion of futility?
- 6) The two passages in Acts depict instances where Paul chose to no longer pursue evangelistic outreach to the Jews in question. Does this imply that he deemed further evangelistic efforts futile? How do we know which limited resources to apply to needs at hand, and which to save for more likely return on investment?

- 7) In Romans 1 it mentions that God “gave them over” to sinful desires, shameful lusts and a depraved mind. Does this mean that he quit wooing them to himself? Does there ever come a time when we are to quit sharing Christ with our friends and neighbors?
- 8) In Luke 19 the three servants are held responsible for the way that they deal with the talents the king gave them. Does this accountability principle apply to arguments regarding futility? If so, how? Please elaborate.
- 9) Have you seen instances when you felt racism played a role in medical decision-making? In surveys taken across racial and ethnic lines, members of minority groups answer this question affirmatively much more frequently than do whites.
- 10) Very few patients with A. L. S. (Amyotrophic Lateral Sclerosis, Lou Gehrig’s Disease) are placed on artificial ventilation and feeding at the end of life. The patient’s mind remains lucid. In light of the patient’s prognosis, though, most doctors, families and patients do not choose to do so. How is this different from Christopher Reeves? If we justify it for him, why don’t we justify it and encourage it for all A. L. S. patients?
- 11) “With God, all things are possible.” Does this imply that no action on the part of the medical team should be deemed futile until God decides the patient should die?
- 12) Can you think of a situation where “concurrent responsibilities to all persons involved” might dictate a different course of action than solely stressing fidelity to the doctor-patient relationship?

Comments

- 1) Patient and family autonomy sometimes push physicians to do more than they think is medically indicated. Physicians are not compelled to perform medical therapies that they feel are not medically indicated, but sometimes, the medical team, afraid of bad publicity or malpractice lawsuits, give in, rather than argue. It might be instructive to role-play a situation where you are a doctor asked to perform futile surgery for a dying man.
- 2) Patients with commercial insurance sometimes abuse the system by seeking a fourth or fifth medical opinion for what is essentially an untreatable condition. Health Maintenance Organizations (HMOs) have strict guidelines in place to prevent this waste. It is important when thinking about medical decision-making to consider how incentives are aligned. In the old fee-for-service model, incentives encouraged doctors to order more tests than were needed. In the new HMO models the opposite is often true.
- 3) Some people hold that the doctor not only has a responsibility to his or her own patient, but to all society. From this perspective the doctor would often not be the patient’s advocate, but society’s advocate.
- 4) God doesn’t answer all prayers the way we wish he would. It is not always easy to reconcile this fact with passages like “Ask and it shall be given to you, seek and you shall find, knock and the door shall be opened unto you.” We will never understand some things till we see Christ face to face.
- 5) An interesting learning exercise for your group might be to role-play a discussion in which a husband tries to tell his wife that he does not wish futile care to be performed

on his behalf. Have the wife inquire very pointedly who, when, what, where, and why she should decide that further treatment on her husband's behalf is futile.

- 6) Futility in medical therapy is often difficult to define. Some physicians define it loosely as "I think that this is very unlikely to help." Others look for a more rigorous standard, such as "I have not seen anyone survive in this setting, of the last 100 patients that I have seen."

PRAYER REQUESTS: As you close today's lesson together, pray that God will help you know what needs in your world he would have you spend your time and effort on. Ask the Lord to reveal to you any areas where you should no longer invest time or effort, and to guide your thoughts as you think about issues of futility.

For Further Reading:

William F. May, *Testing the Medical Covenant* (Grand Rapids, MI: Eerdmans Publishing, 1996). This book was supported in part by The Institute of Religion, founded in 1954 in the Texas Medical Center. It reflects the "intersection of healthcare and religious commitment." Pages 85-99 are on futility of care.

A valuable journal article is in *JAMA* (Journal of the American Medical Association), March 10, 1999, Volume 281, No. 10, pages 937-941, entitled Medical Futility in End-of-Life Care, Report of the Council on Ethical and Judicial Affairs.

Charles Junkerman, M.D., and David Schiedermayer, M.D., *Practical Ethics for Students, Interns, and Residents—a Short Reference Manual*, 2d ed., (Frederick, Maryland: University Publishing Group, Inc.: 1998). True to its name, this concise manual nonetheless offers some valuable reviews of selected clinical topics. The brief chapter on futility/unreasonable patient requests covers these issues from the perspective of a practicing physician.

Steven H. Miles, M.D., "Medical Futility," *Law, Medicine & Healthcare* 1992; 20(4): 310-315. Dr. Miles argues that while the concept of medical futility is useful and necessary, it is best implemented on an institutional basis, as opposed to through legislative channels.

The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Bloomington, Indiana: Indiana University Press and the Hastings Center, 1987). On Pages 8 and 9 of this text, hammered out by an eminent group of physicians, thinkers, administrators and lawyers between 1985 and 1987, the health care provider is encouraged to help the patient discern what is in their best interest regarding issues of futility.

Decisions Near the End of Life is an "institution-based, multi-disciplinary continuing medical education program jointly sponsored by Education Development Center, Inc. (EDC), The Hastings Center, The American Medical Association, and the Hospital Research and Educational Trust, an affiliate of the American Hospital Association." The

Decisions program is presented on a continuing basis in large metropolitan centers throughout the United States. For information about upcoming programs contact EDC, 55 Chapel Street, Newton, Massachusetts 02158.

Chapter Ten

Advance Directives

Betty Youngerman collapsed in the aisle of Country Market Grocery Store, clutching her chest and gasping for air. The Emergency Medical System was activated and in less than four minutes the EMTs arrived on the scene. No family was readily available, and as Betty did not have a Medic Alert bracelet stating “No Code” or “Do Not Resuscitate” they immediately began Cardio-Pulmonary Resuscitation (CPR), and began the rapid transit into Garland Medical Center, continuing resuscitative efforts en route.

At Garland, while continuing resuscitation, they rifled through Betty’s purse to find any mention of family or personal physician. Six phone calls later they found Sylvia, Betty’s daughter, supervising the girls at the Second Avenue Brownie Troop meeting. When they explained everything to Sylvia, she was shocked. Hadn’t her mother sent in those papers they had been discussing for two weeks? With her early Alzheimer’s disease and her leukemia they had decided as a family that in the event of an acute cardiac failure no CPR or Defibrillation was to be performed. Sylvia told the nurse to stop the Code Blue.

By the time that Sylvia got to the Emergency Department, they had straightened up the room and removed some of the unnecessary equipment. But as Sylvia talked with Dr. Poulter she learned that the entire Code had gone on for a total of thirty minutes, and that her mother had received a series of eight defibrillations. Her ribs had been cracked in the process. “What a pity,” thought Sylvia. “Her mother could have gone peacefully, but because they never sent that paperwork back in to the hospital she had to go through all of this.”

Emilio Bandera had been estranged from his wife for six years, though they continued to live in the same Ohio town. Since Cynthia had left him and moved in with another man, Emilio had made some major changes in his own life as well. Engaged to Kathy Gomez, they were planning to marry as soon as he could get the divorce processed. Now here he was in St. Elizabeth’s Surgical Intensive Care Unit after nearly killing himself when he fell off his roof while cleaning his gutters.

Important decisions needed to be made about how aggressive the surgical team should be, whether they should proceed with surgery, and if, in the event of a failed surgery, Emilio wished his organs to be donated to those in need. As the social worker gathered all the information and discussed it with the intensivists, an awkward realization dawned on them all.

Under the law, Cynthia had all the legal say about these important decisions. If she chose to consult the grown children or Kathy she could, but legally she was not compelled to consider their wishes. As the divorce had not been finalized, and the will had never been changed, Cynthia would be the sole heir to all of Emilio’s property if he died, but if he lived she would likely receive very little in the divorce settlement. After all, she had deserted Emilio, and there were no longer minor children to consider.

While everyone realized the obvious conflict of interest, legally the precedent was clear. Dr. Jenkins sat down with Cynthia and began reviewing treatment options.

Bobby Jo Montgomery's wishes were quite clear, or so they seemed. In the event of a cardio-respiratory arrest he did not wish to be resuscitated. He had witnessed his father linger in a coma for three months and vowed that that would never happen to him. So he was not intubated, CPR was not performed and he died.

So he got what he wanted? Not really. Bobby Jo had imagined a specific scenario and locked himself into specific actions based on his suppositions.

The real story was that he had completed the Living Will within two weeks of his father's death, and then had never thought about the document again. In the meantime he finished school, landed a great job, married, had three children, and on this fateful afternoon was eating a hamburger that he had just grilled at his twins' eighth birthday party. A large piece of burger lodged in Bobby Jo's airway. Within less than a minute he was wheezing and gasping for air. His neighbor threw him in his car and raced to the local hospital, calling ahead on his cell phone. As they arrived, a nurse with a wheel chair met them at the door and scurried him back into the treatment room. A series of Heimlich maneuvers failed to dislodge the meat, and Bobby Jo was turning dark blue. Dr. Jensen called for a crash cart, a tracheotomy cut-down kit and an endo-tracheal tube. He was ripping open the cut-down tracheotomy kit, and was just about to start the tracheotomy to insert the tube when the nursing assistant came rushing into the room.

Waving his chart frantically, she shouted: "Did you know that he signed a Living Will? He specifically says: Do Not Resuscitate, Do Not Intubate."

Dr. Jensen froze with his hand halfway to Bobby Jo. Now what? Should he do his best to save Bobby Jo, and possibly be sued for assault and battery, or should he respect his wishes and hope for the best?

The term "Advance Directive" may refer to several different types of documents. The two most widely used are the Living Will (LW) and the Durable Power of Attorney for Health Care (DPAHC). A third scenario, where no specific wishes are delineated, and where no person is denoted as the decision-maker, is accounted for in many states by a surrogate law in some form. In Illinois this is called the Health Care Surrogate Act (HCSA).

Through the Living Will, which is legal in most states, people may decide and document in advance exactly what types of medical therapies and interventions they will allow the medical team to do on their behalf. An obvious advantage of this is that if they strongly do not wish certain procedures, such as intubation or defibrillation, to be performed, they can exclude these treatments in advance. One of the largest disadvantages of LW is that it is impossible to predict all the variables that may come to play in a complex decision at some point in the future. The closer to one's death that the LW is written, the closer it will approximate the patient's true wishes, but even this is not always true. Another problem with LWs, moreover, is that in most states the LW does not take effect until a determination of terminal illness or persistent vegetative state is made. Because of some of these problems, many find the DPAHC a more suitable document.

DPAHC documents specify in advance the person or persons who will be authorized to make health care decisions for the patient in the event of patient non-competence. Thus, the determination of imminent death or Persistent Vegetative State is not necessary. Some persons include the DPAHC as a separate part of the same document that specifies the LW. Thus, a person could say in the event of imminent death the LW is

to take effect, but in the event that the patient is not able to make decisions due to acute injury or non-competence the DPAHC will be in effect. Many Christians find the DPAHC to be more reasonable, but it requires that the patient speak clearly and at length with the designated decision-maker regarding their wishes.

Where both the LW and DPAHC have not been written, surrogate laws take effect. Depending on the state the exact priority list may differ, but each statute states who has decisional authority. Usually this is prioritized: 1) spouse, 2) children who have reached majority, 3) parents, 4) other relatives, and finally, 5) close friends. The person who is deciding for the patient is called a proxy, agent or surrogate. The proxy is supposed to make decisions for the patient based first on “Substituted judgment”, meaning “I believe that this is what the patient would have chosen.” When this is not discernible, the decision should be based on “Best interests”, meaning “I believe that this is in the best interest of this patient given these facts.”

An underlying assumption in all of the above discussion is that patient autonomy is very important, and should be given first place in authority for deciding difficult questions.

What does the Bible say about principles that apply to Advance Directives? Let’s look and see.

Scripture and Discussion Questions

Ecclesiastes 4:10-12

Mark 12:28-31

Proverbs 13:16a, 20

Proverbs 15:22

Proverbs 19:21

Proverbs 22:3

Proverbs 3:5,6

- 1) Ecclesiastes 4:10-12 discusses the benefit of facing life as part of a team. Does this concept have any application in a discussion of Advanced Directives?
- 2) Mark 12:28-31 and Matthew 22:34-40 tell us that the greatest commandment is to love God, and the second great commandment is to love others. How does this fit in with a discussion of autonomy? Can you think of other scriptures that emphasize autonomy? What is communitarianism?
- 3) Proverbs 13:16a tells of the importance of making decisions from a base of knowledge. Does this pose a challenge to you as you think about Advanced Directives? Do you really know what your options are in end-of-life decision making?
- 4) Proverbs 15:22 talks about “many advisers” helping plans to succeed. In the case of Advanced Directives might this suggest any particular phrases you should include if you decide on a Durable Power of Attorney for Health Care?
- 5) Given Proverbs 19:21, do we really have any obligation to think about Advance Directives, or should we leave it all up to God? (Who decides if we do not?)

- 6) Proverbs 22:3 discusses the need to plan ahead. But if we know that it is all in God's hands anyway, why should we bother planning ahead? What is our responsibility?
- 7) Proverbs 3:5,6 remind us that God is to be the focus of our lives. Realizing this, and remembering the Mark and Matthew references, above, how would this affect our decision-making process?
- 8) Is it immoral to take one's viable kidneys, corneas and heart to the grave when these might prevent pain and suffering for others? Conversely, would it be immoral to not share your no longer needed body parts with others when you die?
- 9) "Conflict of Interest" is an important consideration in many ethical decisions. The Bible tells us that we are to "avoid the very appearance of evil". Yet, our lives are filled with relative conflicts of interest. How do we decide when a conflict of interest is legitimate?
- 10) The Bobby Jo Montgomery vignette offers a springboard for discussion. How specifically have the members of your class discussed their wishes with their family members?

Comments

- 1) Some families who have poor or no insurance coverage may receive very large bills for all the activities that occur within the last hour of a loved one's life. Ambulance costs, Emergency Department fees, medications, respiratory therapy, doctors' fees, and radiology charges can add up quickly. If the patient has definitely decided that they do not want this type of treatment they need to make this obvious to their family, and to any Emergency Medical System personnel who might be involved. A Medic Alert™ bracelet is a simple way to do this.
- 2) Due to our infinite ability to deny our mortality, we may not update our wills as frequently as we should. Remind your class to consider this.
- 3) Sometimes the Living Will creates more problems than it solves since it cannot accurately predict the questions that will arise. The DPAHC is a superior document. If one then wishes to spell out a few particular preferences this still allows the person designated as Power of Attorney appropriate latitude.
- 4) In addition to "Substituted Judgment" and "Bests interests of the patient", another guideline sometimes used is "What would a reasonable person who had all the available information want to do in this situation?" This is not quite as specific as "Substituted Judgment" and provides an additional parameter to the concept of "Best interest of the patient".
- 5) Autonomy is the framework for this whole discussion, but the constraints of the futility discussion apply as well. If the LW or DPAHC requests futile measure be undertaken the medical team has no obligation to perform these measures.
- 6) The Bio Basics booklet referenced for this lesson is really quite brief. Reading this in advance of the lesson might prove very valuable.
- 7) In the second vignette, when the doctors realized that Cynthia had an obvious conflict of interest, their hands were not really tied. They could have consulted their hospital attorney, sought a judicial ruling, or referred the case to their hospital Ethics Committee. In most hospitals almost anyone, including nursing, family, physicians or even janitorial staff can contact the Ethics Committee and request a consultation.

PRAYER REQUESTS: As you close today's lesson together, pray that God will help you begin to think about your end-of-life decision making, and give you wisdom as you discuss some of these issues with your parents, spouse, children or close friends.

For Further Reading:

Gary P. Stewart, William R. Cutrer, Timothy J. Demy, Donal P. O'Mathuna, Paige Cunningham, John Kilner and Linda Bevington, *Basic Questions on End of Life Decisions—How Do We Know What's Right?* (Grand Rapid, Michigan: Kregel Publications, 1998). This brief booklet is part of the Bio Basics Series sold through The Center for Bioethics and Human Dignity. It is authored by true Christian authorities, but can be read by most people in less than two hours.

Franklin E. Payne, Jr., M. D., *Biblical Healing for Modern Medicine* (Augusta, Georgia: Covenant Books, 1993), pages 101-102. Dr. Payne offers some alternative views on living wills and durable powers of attorney.

Note: Case Study #3 from *Breathtaking Decisions*, uses a case from Bette-Jane Crigger, ed., *Cases in Bioethics*, 2d ed., (New York, New York: St. Martin's Press, 1993) which in some ways is parallel to the Bobby Jo Montgomery vignette. *Breathtaking Decisions* is a weekend seminar sponsored by Center for Bioethics and Human Dignity, of Bannockburn, Illinois. If your community is interested in sponsoring or co-sponsoring such a weekend event, please contact Dr. John Kilner—see lesson thirteen, for further information.

A. A. Howsepian, MD, 'Are Advance Directives an Advance?' in *Ethics and Medicine--An International Christian Perspective on Bioethics* 14:2 (1998) p. 34-41. Dr. Howsepian is not sure that they are. Read why in this well-researched, comprehensive look at Advance Directives.

William F. May, *Testing the Medical Covenant*, (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1996). Dr. May, on pages 31 and 32 raises concern that even when Advance Directives are appropriately executed, they are often, unfortunately, not followed.

Charles Junkerman, M.D., and David Schiedermayer, M.D., *Practical Ethics for Students, Interns, and Residents—A Short Reference Manual*, 2d ed., (Frederick, Maryland: University Publishing Group, 1998). Offers a concise overview of living wills, durable powers of attorney for health care, and non-statutory forms. The book compares and contrasts these documents.

Euthanasia and Assisted Suicide

Elizabeth Avon had always been a spunky, energetic, life-of-the-party type of woman. When her children were young, their friends always loved to come to the Avon house to play because Elizabeth made everything seem like such an adventure. Back-yard games, craft projects, story hour, even watching videos together became times of excitement and fun under Elizabeth's magical touch

And now she had terminal cancer. The physical pain was not too severe, but the crushing sense of despair was overwhelming. First chemotherapy, then radiation were tried, but neither was able to stop the spread of the illness. Her doctor suggested that she probably would not live till Christmas, six months away.

She could not get excited about anything or anyone any more. Her children and her husband did their best to interest her in people, activities, and social functions. None of her former past-times seemed to spark any interest. What was the point of all this?

Elizabeth was repulsed at the idea of deteriorating and losing control in front of her family and friends. She had always been a mover and a shaker, and she wasn't going to let her loved ones' last memories of her be those of increasing dependence, pain, and disability. That was why she carried that Michigan doctor's address in her wallet.

Some people may say bad things about that man, but knowing that his help was available gave her great solace. When her family was all out of the house Elizabeth jumped at the chance and gave him a phone call and made the arrangements. Next month, before the pain became too intense he agreed he could come and see her. Now she just had to convince her family.

Betty Krauss sat across the desk from Dr. Dan Smyth. "What I need to hear from you is that you will honor my wishes," she said. "I refuse to die slowly and painfully like my cousin Sabrina did. When the nausea and weakness become too great I want to be able to know that you will be in my corner and will help me depart this 'vale of tears' without a hitch. Can I count on you?"

Dan looked down at his hands. What were things coming to? This was the third patient this month to approach him with a similar request. Was it really such a big deal? After all, they were all terminal patients anyway. What did a few months one way or another matter?

Don Omega, R. N., pushed his medicine cart quietly down the hospital corridor. The night shift on the surgical ward could be pretty lonely at times. And speaking of lonely, what about Miss Jennifer Bailey in 4363? This was her fourth admission to Ben Davidson Hospital in the last six months. No one came to see her, and each new stroke left her more debilitated.

Her right side was now functionally useless, and she no longer could speak in any comprehensible manner. After the first stroke she had made some recovery, but since then it had all been downhill. She moaned frequently in a meaningless pitiful fashion, and saliva ran constantly down her cheek.

He remembered Miss Bailey when she had been a teacher at Park View High School. What a beautiful, talented, caring teacher she had been. He remembered how as a junior he had fallen madly in love with her as he watched her every third period from his seat in the fourth row. What a knockout! Now he had only pity for her.

Wouldn't it be better to just let her go? He could easily give her a shot of medicine in her I.V. Since she wasn't on telemetry monitoring, it would probably be thirty minutes before the nursing assistant would discover her dead on her rounds to take vital signs. Though he had been toying with this thought for several nights, it seemed to come to him in an instant flash of decision. Where was that potassium vial he had tucked into his pocket last week?

The idea of euthanasia, "good death", has captured public attention in the last few years. This is particularly due to efforts by Derek Humphrey, formerly with the Hemlock Society, Dr. Jack Kevorkian, who has assisted in killing a number of patients—many with non-terminal diseases, and other similar people. The concept, however, is thousands of years old. Hippocrates, famous Greek physician and founder of a school known by his name, said in his famous oath: "...I will not give poison to anyone though asked to do so, nor will I suggest such a plan."

Terminology is somewhat murky in regard to euthanasia, but three distinct categories of death are usually discussed: suicide, assisted suicide and active mercy killing. Suicide and assisted suicide are self-evident terms. Active mercy killing can be further subdivided into voluntary, involuntary (against the patient's wishes), and non-voluntary (without input from the patient). Each of these three types of active mercy killing is quite different in moral implication.

Proponents of legalizing euthanasia in the U. S. often tout the history of euthanasia in the Netherlands. While many Americans assume that the Dutch experience is one of voluntary euthanasia, a major study conducted by the Dutch government revealed that many deaths in the Netherlands fall into the other two categories.

Some use the nomenclature "passive euthanasia" versus "active euthanasia." This is meant to differentiate between fatal withholding of treatment versus direct intervention to cause death. "Passive euthanasia" can again be subdivided into voluntary, involuntary and non-voluntary categories. Others feel strongly that refusing to proceed with further treatment is at times the most humane, Christian action to take. They feel that to besmirch this with the label "passive euthanasia" is not only unclear, but also a grave disservice to those loving physicians who offer this to their patients. They feel that "vitalists," persons who hold that everything must be done for any patient as long as there is any remaining life, often inflict unnecessary pain and suffering on already-hurting families and patients.

This complex discussion revolves around a number of overlapping questions:

- 1) Who owns our lives, any way? Do our lives belong to us to claim at will, or are they trusts lent to us by God? Are we owners or the fiduciaries?
- 2) Is it ever moral to hasten someone's death? If it is moral, on what grounds may we base this decision?
- 3) When does the imminence of death preempt the need to fight death as a bitter enemy?

- 4) Is it possible to over-treat a patient in an attempt to avoid death? Are we always morally compelled to take all possible action that might temporarily stave off the inevitable?

Does the Bible speak to us about euthanasia and assisted suicide? Let's look and see.

Scripture and Discussion Questions

1 Corinthians 6:19-20
2 Corinthians 4:16-18
Exodus 20:13
1 Samuel 31:1-6
Philippians 1:21
2 Samuel 17:23
Psalm 116:1-6
Psalm 139:13-16

- 1) 1 Corinthians 6:19-20 is often quoted as an argument against the use of tobacco and alcohol. In the light of today's discussion, what would these verses say regarding "the right to die" or "it's my body"? We do not have rights over the possessions of others.
- 2) 2 Corinthians 4:16-18 offers great hope to the believer. Does it also offer motivation to the believer to work diligently to prevent easing of assisted death laws? If so, why?
- 3) Exodus 20:13 would clearly apply to premeditated murder. Does it also apply to active euthanasia? What about passive euthanasia?
- 4) Saul committed suicide in 1 Samuel 31:1-6 and so did his armor-bearer. Thus, since the Bible relates a case of suicide when death was imminent, does this offer us an example of what to do in similar situations? Why or why not?
- 5) Philippians 1:21 quotes Paul talking to the Philippians. Is this a veiled cry for help? Is he advocating that we Christians should hasten our departure to be with Christ? What is the difference between suicide and martyrdom?
- 6) 2 Samuel 17:23 relates the story of a man who was known for his wisdom. When Absalom rejected his counsel, Ahithophel chose death over perceived humiliation. Does this have a parallel with Elizabeth Avon's story? Is this a story of insurmountable pain or remediable depression? What are the situations in Dr. Jack Kevorkian's assisted suicides?
- 7) In Psalms 116:1-6 the psalmist details an account of God's intervention at a time of great need. But God does not always intervene. Relate a time when God did not intervene in a way you requested but that he used, nonetheless, to glorify himself and help you grow.
- 8) Psalms 139:13-16 describes God's great love and foresight over us from before our birth till the time of our death. When we take the initiative and cause our own death are we rewriting our story, is this what he pre-ordained, or is there another explanation?

- 9) If you had a chronic illness would you go to a doctor who publicly acknowledged being in favor of euthanasia? (The vast majority of patients asked this question said they would not.)
- 10) As Christians we, of all people, should not be afraid to die. If this is the case, why don't we volunteer to commit suicide as our life winds down so that we will spare expense and heartache for our loved ones?
- 11) In the first vignette, what is Elizabeth Avon really afraid of?

Comments

- 1) Some physicians who specialize in Palliative Care feel that if any patient dies in any significant pain it means that the doctor just did a poor job of pain control. They would contend that there is never a need for euthanasia for pain control. In a recent survey of Oregon patients who requested physician-assisted suicide, many claimed that the request was based on irremediable pain.
- 2) The American Academy of Neurology takes a strong position against euthanasia. As a secular document it does not quote scripture or natural law, but effectively uses utilitarian logic. The document implies that since neurologists care for many patients with chronic and terminal illness if the doctors ever start employing euthanasia many of their patients will lose all trust in their doctors.
- 3) Some people feel strongly that we must avoid the "slippery slope" of early compromises that might lead to great evil. Others feel that this is a non-issue. There are many examples from Nazi Germany and modern-day Netherlands that would seem to support the first position.
- 4) The issue of euthanasia really comes back to the question of who is the owner of one's life. Non-theists obviously would not give God this honor, but many theists do not, either. Note how autonomy and complete submission to Christ's authority may be directly at odds.
- 5) There is a significant link between abortion and euthanasia. It might be illuminating for your class to draw up a list of comparisons on the chalkboard.
- 6) If euthanasia becomes legal, many fear a new obligation to die. If Grandma is dying slowly and using up the inheritance she would have left for her children, she may feel subtle and not-so-subtle pressures to assent to euthanasia. Some dying patients, based on surveys from Oregon and Holland, already feel this pressure.
- 7) Jack Kevorkian has stated that he is performing assisted suicide to help patients out of their suffering. However, many of his patients were 1) clinically depressed, 2) not facing imminent death, or 3) inappropriately medicated for pain.

PRAYER REQUESTS: As you close today's lesson together, pray that God will help you as you process some of these questions this week, and as you face these questions in the future that he will give you wisdom in decision-making. Pray that he will help you refrain from wrongful acts of commission and omission.

For Further Reading:

Much of the material for this chapter is borrowed from: Gary P. Stewart, William R. Cutrer, Timothy Demy, Donal P. O'Mathuna, Paige C. Cunningham, John F. Kilner, Linda K. Bevington, *Basic Questions on Suicide and Euthanasia—Are They Ever Right?* (Grand Rapids, Michigan: Kregel Publications, 1998). Another Bio Basics Series booklet, this offers wisdom in a concise format.

Assisted Suicide and Euthanasia—A Christian Perspective (Resource Notebook), Harold O. J. Brown, Nigel M. de S. Cameron, John S. Feinberg, Paul D. Feinberg, and John F. Kilner, eds., (Bannockburn, Illinois: The Center for Bioethics and Human Dignity, 1998). A helpful, concise overview of these two related topics reviewed by a Blue Ribbon panel of Christian ethicists, this handy reference highlights a sermon by C. Ben Mitchell, M. Div. (now Ph.D.), entitled “Physician-Assisted Suicide and the Great Physician.”

Robert Orr, M.D., David Biebel, D. Min. and David Schiedermayer, M.D., *More Life and Death Decisions* (Grand Rapids, Michigan: Baker Books, 1990). Chapter four is devoted to euthanasia and assisted suicide, complete with discussion questions and references.

John McDowell and Norm Geisler, *Love is Always Right* (Dallas, Texas: Word Publishing, 1996). An apologetic for the place of moral absolutes in Christian problem solving, this readable book offers a solid foundation for the place of reason and scripture in this process. Chapter fourteen looks at euthanasia, suicide and capital punishment.

Nigel M. de S. Cameron, *The New Medicine—The Revolution in Technology & Ethics* (London, England: Hodder and Stoughton, 1991). Dr. Cameron examines the Hippocratic Oath, its modifications, and the evolution of medicine over time with respect to the oath. Chapter three presents a stunning, sobering picture of the creep of euthanasia into the Nazi regime, its necessary early rationalizations, and eventual wholesale acceptance by the German people.

John S. Feinberg and Paul D. Feinberg, *Ethics for a Brave New World*, (Wheaton, Illinois: Crossway Books, 1993). Chapter four offers a very readable, thorough, but concise look at the major elements and definitions in the euthanasia debate.

Chapter Twelve

Rationing of Care

The Honorable Ms. Derrickson, State Senator from East Carolina stood before the state senate: “If we had enough money to pay for every health care need that we have, this job would be easy, but obviously we do not. Our committee has thrashed this around for weeks, and the only solution that we can propose for the current health crisis in East Carolina, is some thoughtful form of rationing. They have already done this in Oregon, and now it is our turn to do it here.”

“How dare we take such a drastic step?” interrupted her fellow-senator, Mr. James, from the back of the auditorium. “If we do this, we will never be able to look our constituents in the eyes.”

Ms. Derrickson snorted in exasperation. “Are you kidding? May the record show that every single state and federal agency in these United States already rations health care. *Whether* we ration is not at issue. What is at issue is the *exact manner* in which we will ration—that is, choose to allocate our limited resources.”

The Health Care Budgetary Guidance Committee brings a unanimous opinion forward to the senate. It is our deliberated opinion that unless a task force is appointed to address this rationing issue immediately, we as a state are doomed to repeat our cost over-runs in health care again this year. We predict that our yearly health care budget will be entirely consumed by mid-August. This year’s budget is a farce, in light of exploding health care costs. Unless we act immediately, next year’s budget will be ruined as well.”

After less than thirty minutes discussion the speaker entertained a motion to call the question. By a margin of 74 to 12 East Carolina approved the appointment of a task force to bring an initial proposal to the senate by its next seating, to outline a rationing plan that would stem the burgeoning health costs for the state.

Audrey Perlstein had an intractable seizure disorder. She had been tried on eight different anti-epileptic medications with seemingly little improvement. She had frequent, moderately severe complex partial seizures that essentially made her unemployable, and consequently totally disabled. She often fell down and injured herself during her seizures. She had broken several bones, and had had numerous visits to the local Emergency Department to repair large lacerations on her forehead and posterior head from falls associated with her seizures.

But now, on the television, she was seeing something beyond her wildest dreams. A center in California was evaluating patients for a special kind of surgery. If the surgery was successful, seizure frequency and severity could drop dramatically. One person highlighted on the show went from two severe seizures per day, to two small seizures in the last fifteen months. Audrey couldn’t believe her eyes.

The next day she called her family physician, Dr. Drew Fancil. Dr. Fancil agreed to meet with her later that week to discuss her concerns. She could hardly wait, knowing that soon, with the proper intervention she might be seizure-free.

On Thursday, when Audrey told Dr. Fancil about the TV show, he just nodded.

“I thought that you would be flabbergasted and delighted,” said Audrey. “Instead, you don’t even seem surprised. What gives? If you knew about this all along why didn’t you tell me about it?”

Dr. Fancil looked tired and sad. “The concept of these seizure surgeries has been around for years. It is a proven remedy that really does change the lives of some patients. I have sent seven patients for surgical evaluation in the last three years, and four of them received the procedure, and had excellent results. The reason that I didn’t send you is that due to a senate bill passed a few years ago in this state, this type of surgery is no longer covered on your Public Assistance card. Most commercial insurance does cover this type of evaluation and surgery, but your card won’t help you. If you have to pay out-of-pocket the cost will probably run between \$30-40,000. I knew that you didn’t have that kind of money, so I didn’t bring it up so you wouldn’t feel any worse than you already do.”

Audrey shook her head slowly. “You mean to tell me that because I have epilepsy and can’t hold a job, and can’t get insurance, that I cannot get the surgery done that might give me back my life? What a scam! This is terrible! How can they do this to me?”

“I agree,” said Dr. Fancil quietly. “It is terrible, it is a shame, it seems just plain wrong, but there is nothing I can do about it. They can do it to you because they just don’t have enough money to go around. They have to make terribly difficult choices, and people like you sometimes get left in the lurch.”

Audrey brushed tears from her eyes as she walked to the pharmacy to pick up her generic medications. So close and yet so far, her solution was just beyond her grasp.

Betty Ferguson had delivered a strapping ten-pound baby boy twenty-seven hours ago, and now she was checking out of the hospital. She still felt pretty sore, and very tired, but rules were rules. From now on mothers with routine deliveries, who were covered by the Purple Star Intermountain Health Plan were to be discharged within less than 36 hours, or they could personally pay the difference.

What happened to the days when a new mother typically spent six days in the hospital after delivery to regain her strength, learn about her new baby, and have someone else help with those first fitful days? Who knew? She guessed that there was no use complaining. She just hoped that little Bobby would be all right. If he wasn’t and they had to come back into the Emergency Department at night, she would have a co-pay of \$50 for each visit. As a recently divorced mom her budget was pretty tight. She thought wryly, “I guess I am pretty fortunate to have insurance at all.”

In some political settings the buzz word “rationing” has been used to imply an evil process where no one receives appropriate medical care. As can be seen from the above vignettes, however, health care rationing is already with us all throughout the U.S. and the world. No one except the very rich are getting all the services they want, whenever they want, at no additional cost. So, the real question, as the fictional Senator Derrickson, above, pointed out to her colleagues is “How are we going to thoughtfully proceed with the rationing process?”

A number of answers to this question are already in place in different venues. Some of these may seem reasonable at first blush, but on closer examination most come up short. In *Life on the Line*, Dr. John Kilner, (see full reference below), devotes ninety

pages (plus notes) to rationing, beginning first with rationing processes currently being used and their shortcomings, followed by his proposal for a Christian rationing process. Age, length of medical benefit, quality of medical benefit, likelihood of medical benefit, psychological ability, ability to pay and a number of other criteria are examined and found to be wanting. All are fraught with the inherent difficulties of attempting to predict an uncertain future, and weighing highly subjective value-laden bits of information in an attempt to allocate limited resources. Decisions based on these tenuous efforts will allow some to live and cause others to die.

Within the context of 1) God-centered, 2) Reality-bounded, and 3) Love-impelled ethics, he proposes six criteria to consider in rationing decisions:

- 1) Is the patient in question, willing and interested in pursuing the proposed therapy?
- 2) Is the patient likely to receive significant medical benefit from the intervention?
- 3) Is priority granted to those facing imminent death?
- 4) Is the selection process impartial, avoiding favored group status and prejudice?
- 5) Are patients who require fewer of the limited resources being given priority over those who might require extensive resources?
- 6) Are those whose lives are truly indispensable (a rare thing) to be given priority?

He summarizes his approach (a direct quote from page 223) to resource allocation:

- 1) Only patients who satisfy the medical-benefit and willingness criteria are to be considered eligible.
- 2) Available resources are to be given first to eligible patients who satisfy the imminent-death, vital-responsibilities, or resources-required criterion.
- 3) If resources are still available, recipients should be impartially selected, generally by lottery, from among the remaining eligible patients.

What does the Bible have to say about rationing of resources? Let's look and see.

Scripture and Discussion Questions

Matthew 18:1-4

Matthew 22:34-40

Matthew 25:14-30

Acts 6:1-6

1 Timothy 5:1-8

James 5:13-16

Leviticus 19:9,10,15

- 1) Jesus instructs his disciples in Matthew 18 about the importance of a child-like faith and humility. Does this passage offer you any guidance as you consider rationing?
- 2) If we are to love our neighbor as ourselves (Matthew 22:34-40), how would this affect our rationing decisions?
- 3) Matthew 25:14-30 tells about three servants who were entrusted with finite, limited resources. The master praises the servants who take care to use the entrusted resources in a worthy manner. Elaborate what bearing this could have on different rationing considerations.

- 4) Acts 6:1-6 relates a particular food rationing welfare system present in the first century church. Does the manner in which these early Christians resolved their dilemma help us today?
- 5) In 1 Timothy chapter 5, Paul instructs Timothy in the area of respect for all others, but he particularly points out the needs of the elderly men and women. Is there a trend in our current bioethical milieu to foster disrespect for the elderly? Give examples for your answer.
- 6) (James 5:13-16) Should the Christian community have a different manner in which they solve their health care shortages? Do you know of any examples of this in practice today?
- 7) We have looked at Leviticus 19 before as we considered general welfare in Chapter One of this study guide. Why might we want to consider these same verses again in a discussion of rationing?
- 8) What other Bible passages shed light on this complex discussion?
- 9) In the United Kingdom, patients above certain age limits do not receive specific therapies unless they can pay for them out of their own pockets. Is this a Biblical concept?
- 10) The U. S. government, in an attempt to control costs will only pay fixed amounts for given procedures, surgeries, and therapies—*regardless of what these actually cost*. Some doctors and hospitals actually lose money for every Medicaid patient that they treat. Is this Biblical?
- 11) Other doctors and clinics refuse to treat welfare patients at all, based on the above statements. Is this a Biblical way to act toward suffering persons?

Comments

- 1) By some estimates, up to forty million Americans are medically uninsured. We have a long history of providing care for the extremely poor, but the working middle class often are uninsured or underinsured.
- 2) The amount that Americans spent on prescription pharmaceuticals doubled between 1994 and 1999. Estimates are that the cost will double again by 2003.
- 3) Insured Americans have access to the best health care in the world, but we also spend a higher percentage of our gross national product on health care than any other country.
- 4) British healthcare is high quality, but patients must wait long periods of time to receive surgeries and diagnostic tests that Americans can have performed relatively quickly.
- 5) Costly, high technology interventions such as bone marrow transplants are sometimes performed on patients when there is no convincing evidence that they will be efficacious. The attitude sometimes seems to be: “Well, nothing else has worked, and it is possible that this might help.” A new movement in medicine, called “Evidence-based medicine” is an attempt to bring more rational proof to medical decision-making.
- 6) Many Americans concede that it is wrong for so many people to be medically uninsured, but nonetheless will not vote for measures that would increase taxes to

provide the care needed. (If this is to be paid for, should this be done on a local or national level?)

- 7) In the second vignette, Audrey thinks that if she had the surgery to cure her seizures she would be able to get back to work. Studies show, however, that once a patient has been on disability for over one year, for any reason, chances are very slim that they will ever return to work. Most patients with seizures who make good recoveries from their surgeries and have a significant decrease in their seizure frequency still do not become employed.
- 8) Many rationing plans employ a utilitarian approach. If one person would likely receive twenty years of improved life versus another person that would likely receive ten years of benefit, the first person would be given priority. This assumes that our predictions of the future are valid. This also is prejudicial against older patients.

PRAYER REQUESTS: As you close today's lesson together, pray that God will help you to be wise, loving and generous as you consider health care, food, clothing, shelter and job needs in your community. Pray that the Holy Spirit will enlighten you regarding ways that you might be part of the solution in this important area.

For Further Reading:

The most important background for the didactic portion of this lesson is from: John F. Kilner, *Life on the Line—Ethics, Aging, Ending Patients' Lives, and Allocating Vital Resources* (Grand Rapids, Michigan: Eerdmans Publishing Company, 1992). See comments from Chapter Six. Dr. Kilner offers Christian wisdom to ponder, on some important, controversial topics.

Paul Ramsey, *The Patient as Person—Explorations in Medical Ethics* (New Haven, Connecticut: Yale University Press, 1970). Dr. Ramsey, an early Christian medical ethicist provides a classic exposition on some of the important pitfalls of resource allocation in Chapter Seven of his book, entitled "Choosing How To Choose: Patients and Sparse Medical Resources."

American Medical Association, *Code of Medical Ethics—Current Opinions with Annotations* (Chicago, Illinois: American Medical Association Press, 1997). Offers two rather succinct statements regarding organized medicine's official position on rationing in sections 2.03 and 2.095.

John F. Kilner, Robert D. Orr, and Judith Allen Shelly, eds., *The Changing Face of Health Care* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1998). This book is devoted to analyzing "managed care, resource allocation and patient-caregiver relationships."

Under the broad category of Justice, Thomas L. Beauchamp and James F. Childress, in *Principles of Biomedical Ethics*, 4th ed., (New York, New York: Oxford University Press,

1994), look at the topic of resource allocation (rationing) from the perspectives of egalitarianism, communitarianism, libertarianism and utilitarianism.

Judith C. Ahronheim, Jonathan Moreno, and Connie Zuckerman, *Ethics in Clinical Practice* (Boston: Little, Brown and Company, 1994). This is primarily a case book of ethics, but begins with 83 pages of overview and general principles. Pages 34-39 have a concise overview of rationing under the heading “Justice: Allocating Resources.”

Chapter Thirteen

What is a Christian to Do?

The Nazi government had already required all the Jewish families in the neighborhood to register with the local Gestapo office. After that, the Jews were required to wear yellow “Star of David” patches sewn onto their clothes. When rumors of late night pogroms in the Hebrew ghetto across town were explored, they were found to be true. Windows had been broken, Jewish residents roused from their beds, and eight buildings had been burned. Several people were seriously injured.

Dietrich Schwarz and his wife Katrina were uncertain what to do. They attended the Lutheran church on the corner, and their pastor was encouraging his parishioners to keep a low profile. “If we make too much noise, the Gestapo will start bothering us next,” He warned. “Besides, the Jews have charged exorbitant interest on their loans to us non-Jews for years, and don’t forget who killed Christ himself.”

Katrina and Dietrich had never had any close Jewish friends, but they had always been on friendly terms with their tailor and the owner of the hardware store and his family, all of who were Jews. Somehow it didn’t seem right to stand by and watch while their lives were being gradually destroyed. But what could they do?

Trudging through the cold dark night with only the stars and Jacob Whittier to guide them, Bessie and Sam prayed constantly. Singing was out of the question. If anyone caught them walking northward with Jacob they were all in for a great deal of trouble. Sam and Bessie would be chained up and thrown into the wagon. When they got back to Alabama their captors would reap cash rewards and the runaway slaves would be beaten unmercifully before they were locked up in the barn. When they healed up some, it would be back to the fields, and the unceasing pain and heartache of slavery.

As an abettor to runaway slaves, Jacob might just be strung up on the nearest tree. Aiding runaways was a capital offense, and as the bounty hunters did not have the time to wait around for the legal system to work, they might just provide their own brand of justice for Jacob—swift and sure.

So why did Jacob Whittier and his family participate in the “Underground Railway”? Jake was not an eloquent man, but he was God-fearing. As he told his wife: “God is no respecter of persons, and I am sure he loves all his children, no matter their color. If we don’t help them, and they end up back where they came from, it’ll be ours to blame, and that ain’t right.”

Levi Abrams was a Born Again Jew. He had come to Christ in his adulthood. After obtaining his Ph.D. in Genetics, completing law school and moving to New York, the only thing on his mind was making big bucks in the big city. He planned to become a wealthy patent attorney in the exploding world of bioengineering. He was well on his way to partnership in one of the world’s largest law firms when Eva Simons changed his whole life.

Actually, that is giving too much credit to Eva, but she certainly got him headed in the right direction. Eva was another attorney in Steinbrenner, Hart, Schafner and

Larson, and at first their relationship was all business. But after working together on three multi-million dollar cases, Levi had begun to appreciate a side of Eva that wasn't immediately apparent. She was bright, hardworking, creative, attractive, and at the same time she was confident about her relationship with a real God, and his real Jewish son.

After attending church for two months with Eva in a "Completed Jew" Congregation, Levi was surprised to find that not only was he falling in love with Eva, he was starting to think that this Jesus thing wasn't as crazy as he had believed. Six months later he accepted Christ into his life. Two months after that Eva and Levi were married.

What a bright future lay ahead of them, thought Levi, and the next three years, on his way to partnership seemed to prove him correct. Status, money, and power were all his. But then the Lord brought some interesting people his way. Jack Toland from the Christian Genetics Council called him first, then David Gray from United Christians for Ethical Laws phoned him at work. In short order, it became apparent to Levi that there was an immediate need for a full-time Geneticist/Attorney to help mold the future of American Law. Funding was available from concerned Christians, but if he were to walk away from his new partnership at SHS&L he could kiss his legal future good-bye. And he would take a 90% cut in salary.

What was God calling him to do? He could stay where he was, have oodles of money and be a partner in one of the top ten international law firms, or he could obey this new inner voice of the Spirit. What a choice!

Throughout human history, humans have had to choose. In each of our lives, we will face choices that require godly insight. One path may seem to promise power, fame, money or gratification. Another path may be less certain. When we are faced with these personal decisions we must seek God's leading through the prayerful use of Scripture, Reason, Tradition and Experience—most importantly including the inner witness of the Holy Spirit.

Today, we are confronted with a number of bioethical dilemmas. They meet us everywhere we turn, whether we like it or not. In this study I have attempted to point you toward some of these concerns. I have particularly attempted to encourage each of you to use our four guideposts in sorting through these issues. I will have failed if this study does not prompt thoughtful consideration, introspection, and prayer concerning possible ways that you may choose to serve God in these areas.

God is probably not going to call most of you to quit your jobs and work full-time in the area of bioethics. (But if He does, we certainly hope that like Levi Abrams, above, you will seek God's leading in this matter.) For most of you, the question will more likely be "How can I best serve Christ faithfully today?" Hopefully, as you ask this question, you may also ask "What can I do to stand for God, both proactively, and reactively in this developing minefield of bioethics?"

To get you started thinking and discussing this together, let me suggest a few:

- 1) Volunteer at your local Crisis Pregnancy Nursery once a month.
- 2) Volunteer with your local Hospice organization.
- 3) Find out what your local politicians believe about key bioethical issues and vote.
- 4) Volunteer to pray for your local Christian politicians, doctors, social workers and school counselors.

- 5) Become a volunteer at your local hospital, and see if there are any lay positions on your hospital ethics committee.
- 6) Contact Christian organizations that are working to set policy regarding these tough issues, (see the end of this lesson), and offer your prayers, monetary gifts and time.
- 7) Read good books on bioethics, like the ones discussed in this study curriculum, so that when you are asked about these issues you can give a reasoned Christian response.
- 8) Can you name some other ways to be part of the solution?

What does the Bible say to us about tough spiritual battles? Let's look and see.

Scripture and Discussion Questions

Nehemiah 1:1-4, 2:1-6

Esther 4:12-17

Daniel 3:9-18

Luke 22:39-46

2 Corinthians 11:23-29

Acts 7:54-60

Revelation 2:8-11

Acts 5:27-29

- 1) As cupbearer to the king, Nehemiah was in one of the most opulent settings and influential positions in the then known world. Yet, he jeopardized all of this, and in fact his continued life, by speaking up to the king about Jerusalem's plight. Why was this so important to Nehemiah? Have you ever laid your entire life on the line for a principle? If so, share your story.
- 2) Esther's uncle, Mordecai, minced no words talking to his niece about her responsibilities. What responsibilities is the Lord laying on your heart? How will you respond to the Holy Spirit?
- 3) Everyone has heard the stories of Daniel and his three partners in Babylon. Sometimes when we hear stories as children we do not realize the full importance of the actions taken by the main characters. Give three easy rationalizations that the Hebrew men might have used to avoid this danger. What were they risking?
- 4) Luke 22 describes Jesus' last night with his disciples before his crucifixion. Was this really a temptation for Christ? In what way? How did he deal with this temptation?
- 5) 2 Corinthians 11 tells of some very difficult experiences. How does this jibe with "The Prosperity Gospel"? Why would Paul allow himself to be put through such torture?
- 6) Stephen not only gave up his life for Christ in Acts 7, but he did two things that for most of us seem mutually exclusive: a) He confronted the evil he saw, in verses 51-53 and b) he continued to love his tormentors, in verses 59-60. Does this give us any guidance as we think about our response to abortionists, mothers who have aborted their children, homosexual persons with AIDS, and other "notorious sinners"?

- 7) Revelation 2:8-11 is written to the church in Smyrna. Polycarp was later pastor at Smyrna, and suffered a martyr's death. Most of us will not be faced with this end, but may face on-going persecution of a different nature. What do you fear most as you think about taking a stand on the issues this study has addressed? Is God sufficient to the task of protecting and caring for you?
- 8) Should your pastor preach politics from the pulpit? Why or why not?
- 9) See Acts 5:27-29. When is it Biblical for a Christian to disobey the government?
- 10) Which Christians are not involved in "full-time Christian work"?

Comments

- 1) Mahatma Gandhi preached non-violent civil disobedience. Martin Luther King and the Southern Christian Leadership Coalition used these same ideas.
- 2) Many people in the "Underground Railway" had to lie, steal, and on occasion commit acts of violence in order to save the runaway slaves from death. While the ends do not justify the means, there may be occasions when degrees of priority may need to be established. This might prompt some good discussion in your class.
- 3) God probably will not call you to quit your job and go to the mission field. But, he may ask you to choose a less lucrative form of employment that will be more beneficial to society and his work. Discuss the ways that we Christians can be certain of God's call and direction in our lives.
- 4) Some Amish people feel that we should avoid any involvement in governmental affairs. "Liberation Theology" preaches that unless capitalist systems are overthrown and replaced with Marxist systems, justice is not being done, and God is not being served.
- 5) Dr. James Dobson often strongly urges his listeners to write their congressional representatives, voicing a Christian opinion on important issues. Other Christians feel that our task is to save souls and not to be concerned with governmental affairs. Good Christians can be found in both camps.
- 6) Tithe is a concept that is often applied only to money. However, if God owns us completely, this concept should apply to our entire lives. Discuss other areas of your lives that are appropriate for the concept of tithing.
- 7) Sometimes when people think about getting involved in the political process they are thinking about running for elected office. Discuss other, less glamorous ways that each of us might enter into the political process.
- 8) The prophet Daniel was uprooted from Israel as a youth, and then over the course of his life was used by God to serve in leadership in four different Asian kingdoms. His life work was serving God in a pagan government system.
- 9) Martin Luther had taken vows of obedience to the Roman Catholic Church. He then broke those vows when he posted his theses on the Wittenburg Cathedral door. So, all of us Protestants owe our spiritual roots to a man who took an oath and then purposely broke that oath. Discuss.

PRAYER REQUESTS: As you close today's lesson, and this thirteen-week study together, pray that God will heighten your awareness of bioethical issues, and help you

know when to listen, when to speak, when to pray, and when to give. Pray also that he will help bring to your mind often those Christians who are on the front lines of these bioethical battles today.

For Further Reading:

In this thirteen-week study, we have referenced a number of good books already. For additional information on bioethics from a Christian perspective, or to become more actively involved in Christian bioethics in your community contact:

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The Center for Bioethics and Human Dignity
2065 Half Day Road
Bannockburn, Illinois 60015
888-246-3844
847-317-8153 (fax)
www.cbhd.org, or for breaking bioethical stories: www.bioethix.org

One can sign up for membership with CBHD. A number of resources are available through the Center, including a web site, newsletter, journals, books, videotapes, audio tapes, and study guides.

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Christian Legal Society
4209 Evergreen Lane
Suite 222
Annandale, VA 22003-3264
703-642-1070
703-642-1075 (fax)
www.clsnet.com

Active in many of the cutting edge policy and legal debates of the day. One need not be an attorney to support or join this organization.

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Americans United for Life
310 S. Peoria Street, Suite 300
Chicago, IL 60607-3534
312-492-7234

A powerful voice for encouraging public awareness about abortion issues and life options, this group crosses church and society lines in its efforts to promote its cause.

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Christian Medical Association (formerly CMDS)
501 Fifth Street
P.O. Box 5
Bristol, TN 37621
423-844-1000
423-844-1005
www.cmds.org

Christian Medical Association serves to encourage and strengthen Christian physicians in their walk with Christ and in evangelism in the United States and around the world.

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Focus on the Family
Colorado Springs, CO 80995-7451
800-A-FAMILY (800-232-6459)
719-531-3424 (fax)
Email: www.fotf.org

Dr. James Dobson and Focus on the Family have many resources available to help Christians serve Christ in their communities. Specific journals address concerns of pastors, doctors, single parents, children, seniors and more. Dr. Dobson's daily radio program frequently addresses bioethical issues of pressing concern.

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The Centre for Bioethics and Public Policy
58 Hanover Gardens, London, SE11 5TN
0171-587 0595 (tel.)
0171-587 0595 (fax)
Email: 100524.1567@compuserve.com

Closely allied with CBHD, CBPP is a voice for Christian bioethics in England and the European mainland.

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The Rutherford Institute
P. O. Box 7482
Charlottesville, VA 22906
804-978-3888

The Rutherford Institute takes on legal cases for clients who they feel are unjustly having their Christian freedoms limited. They have defended prayer in public ceremonies, wider use of creation-based biology curricula, discrimination in the workplace and other timely concerns.

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National Conference of Catholic Bishops
800-235-8722
In Washington, D. C., or outside the U. S. A., call:
202-722-8716
www.nccbuscc.org

The National Conference of Catholic Bishops have some excellent, well-reasoned directives on Catholic Health Care Services, Health and Health Care, HIV and AIDS, and other topics available to the public at a nominal fee.

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The Free Methodist Church of North America
World Ministry Center
770 North High School
Indianapolis, IN 46214-3756
317-244-3660
<http://fmcna.org/>

The Free Methodist Church of North America recently appointed a Study Commission on Bioethics, of which I am a member. We seek to speak clearly, if briefly, on key issues for Free Methodists around the world. We align ourselves ethically closely with the Center for Bioethics and Human Dignity and Christian Medical Association.

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Glossary

Alpha-fetoprotein—natural human biochemical marker reflects likelihood of multiple births or birth defects

A. L. S.—Amyotrophic Lateral Sclerosis, Lou Gehrig’s disease, characterized by degeneration of the motor neuron cells in the spinal cord, causes progressive neuromuscular decline and death; no effective treatment at present

Autonomy—individual independence or freedom

Beneficence—attitude of good will to other persons

Blood gases—a blood test that reflects the degree of oxygenation of blood, as well as level of Carbon Dioxide, pH, and other factors.

Brain Stem signs—on physical examination, findings that reflect integrity of the portion of the brain called the brain stem; absence of all brain stem signs constitutes brain death

Cardiologist—physician specializing in care of the heart and circulatory system, who does not perform surgery, but may perform invasive diagnostic and therapeutic procedures

Code, Code Blue—extensive resuscitation process, usually involves CPR, defibrillation, and placement of an endotracheal tube for artificial ventilation

Communitarianism—the political/social philosophy which states that the interests of the whole group need to be given high priority in personal decision-making.

Confidentiality—particularly in medical relationships, the policy of keeping private information secret between patients and their physicians

Co-pay—amount of money necessarily payable by insured person to receive health care; may apply to medicines, surgeries, office visits, or durable supplies

DNA—deoxyribonucleic acid, the building blocks for the genes, which are located on the chromosomes, which transmit all genetic information to offspring

Doe v. Bolton—landmark abortion case tried before Supreme Court, broadly defined health of mother to include emotional health, thus allowing legal justification for many abortions, 1973

Embryo—the young of a viviparous mammal, in early development, in the womb; in humans up to the end of the second month of gestation

False Negative—an incorrectly negative answer on a given medical test. This gives the physician the impression that a given disease has been ruled out, but this is not true.

False Positive—an incorrectly positive answer on a given medical test. This gives the physician the impression that a given disease state has been identified, but this is not true

Fetus—the embryo after the end of the second month gestation

Fiduciary—a person who is in a position of responsibility and trust, in care of something vital to another person or persons, such as health or finances

Gamete—a mature reproductive cell, as in an egg or a sperm; a fertilized gamete is an embryo

Genome—the complete set of hereditary factors contained in the DNA (see above)

HIV+--(HIV positive) evidencing by blood test the presence of the Human Immunodeficiency Virus

Hyperovulation—hormonal process by which multiple eggs are caused to mature simultaneously, usually for harvest for artificial fertilization

Intensive Care Unit--hospital location for seriously ill patients, frequently on artificial ventilation or artificial feeding.

Internist—physician specializing in care of adult patients; training requires a minimum of three years supervised study after medical school, does not perform surgery (To be differentiated from Intern, a first-year post-medical school trainee doctor.)

Intubation—placement of endotracheal tube for artificial ventilation

In Vitro—occurring “in glass”, or under laboratory conditions

In Vivo—occurring “in life”, or under normal biological conditions

Justice—a broad term which includes the meaning of fair distribution; that is, each person should receive like goods, services, and opportunities

Neurologist—physician specializing in care of the brain, spine and nervous system, but who does not perform neurosurgery

Non-maleficence—absence of malice toward other persons

Ova—(plural), Ovum—(singular)—human female egg

Person—seemingly a straightforward word, but in utilitarianism this is defined as a living thing with the capacity to grow, learn and establish social ties; thus, many humans are not persons, and many animals are persons under this model

Respirator, artificial—machines employed to cause patients to breathe; they control the rate, volume, and oxygen content of inspired air

Roe v. Wade—landmark Supreme Court decision legalizing abortion in 1973

Teleology—The study of final causes; in many disciplines it means a method of explanation in terms of intention or purpose; in ethical decision-making it identifies a method which focuses on likely outcomes

Tithe—a tenth part set apart for God; Any tax, levy or the like, especially a tenth

Utilitarianism—philosophy based on “Most benefit for the most persons”

Ventilation, artificial—see Respirator, artificial

Pre and Post-Tests

If you wish, you might find it a useful exercise to give the following test to your class before you even start the first lesson, and again after completing your last lesson. I would suggest that after your class turns in the first test you file them without discussion. At the end of the course, give them the same test again. Next, give them the answer key along with their first test and have them calculate the difference in scores between the two tests.

- 1) What are the two most frequently used methods employed in bioethical decision-making? Pick two of the following: A. Talmudic logic, B. Hegelian discourse, C. Teleology, D. Rule-based reasoning, or E. Natural law
- 2) John Wesley, English reformer employed four rules for decision-making. Out of the following list, pick four. A. Appeal to Natural law, B. Reason, C. Urim and Thummim, D. Drawing Straws, E. Scripture, F. Experience—including the inner witness of the Holy Spirit, G. Tradition, including creeds, H. Talmudic logic
- 3) People who believe that everything possible should be done for every person as long as they remain alive are called: A. Totalists, B. Vitalists, C. Extremists, or D. Christians
- 4) The historical proponent of Natural Law was: A. Polycarp, B. Thomas a Kempis, C. David of Chalcedon, D. Thomas Aquinas, E. Pope John Paul XIII
- 5) “The end justifies the means” is the motto of: A. Communitarians, B. Utilitarians, C. Anabaptists, or D. Zoroastrians
- 6) In secular bioethical discourse four guideposts are frequently used. Pick four: A. Natural Law, B. Justice, C. Brotherhood, D. Diversity, E. Autonomy, F. Equality, G. Beneficence, H. Charity, I. Hope, and J. Non-maleficence
- 7) Roe v. Wade was a famous abortion Supreme Court case, that was decided on the same day as: A. Plessy v. Hammerschmidt, B. John Brown v. Illinois, C. Doe v. Bolton, or D. Kessler v. Arizona
- 8) Living Wills are essentially the same as “Do Not Resuscitate” physician orders (True or False)
- 9) The Netherlands experience proves that the “slippery slope” argument is worth considering (True or False)
- 10) The Bible tells us that as long as we are sincere God will bless our efforts (True or False)
- 11) Brain Death is defined primarily as when: A. There is no speech or reason, B. When all vital signs are absent, C. When brain-stem signs are gone, or D. When the patient responds only to deep painful stimuli.
- 12) Rationing sounds wicked, but may be an appropriate concept for Christians to employ at times (True or False)
- 13) To be legal, only a court order can “turn off the machine” on a critical patient in the Intensive Care Unit (True or False)

Answers:

- 1) C and D
- 2) B, E, F, and G
- 3) B
- 4) D
- 5) B
- 6) B, E, G, and J
- 7) C
- 8) False
- 9) True
- 10) False
- 11) C
- 12) True
- 13) False

Final Note

This study curriculum is provided, without cost, for use in personal or group study. This is not copyrighted, and you may download and make as many copies as you like. It is my hope that God will use this to help you learn more about Bioethics and become his Salt and Light in your community.

If you use this, my one request is that you would let me know where it is being used, and how many are involved in your group. I can be notified by email at:

robert.cranston@carle.com

Or by snail-mail at:

Robert E. Cranston, MD
C/O Carle Clinic
602 West University Avenue
Urbana, Illinois 61801

Thanks and God Bless.

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