Bioethics—Getting the Big Picture Right

I. **Definition**: "Bioethics" is more than just medical ethics (that is, the specific moral guidelines that govern doctors), but a larger field of inquiry that asks deeper worldview questions like:

A. What does it mean to be human? Is human nature objective (fixed) or are we free to transcend or alter it?

B. What makes humans valuable? Are they valuable by nature or function? Put differently are they endowed with fundamental rights or do they gain them by cognitive performance?

C. What is the purpose of medicine, to repair or enhance? And who decides what traits we should enhance?

D. What is the nature of right and wrong as applied to medical treatments? Are there objective truths or are consent and autonomy enough?

E. How should questions of human value and morality impact public policy? Should our laws reflect deeper worldview considerations?

II. Life on the Edges—Three Key Areas Where Bioethics is Debated:

A. Area #1: Beginning of human life—Reproductive (assisted) technologies. Types of RTs include:

1. Intrauterine insemination (IUI)—Sperm is artificially inserted into the uterus via a catheter. Fertility drugs are often used to produce multiple eggs. There is no way to control the number of resulting embryos. Thus, the risk of selective termination of embryos is real. To avoid multiples, IUI should be preformed without multiple ovulation drugs.

2. Gamete intrafallopian transfer (GIFT)—Sperm and egg are removed and placed in close proximity to each other in the fallopian tube. Thus, fertilization occurs in woman's body.

3. In vitro fertilization (IVF)—Like GIFT, sperm and egg are collected. However, unlike GIFT, they are joined in a test-tube rather than the woman's body. The resulting embryos are either implanted or stored on ice.

4. Zygote intrafallopian transfer (ZIFT)—Similar to IVF, only embryos are implanted in the fallopian tube rather than the uterus.

5. Egg donation—Donor woman is given hormonal stimulation to release multiple eggs which are retrieved via surgery. The eggs are then given (sold, really) to the infertile couple and are fertilized using GIFT or IVF. Egg donation is expensive, difficult, and involves powerful hormonal drugs to produce multiple eggs.

6. Surrogacy–two types:

(a) Genetic surrogacy: Surrogate is inseminated with husband's or 3rd party sperm. She provides the egg and the womb. After conceiving and carrying the child, she turns over her parental rights to the contracting couple. The genetic surrogate is not only the child's biological mother; she is also the legal mother until the adoption is complete. In short, a child is conceived for the express purpose of being turned over to someone else.

(b) Gestational surrogacy—Surrogate provides the womb but not the egg. Embryos created via IVF are implanted in the surrogate. Upon birth, she relinquishes all rights to the child. Gestational surrogacy is commonly known as "womb renting."

Either type of surrogacy—genetic or gestational—can be done for a substantial fee (commercial surrogacy) or for no fee (altruistic surrogacy). Both involve creating a child for the express purpose of giving him up to someone else.

B. Area #2: End of life issues—Definitions:

1. Euthanasia—physician kills patient with lethal injection
2. Doctor-assisted suicide—physician provides patient with lethal drugs. Patient takes the drugs.

C. Area #3: Improvement or altering of human life—key questions:

1. Biotechnology: Is our purpose to restore the body or enhance it?
2. Is it okay to alter human nature so we can transcend our natural limits?
3. What's the difference between somatic cell gene therapy and germ-line therapy?
4. Is germ-line therapy—which impacts all succeeding generations minus their consent ethical? What if the risk to future generations is unknown? Will it be used to heal or enhance? Will it be used for eugenics, to create super race of humans? Or, will parents use it to select traits such as eye color for children they manufacture?

III. Bioethics: Moral and Theological Considerations:

A. **Beginning of human life**—Assisted Reproductive technologies are not wrong provided they fall within six biblical fence posts:[1]

1. The status of **the unborn**. Any reproductive technology that intentionally destroys human life is out of bounds.

2. The gift of **common grace**. Technological advances that improve the lot of mankind and help alleviate the effects of sin's entrance into the world are part of God's common grace, His general blessing on creation. Infertility is an effect of the Fall, thus, in principle, there is no biblical reason why medical technology can't be used to treat infertility like it does malfunctions of the liver, heart, kidney, or other organs. Medical technology is God's gift to human beings, especially when used to help the human race fulfill its mandate to multiply and fill the earth (Gen. 1:27). Of course, some reproductive technologies are morally problematic. However, it doesn't follow infertile couples can't use any assisted technologies.

3. Pro-creation is to happen within **marriage**. Without exception, when Jesus and Paul describe marriage within the context of the new covenant, they do not appeal to the polygamist kings and patriarchs of the Old Testament, but the pre-fall monogamous union of Adam and Eve in Genesis 2. It's here we find the norm for marriage and sexuality. "For this cause a man shall his father and his mother and shall cling to his wife; and they shall become one flesh" (Gen. 2:24; Mt. 19:5; Mark 10:7-8; 1 Cor. 6:16; Eph. 5:31). It's within this context of permanent, heterosexual marriage God commands the man and wife to be fruitful and multiply. In short, the mandate to procreate is given to Adam and Eve within the context of leaving, cleaving, and becoming one flesh (Gen. 2:24). And though polygamy, surrogacy, and divorce were allowed in the Old Testament, they were never sanctioned. The norm was the creation account. Meanwhile, children born into a marriage do better on every level than ones raised by single parents or homosexual parents. Conjugal marriage brings together the two halves of humanity (male & female) in a monogamous relationship that is permanent and ordered toward the begetting of children. Marriage provides children a relationship with the man and woman who made

[1] This section relies on Scott Rae, *Moral Choices: An Introduction to Ethics* (Grand Rapids: Zondervan, 2009).

them. Maggie Gallagher: "Sex makes babies. Society needs babies. Babies deserve mothers and fathers."

4. Adoption as a **legitimate rescue** mission. Biological lines of descent matter. However, traditional adoption is not like surrogacy arrangements where a child is created with intent of placing him with someone other than the mother who carried and/or conceived him. Rather, the child already exists and we provide a necessary rescue.

5. Trust in God's **sovereignty**. Any reproductive technology can fall outside biblical parameters if motivated by desperation. There is no unrestricted right to procreate.The virtue of contentment is part of the Christian walk (1 Cor. 7:17-28). This does not mean passive acceptance of infertility or rejection of assisted technologies, but a refusal to make having a child an ultimate good (idol).

6. Carefully consider the **risks** of reproductive technologies:

    (a) Risk of major multiples when fertility drugs are used with IUI
    (b) Risk of leftover embryos w/ IVF treatments
    (c) Risk of seeing children as products of parental desire rather than gifts we receive.
    (d) Risk of donor gametes—outside biblical model of procreation w/in marriage
    (e) Moral issues with surrogacy: First, commercial surrogacy looks like baby selling and thus violates the 13th Amendment—which outlaws selling human beings. Second, commercial surrogacy violates the dignity of human beings. Persons are not to be sold as objects. Third, surrogacy of any kind creates a moral and legal mess: The biological mother conceives a child for the express purpose of giving him up to someone else! Fourth, commercial surrogacy exploits poor women in impoverished nations who "rent their wombs" (either as gestational or genetic surrogates) for desperately needed cash.

7. In short, reproductive technologies are not forbidden, but…

    (a) Couples who use assisted technologies must take personal responsibility for every embryo created. All deserve to be implanted.
    (b) Leftover embryos (those in storage) should be kept to a minimum. Thus, fertility drugs should not be used to create more embryos than the couple can implant during their reproductive years. If excess embryos remain, the only ethical option is donation to an adopting couple.
    (c) Couple should not implant more embryos than the wife can safely carry. Embryo "reduction" is the moral equivalent of abortion.
    (d) Pre-implantation screenings, like pre-natal screenings, should be rejected. It turns children into commodities we produce for our enjoyment. Worse still, it's used as a search-and-destroy mission to weed out defective embryos.

    Summary: Technological advances that help alleviate the effects of sin's entrance into the world are part of God's common grace, His general blessing on creation. Infertility is an effect of sin's entrance to the world; thus, there is no biblical reason why medical technology can't be used to treat it. Of course, some reproductive technologies are morally problematic, but not all are. A couple using them must take personal responsibility for any resulting embryos. At a minimum, it means only creating embryos the woman can safely carry to term. Moreover, reproductive technologies are not neutral. They teach us to think about children as commodities who are made rather than begotten. The result is the self-centered production of children for our benefit. When a couple destroys an embryo who does not measure up to particular standards, the child's intrinsic worth is sacrificed for the parent's quality of life. Under those conditions, children are no longer a gift, only the property of parents. Christians in particular must resist the idolatrous desire to have children at any cost. They must also reject functionalist accounts of human value. The claim that destroying excess embryos for research is no big deal because they are not self-aware is deeply problematic. How self-aware must you be to count? And if self-awareness

determines value, don't those with more of it have a greater right to life than those with less? The result is savage inequality. Finally, Christians should avoid third-party gametes and surrogacy arrangements that undermine the one-flesh union of husband and wife and blur biological lines of descent.

B. **End of human life**—When is it okay to withdraw or withhold treatment from a dying patient? Is it okay for a physician to cause or hasten death? What if morphine, used to control pain in dying patients, hastens death?

1. Withholding treatment that no longer benefits a patient is morally permissible but intentionally killing him is not. The biblical case against euthanasia and physician assisted suicide is clear: Humans bear the image of God and thus have value (Gen. 1:26-27). Because humans bear the image of God, the shedding of innocent blood—that is, the intentional killing of innocent human beings—is strictly forbidden (Ex. 23:7; Prov. 6:16-19; Matt. 5:21). Euthanasia and physician assisted suicide shed innocent blood—that is, both intentionally kill innocent human beings. Therefore, euthanasia and physician assisted suicide are wrong.

    (a) Christians are *not* masters of their own fate. They belong to God (1 Cor. 6:19-20). They are to honor God with their bodies, not destroy them. The timing of one's death belongs to God alone (Heb. 9:27). Meanwhile, a *desire* to die is not the same as a *right* to die.

    (b) Autonomy is not absolute. You cannot use your body for prostitution or illegal drugs. Moreover, if the right to die is grounded in autonomy, you can't limit that right to dying people. Anyone—sick or well, old or young—must be able to exercise it and government must compel others to help them exercise it. But this undermines the autonomy of physicians, who are forced to participate in assisted-suicides or quit.

    (c) We can control pain without intentionally killing the patient. Even if we heavily sedate them so they "sleep" before they die, the intent is not killing, only controlling their suffering.

    (d) The argument from utility is problematic. The argument goes that the right to die results in good consequences for all given patients are relieved of suffering and society saves on healthcare costs. The worldview in play here is utilitarianism—namely, we should forget objective moral rules and pursue the greatest good for the greatest number. However, utilitarianism is flawed. First, some acts are wrong in themselves—such as torturing toddlers for fun or framing innocent people for crimes they didn't commit—even if the majority benefits. Second, it's an incomplete theory: Utilitarianism can't define "good" without borrowing from other, deontological systems. Third, utilitarianism fails to give guidance on decision making. That is, it can't calculate the greatest good. For example, suppose you have $5,000,000 to help the poor. Should you give one dollar to 5,000,000 people or give the whole sum to an agency that will feed one thousand orphans for a decade? Fourth, the consequences of an act are difficult to measure. How long must we wait to know if the greatest good was served? Finally, who decides what is useful/good? Might makes right in this system.

2. For the Christian, death is indeed an enemy, but it's a conquered enemy. The resurrection of Jesus Christ secures a resurrected and perfected body for every believer (1 Cor. 15).

3. Because death is a conquered enemy, it must not always be resisted. In cases where further treatment is futile or burdensome to the dying patient, death can be welcomed as the doorway to eternity. Earthly life, while good, is not our ultimate good. Eternal fellowship was God is. Allowing natural death to run its course does not violate the sanctity of human life. However, we must never forget that terminally ill

patients—like all humans—bear God's image. Thus, we are never to intentionally kill them via euthanasia or doctor-assisted suicide. We are obligated to always care and never harm.

4. Intent (aim) matters! Are we withdrawing treatment from a dying patient because we intend to kill him or because it no longer benefits him? Agneta Sutton makes a great point: A truly medical (as opposed to quality of life) decision to withdraw treatment is based on the belief that the treatment is valueless (futile), not that the patient is so. So, while doctors are indeed qualified to determine if a treatment is futile, they are no more qualified than anyone else to determine that an individual life is futile. Food and water should only be withdrawn in the final stages when they no longer benefit the patient and will only cause additional suffering. On this understanding, the withdrawing of treatment is not intended to kill, only to avoid prolonged and excessive agony for the patient. True, death will come, but it comes as the result of the illness not my direct action. Gilbert Meilaender puts it well: "The fact that we ought not aim at death for ourselves for another does not mean that we must always do everything possible to oppose it." Thus, rejecting a treatment that is burdensome is not a refusal of life. But here the physician must be both careful and honest. Instead of asking, "Is the patient's life a benefit to him?" the physician should inquire "What, if anything, can we do that will benefit the life that he has? Our task, writes Meilaender, "is not to judge the worth of this person's life relative to other possible or actual lives. Our task is to care for the life he has as best we can."

5. Regarding morphine, we must again draw careful distinctions, this time between euthanasia and sufficient pain relief to dying patients. Put differently, Meilaender says we must distinguish between an act's aim (intent) and its foreseen results. A patient in the final stages of terminal cancer may request increasingly large doses of morphine to control pain even though the increase might (though not necessarily) hasten death. In this particular case, the intent of the physician is to relieve pain and provide the best care possible given the circumstances. True, he can foresee a possible result—death may come slightly sooner—but he does not intend that. He simply intends to relieve pain and make the patient as comfortable as possible. Thus, instead of intentionally killing the patient with a heavy overdose, he provides a carefully calibrated increase in morphine aimed at controlling pain, not bringing about a quicker death. As Scott Rae points out, "it's acceptable for dying patients to sleep before they die." Though death is foreseen, it is not intended. In the end, the patient dies from his underlying illness, not because the doctor intentionally kills him.

6. To sum up, treatment can be removed when:

    (a) competent patient requests removal because treatment is futile; burden outweighs benefit.
    (b) intent (aim) is not to kill, but make the patient as comfortable as possible

C. **Improvement or altering of human life**—Biotechnology: Is our purpose to restore the body or enhance it? Is it okay to alter human nature so we can transcend our natural limits?

1. We live in a fallen world. As noted earlier, the use of medical technology to treat disease is part of God's general revelation to alleviate the effects of sin's entrance to the world. Biotechnology used to repair the effects of the fall clearly within biblical limits.

2. Enhancing existing traits is not reversing or repairing the effects of the Fall. Here is where it gets fuzzy. Where is the line between repair and enhancement? Are all enhancement therapies wrong? What about:

    (a) Orthodontics (braces) / baldness treatments
    (b) Cosmetic surgery
    (c) Anabolic steroids to enhance muscle growth in athletes
    (d) Beta blockers to calm performance anxiety
    (e) Medications like Adderall, Ritalin, etc., have clinical uses, but can be used to enhance.

3. Biblical concerns with enhancements:

   (a) **The imago Dei**: What is our motive/intent for using enhancement therapies? That is, in using them we run dangerously close to buying a premise hostile to a biblical understanding of the imago Dei. Namely, we wrongly assume our value is grounded in our performance (or traits) not our common human nature which bears the image of our Maker. Immoral motivations include beliefs that certain bodily traits (skin color, hair, eye color, etc.) are inferior and should be changed. Accepting that premise is a slam against God's wisdom. Attitudinally, it assumes God erred including such diverse traits in the human race. Practically, it results in discrimination against those we judge inferior because they possess undesirable traits.

   (b) **The distinction of species**: Are we honoring biblical parameters found in the creation account? Cross-species mixing is wrong. Scripture is clear God created living things according to their kinds (Gen. 1). Humans are particular kind of beings, with fixed natures and intrinsic purposes they are to fulfill. The clear distinction between species is called "good."

   (c) **Access**: Are we creating a widening gap between have and have nots? Will families face pressure to enhance or be left behind? Will failure to use enhancement therapies be seen as child neglect? The fate of families who refuse to enhance is unknown.

   (d) **Justice:** What is our obligation to future generations? Is it right to alter the genetic structure of future generations without their consent, especially when the long-term effects of enhancement are unknown? Enhancements have tradeoffs: an enhancement of one trait impacts other traits.

   (e) **Authority**: Who decides which traits are desirable? How many of them must you have to count? And why those traits and not something else? Which worldview determines acceptable traits? Genetic enhancements force parental values on children and future generations.

   (f) **Contentment**: Does our use of enhancement technologies undermine the givenness of life? Will it undermine incentive to put forth a good effort?

   (g) **Human rights**: If human nature is not fixed, neither are the rights that flow from that nature. Those in power will not only decide which traits matter, but who counts as one of us?

4. Conclusion: Genetic therapies that cure disease are morally permissible, but therapies used to enhance the genetic endowment of the person are problematic. Traits like eye color, height, and gender are God-given and His sovereignty in these matters should not be usurped. The notion of designer offspring undermines the unconditional acceptance of children as gifts. Regarding enhancements in general, Christians should skeptically view technologies aimed at re-writing the created order. It is one thing to restore (or repair) human function. It is quite another to alter the natural limits of human nature. As Kevin Vanhoozer points out, the quest for cognitive enhancement is as old as Adam and Eve. It's a denial of the created order and represents salvation through medical technology. For the Christian, transformation does not come through biochemistry, but through growing up in Christ (Ephesians 4:15). The gospel, in particular, is about conforming our minds to Christ, not enhancing them with a substitute bio-chem savior. Enhancing one's cognitive limits implies a wrongful heart towards the Creator's design. The larger biblical narrative is the story of God redeeming the world from the Fall and how He is renewing, not enhancing, all things. For the Christian, the ultimate reality is a resurrected body, not chemical transformation. In short, using technology to repair broken bodies is a gift from God. Using

it to transcend our God-given limits is sin. (Vanhoozer cited in Kilner, pp. 105-124; see also Mitchell, pp. 110-136)

Discussion:

Case Study #1: Dying Patient—

The daughter of a dying patient sends you an email asking a few heart-wrenching questions. How should you reply within the context of a Christian worldview? Be prepared to explain your answer.

My father is nearing the final stages of terminal cancer. He's refusing further aggressive treatment for the disease and is content to die and be with the Lord. The disease is spreading rapidly. His physician tells us that very soon, food and water will no longer benefit him and will only increase his discomfort. At the same time, the doctor said that without heavy doses of morphine (pain control), dad will suffer greatly as death approaches. Three questions: 1) Is it wrong for dad to refuse further treatment? 2) Is it morally permissible to remove his food and water tube? Why or why not? 3) Isn't increasing his morphine tantamount to hastening his death, perhaps a gentle form of euthanasia? At a minimum, it will render him unconscious. What principles should guide my decision? Dad loves Christ and would want me to please God in all this. Please help."

Case Study #2: Infertile Couple—

A childless couple from church in their late 30s seeks your advice. They desperately want a child and their only hope is a controversial in vitro fertilization (IVF) procedure where, after receiving hormonal stimulation, the wife releases multiple eggs that are then fertilized in a test tube with her husband's sperm. The doctor will then place up to five resulting embryos in her uterus in hopes that at least one will implant. But here's the problem: She is not strong enough to handle a multiple pregnancy and if multiple embryos implant, her doctor insists she must "reduce" (abort) the extras or face serious health risks, including the loss of the implanted embryo she desperately wants. He insists "reducing" the surplus embryos is morally permissible because they can't yet function with self-awareness or feel pain. What advice should you give this couple? Are reproductive technologies like IVF intrinsically wrong or is there a way for couples to use them responsibly? What key principles should guide their decision?

Case Study #3: Enhancement Therapy—

Dr. Bright—an enterprising scientist and anatomy professor at a leading medical school—has secretly developed a new germ-line therapy that will radically enhance the cognitive abilities of those who undergo it. It works by altering the gene structure of nerve cells, enabling recipients to radically transcend their natural intellectual limits and thus gain a substantial competitive advantage over their fellow medical students. As one of his medical interns, Dr. Bright wants you to take the therapy, which is completely safe and legal for clinical trials, but will alter your genetic structure and that of your descendants forever. When you hesitate, he asks why you resist transformational change that will enhance human nature and make you better at healing others. Besides, it's not different than a treatment that restores lost brain function. As Dr. Bright's intern, should you participate in a therapy that enhances your natural limits? How does a Christian worldview inform your decision one way or the other?

Appendix—Competing Worldviews in Play: Bioethics and Human Value

Everyone doing bioethics must grapple with worldview questions in five key areas. How one answers these questions profoundly impacts how one approaches bioethics.

1. Metaphysics: What is the nature of reality? What is ultimate reality—material or immaterial?
2. Epistemology: How can we know the world? What counts as knowledge?
3. Anthropology: What is human nature? What makes humans valuable?

4. Ethics/morality: What is right and wrong?
5. Cosmology: How did we get here? What happens after death? Where is history going, guided or unguided?

Neutrality is impossible. Everyone brings certain worldview assumptions to the table when doing bioethics. The two primary worldviews in play are:

- **Philosophical Naturalism**—Reality is strictly physical and consists of the material world alone. Only what we observe via the five senses counts as knowledge (a view known as scientism). Non-material things like souls, minds, morals, and human value are not real, but mere human constructs. Human dignity itself is a fiction and thus has no basis in reality, only religion. Indeed, in a universe that came from nothing and was caused by nothing, human beings are cosmic accidents reduced to their genetic properties. It follows that in a strictly material universe, autonomy and consent drive bioethics. Stephen Pinker is a case in point. For Pinker, the concept of human dignity is "stupid" and lots of people disagree with it. When doing bioethics, we should abandon all worldview considerations in favor of consent and autonomy. However, Pinker assumes naturalism to debunk human dignity. And if disagreement means nobody is right, Pinker's own view is false. After all, many people disagree with Pinker. Moreover, naturalism is deeply flawed. First, it is self-refuting. The claim that all reality is material cannot be verified empirically. It is a philosophic, non-material claim. Second, naturalism can't say why anything has dignity and a right to life—fetuses or adults. Given we're all cosmic accidents, there is nothing special about any of us. Third, naturalism can't account for criminal justice (which assumes free moral agency, not determinism) or the existence of personal identity over time.

- **Christian Theism**—Ultimate reality is immaterial—namely, a personal God who created the material world. The material world actually exists and can be known, but it is not the only reality. Immaterial things like souls, morals, logic, and human nature exist. If non-material things exist, physicalism is false. On theism, Humans have value because they bear the image of their Creator rather than some function they perform. They are not mere biological machines, but living substances with a rational nature that endures through time and change. Meanwhile, theism provides a robust foundation for objective moral rules. Morals are not fiction, but are grounded in the character of a holy God.

Ask: Which worldview does a better job accounting for intrinsic human value and objective moral rules?

Resources: Gilbert Meilaender, *Bioethics: A Primer for Christians* (Grand Rapids: Eerdmans, 2005); Agneta Sutton, *Christian Bioethics: A Guide for the Perplexed* (London: T&T Clark, 2008);C. Ben Mitchell, et al, *Biotechnology and the Human Good* (Washington, DC: Georgetown University Press, 2007); Scott Rae, *Moral Choices: An Introduction to Ethics* (Grand Rapids: Zondervan, 2009); John Kilner, et al, *Why the Church Needs Bioethics* (Grand Rapids: Zondervan, 2011).