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ON THE SCANDAL WITHIN THE SCANDAL OF BIOETHICS

ERIK M. CLARY, MDIV, MA, PHD CANDIDATE

In assessing the state of contemporary bioethics, many are now lamenting the secular state of a field that, by some accounts, emerged largely from the wellspring of Christian theology. The origin of bioethics, I believe, is more complicated than this scenario admits, but it is certainly true that overt theological argumentation, while permeating much of the discipline's early discourse, is largely absent from today's mainstream treatments. Labeled as "The Scandal of Bioethics," this diminution of theological voice in bioethics is a cause for serious concern, and so, I applaud CBHD for focusing our attention on the issue during this summer's national conference.

In this brief essay, I wish to extend the discussion begun by the conference's excellent panel of speakers, and more specifically, I propose that we take a look inward. Tempting as it may be to attribute the Scandal to foes whose mission it is to rid the public square of Christian influence, a careful examination of the matter reveals complicity within the camp of those touting theological credentials. In particular, I am speaking of the willingness of some to set aside theological categories and content in favor of philosophical formulations that are incapable of safeguarding the distinctive morality of a truly Christian bioethics. This, I submit, is the scandal within the Scandal.

As evidence of this deeper scandal, I think it sufficient to consider two examples drawn from mainstream bioethics. First, there is the reigning paradigm in contemporary medical ethics commonly referred to as "principlism." Co-developed and tenaciously defended by Yale-trained theologian James F. Childress, the principlist approach, in fact, requires no positive theological commitments.[1] This is no accident as Childress and his coauthor, philosopher Tom L. Beauchamp have, in deference to pluralist concerns, sought to extract their principles from a putative common morality. For warrant, their appeal is not to theology but to the philosophers—Immanuel Kant, J. S. Mill, and W. D. Ross, in particular.[2] Indeed, not knowing that one of the two chief proponents of principlism had received formal theological training, the reader of their signature work would never arrive at such a conclusion. I expect that Childress would receive such criticism with satisfaction given his apparent desire to deliver a bioethics for the masses, but honestly, I must confess great disappointment not only with the product—principlism, as Gilbert Meilaender has rightly observed, yields an exceedingly shallow bioethics[3]—but, even more, with the process. Should not a theologian be reflecting *theologically* on bioethics? Sadly, the error has been compounded as many moral theologians have taken the principlist ball and run with it—reshaping it, perhaps, to accommodate particular preferences, but nonetheless adopting the paradigm and its flawed starting point for ethical discourse.[4]

As a second example of the flight from theological warrant in bioethics, I offer the case of personhood theory. For almost two millennia, the Christian community was uniformly resolute in its condemnation of elective abortion, infanticide, and euthanasia,[5] but not so in recent decades as some Christian scholars and leaders—evangelicals included—have accommodated their ethics to the proposition that some human beings are nonpersons and thus subject to being used and even destroyed in service to the purported good of those said to reside within the community of persons.

Some influential Christians, like the late W. A. Criswell, a former president of the Southern Baptist Convention, initially accepted the personhood distinction but then rejected it upon later reflection.[6] Others, however, have been tenacious in their defense of the concept, including Lutheran ethicist-theologian Ted Peters, a staunch supporter of human embryonic stem cell research.[7]

As with principlist bioethics, the personhood distinction constitutes a double, black eye for the Christian theological community—not only have some among our number latched on to such a dubious philosophical concept, but the very fountainhead of the idea is located within our camp. Sadly, it is to theology that secular ethicists, including Peter Singer, point when discussing the origins of personhood ethics. As Singer states,

> It is possible to give "human being" a precise meaning. We can use it as equivalent to "member of the species *Homo sapiens*" . . . . There is another use of the term "human," one proposed by Joseph Fletcher, a Protestant theologian and a prolific writer on ethical issues. . . . This is the sense of the term that we have in mind when we praise someone by saying that she is "a real human being". . . . These two senses of "human being" overlap but do not coincide.[8]

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from the director's desk

BY PAIGE COMSTOCK CUNNINGHAM, JD
EXECUTIVE DIRECTOR

I feel compelled to once again address the subject of how we in the church live out what we say we believe. This is one prong of the Center's two-part vision that a Christian approach to bioethics influences both academic scholarship and the practical, lived-out experience of the church. My reflections are prompted by several recent interchanges.

Example number one: A few weeks ago, a group of Christian business owners and senior officers invited me to present the bioethical issues raised by the use of brain boosting drugs in the workplace. Afterwards, a couple spoke to me about their daughter who self-diagnosed herself with ADHD and persuaded a doctor to prescribe a drug like Ritalin. They were concerned about her dependence on the drug, with no discernible need or benefit.

Example two: A pastor described, with some consternation, a young couple in his church dealing with infertility. Distressing, but not shocking. But then he added that they were expecting twins through a gestational surrogate. Their surrogate? The wife's mother.

Example three: a dialogue on Facebook about whether the church should speak out on moral issues like abortion from the pulpit. I was privy to only one side, but what I read concerned me. A few samples:

> "Our church preached the WORD of God but did mention Roe v Wade in the Bulletin. That is the proper perspective: Preach Christ (not politics) but do speak out."
>
> "Christians know that abortion is wrong. What is the point of telling folks who already believe to go out and stop abortion? I can do lots of things including supporting a crisis pregnancy center—but that is parachurch. THAT IS NOT THE CHURCH."

I could recite even more examples, but these suffice to raise the question: is preaching the Gospel sufficient grounding for Christians to make wise moral decisions? Granted there are legitimate questions about the relationship between church and state, but are there better, wiser, more theological ways of helping the church live out its convictions in our pluralistic, secular setting? While for some Christians, the wrongness of abortion is self-evident, I have not found that to be universally true. I think of the Christian house church pastor in China who had an abortion herself and advised others in her congregation to do the same. She preached the gospel under persecution, yet she did not reach the proper moral conclusion about the taking of innocent life.

In the Fall 2011 issue of *Dignitas,* Hans Madueme wrote at length about thinking theologically about bioethics. In this issue, Erik Clary highlights the absence of theological reflection that contributes to the impoverished discourse of principlism and personhood theories in bioethics. In both cases, they are dealing with the significance of theology for bioethics. I would like to suggest that we also take the importance of bioethical thinking for the everyday life of the church one step further. More to the point, how do pastors and the church account for some of the most pressing issues of the 21st century? Why is it that so many pastors feel uncomfortable counseling their congregation about matters such as contraception, infertility, assisted reproduction, behavior- and cognitive-modifying drugs, medical care for the disabled, and end-of-life decisions?

Several dispositions are at work here. One is the approach to preaching. Whether one's homiletics is expository, devotional, textual or topical, without a bioethics "lens," the preacher may never make a connection between scripture and the dignity of the human body. And besides, the ministry of the Word is broader than simply preaching; preaching is important but there are other ways to minister God's Word in the context of the church (e.g., counseling, Sunday school, small group ministry, etc.). Are churches thinking creatively about ways to engage bioethics and other contemporary challenges in the life of the church?

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The Center for Bioethics & Human Dignity (CBHD) is a Christian bioethics research center at Trinity International University.

"Exploring the nexus of biomedicine, biotechnology, and our common humanity."

Dignitas is the quarterly publication of the Center and is a vehicle for the scholarly discussion of bioethical issues from a Judeo-Christian Hippocratic worldview, updates in the fields of bioethics, medicine, and technology, and information regarding the Center's ongoing activities.

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Another is the divine command approach to ethics: "simply do what the Bible says." This reduces the ethical and prescriptive nature of Scripture only to command texts, which make up a small portion of the Bible. One's hermeneutic will affect the commands they see in the text, and the application of those commands. Silence of the text could be interpreted—wrongly, in some cases—as approval. There is no particular verse or passage that directly instructs us about human cloning. Yet, this is a profoundly important moral issue. Do we know how to allow *all of Scripture* to speak into the bioethical complexities of our day? If pastors and church educators do not understand this, we should not be surprised when their congregants flounder in their search for a relevant Bible verse, unaware how Scripture *does* address their moral dilemma.

Another disposition is the ignorance of how the Bible *does* inform bioethical reflection. All the major themes in bioethics are introduced in Genesis. One of them, the account of Sarah, Hagar and Ishmael, would have been a useful starting point for the pastor of the couple using a family member as a gestational surrogate.

Finally, I would like to point out the relegation of abortion and other moral issues to the realm of "politics." Although the practice of abortion clearly affects the *polis* and is therefore a political question, it is fundamentally a moral question, and therefore a matter on which Christian guidance is warranted. How one resolves infertility is more than a private matter; it expresses a theological conclusion about the meaning of marriage and children and the community in which they exist.

Conclusions about these matters are not necessarily intuitive; or, at least good conclusions are not. They involve an understanding of the issue, relevant technologies, ethical principles, and situational application. Pastoral counseling often needs to be informed by experts in the particular field, for example, a psychiatrist to explain a mood-enhancing drug. In too many cases, we do not even know what questions to ask, yet alone how to reach a conclusion. Let me suggest that biblical preaching and teaching should engage the following questions:

What are the boundaries of human life? Who counts as a human being made in the image of God?

What is our theology of the physical body? How do we respect the bodies of the infirm, disabled, elderly and unlovely? Who owns our body?

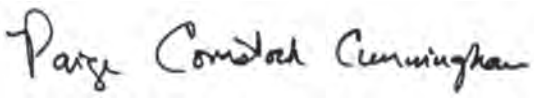
What does it mean to flourish as a human being? Are there limits on our freedom to choose how to treat our bodies?

How do we live in a community, with appropriate regard for the dignity of others?

What aspects of our lives do we receive as gift, and what aspects do we creatively change or improve?

This kind of teaching matters. Let me return to the Chinese pastor. When a Chinese American friend explained the dignity of the unborn child, the protection of innocent life, and the facts of abortion, the woman repented with weeping. She taught her fellow believers what she had learned. Abortions were no longer accepted, because gospel preaching was informed by bioethical teaching. That small flock is now better equipped to live out what they say they believe.

Can we grasp the transformative possibilities that can emerge within our churches? Imagine a future where we are well-equipped to live godly lives and make wise moral decisions. A future where, rather than being the last place to consult, the church community is the natural venue for wrestling with the tough questions of life, death, and flourishing as human beings made by God in his image and as an expression of his great love.



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SCANDAL, CONTINUED FROM PAGE 1

Christian ethicist Gilbert Meilaender writing in 1993 notes,

> The language of personhood has been central to much of the last quarter century's developments in bioethics. It was there at the outset when, in 1972, in the second volume of the *Hastings Center Report*, Joseph Fletcher published his "Indicators of Humanhood: A Tentative Profile of Man."[9]

Those educated in the history of moral theology might object to my invocation of Fletcher and his personhood (humanhood) distinction in this discussion of the Scandal on the grounds that Fletcher had made a very public break with Christianity five years prior to the publication of the article to which Meilaender refers. In response, I would argue that while Meilaender is correct in his identification of Fletcher as the entry point for personhood theory into bioethical discourse, Fletcher had, in fact, hammered out the personhood distinction decades earlier in his 1954 book *Morals and Medicine*.[10] This book was Fletcher's first major contribution to the literature of medical ethics, written ten years into what would be a twenty-four year tenure as professor of pastoral theology and Christian ethics at the Episcopal Theological School. In this seminal work, Fletcher declared: "To be a person, to have moral being, is to have the capacity for intelligent causal action. It means to be free of physiology! It means to have selfness or self-awareness."[11] The occupant of the womb, he argued in defense of therapeutic abortion, was best considered a "pre-personal organism" with no "personal value or development at stake."[12] On the other end of life's spectrum, Fletcher contended for the right of a patient to receive physician assistance in committing suicide, believing such to be required by a presumably supreme duty to respect the moral agency of persons.[13] Against the objection that disease might render a patient unable to recant a previously stated wish to be euthanized, Fletcher commented, "a patient who has completely lost the power to communicate has passed into a *submoral* state, outside the forum of conscience and beyond moral being. Being no longer responsive, he is no longer responsible."[14] Clearly, we have in Fletcher's 1954 offering the essential features of the developmental view of human personhood that permeates much of present-day bioethical discourse: 1) the category of human nonperson, 2) the concept of personal status as a developed, yet tentative characteristic, 3) a cognitive criterion for assigning personhood status, and 4) the attempt to resolve medico-ethical questions by appeal to personhood.

While admitting in *Morals and Medicine* to a "frame of reference in Christian faith," Fletcher preferred his ethics be characterized in nonreligious terms ("personalist" was his cherished term). Indeed, he made little mention in the book of God, Scripture, or prior theological treatments of the issues at hand, and when he did, such were either superfluous or fodder for his modern triumphalist critique. With no intention to bring theology to bear upon medical ethics, Fletcher could only, as he stated in the preface to his work, "*hope*, of course, that the ethical judgments I have reached are within the range and provision of Christian theology."[15]

"The Scandal of Bioethics, I submit, is simply the scandal of what theology has become in the present age for many of its presumed caretakers—a burden to be shed, a hindrance to the effort to discern and articulate moral truth."

In principlism and personhood theory, the two great movements of contemporary bioethics, we have, as the saying goes, "met the enemy, and he is us"—specifically, theologians reticent to make space, much less allow a controlling influence, for theology in ethics. The Scandal of Bioethics, I submit, is simply the scandal of what theology has become in the present age for many of its presumed caretakers—a burden to be shed, a hindrance to the effort to discern and articulate moral truth.

The reluctance of theologians to theologize may seem puzzling, but it is understandable when viewed in light of the deeper crisis in contemporary theology—namely, the crisis of authority. For much of the Church's history, Christians have recognized Scripture as the inspired and infallible Word of God, and thus the chief resource for theological reflection, constituting both its primary source and regulative principle. Aquinas argued that our theological formulations must not "betray the sense of Scripture"[16] and after him, and in more forceful language, Luther spoke of a conscience "captive to the Word of God."[17] Sadly, we encounter in mainstream theology today a much different situation. Propelled by the corrosive judgments of higher biblical criticism, contemporary theologians have jettisoned that which God has graciously extended for our "training in righteousness" and "equip[ping] for every good work" (2 Tim 3:16–17). In the place of Scripture, they substitute human reason and experience, and the consequence for ethics is moral error and terror, as both principlism and personhood ethics, with their capacity to justify elective abortion and euthanasia among other evils, attest.

In conclusion, we rightly mourn the dearth of theological discourse in today's mainstream bioethics, but even more lamentable is the extent to which those with formal theological training have facilitated the secularist shift. Tragic as it may be, it is nonetheless expected that a public square hostile to Christianity will seek to exclude theological voices. Shame on us if we aid

and abet the effort! If Christian bioethics is to be heard—and that, I take it, is the general desire of those most concerned with the diminution of theological input—it must, first and foremost, be *Christian*, and that, as I have argued above, entails a firm connection to the primary deposit of divinely revealed moral truth.

1 Tom L. Beauchamp, and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2008).

2 Whereas Kant, Mill, and Ross receive extensive consideration from Beauchamp and Childress, moral theologians garner little attention. Between them, Augustine and Aquinas receive mention only three times, all of which are buried in chapter endnotes.

3 Gilbert Meilaender, *Body, Soul, and Bioethics* (Notre Dame, IN: University of Notre Dame Press, 1995), 12-19.

4 From the outset, principlism has been criticized for its seeming coronation of individual autonomy as the decisive criterion for medico-ethical decision-making. Of Beauchamp and Childress' other three principles—beneficence, nonmaleficence, and justice—the latter has received significant attention. See, for example, Karen Lebacqz, "Beyond Respect for Persons and Beneficence: Justice in Research," *IRB: Ethics and Human Research 2*, no. 7 (1980). Lebacqz, a Harvard-trained theologian and ordained minister of the United Church of Christ, was one of two ethicists that served on the national commission that, in 1978, brought principlism to the foreground of public bioethical discourse in its publication, *The Belmont Report*.

5 For an excellent treatment on the history of Christian moral reflection on the status of the unborn, see David Albert Jones, *The Soul of the Embryo: An Enquiry into the Status of the Human Embryo in the Christian Tradition* (London: Continuum, 2004).

6 "Abortion Decision: Death Blow?" *Christianity Today*, February 16, 1973. In the immediate wake of *Roe v. Wade,* Criswell proclaimed, "I have always felt that it was only after a child was born and had life separate from its mother that it became an individual person, and it has always, therefore, seemed to me that what is best for the mother and for the future should be allowed." Criswell reversed course and became a staunch opponent of abortion. See, for example, his sermon entitled "The Marvelous Mystery of Mankind" in Larry Lewis, ed. *Proclaiming the Pro-Life Message: Christian Leaders Address the Abortion Issue* (Hannibal, Missouri: Hannibal Books, 1997), 13-19.

7 Ted Peters, *The Stem Cell Debate* (Minneapolis: Fortress Press, 2007); Ted Peters, "Embryonic Stem Cells and the Theology of Dignity," in *The Human Embryonic Stem Cell Debate: Science, Ethics, and Public Policy*, ed. Suzanne Holland, Karen Lebacqz, and Laurie Zoloth (Cambridge, MA: MIT Press, 2001). Peters asserts that personal status (dignity) is acquired through the conferral of relationship by both God *and* human beings. The embryo assigned to the Petri dish, he contends, cannot be considered a person because it is "not in a dignity-conferring relationship."

8 Peter Singer, "What's Wrong with Killing," in *Writings on an Ethical Life*, ed. Peter Singer (New York: HarperCollins, 2000), 127.

9 Gilbert Meilaender, "*Terra es Animata:* On Having a Life," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey (Grand Rapids: Eerdmans, 1998), 393. The essay of Fletcher's referenced by Meilaender is "Indicators of Humanhood: A Tentative Profile of Man," *Hastings Center Report* 2, no. 5 (1972): 1-4.

10 Joseph Fletcher, *Morals and Medicine: The Moral Problems of: The Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia*. (Princeton: Princeton University Press, 1954). This book stems from Fletcher's 1949 Lowell Lectures delivered on the campus of Harvard University.

11 Ibid., 218.

12 Ibid., 150, 205.

13 In 1968, one year after his public apostasy, Fletcher took personhood ethics a step further in arguing for the moral permissibility (and even duty) of killing infants with severe mental retardation. Such infants, he argued were not truly human. "To be a human," he declared, "is to be self-aware, consciously related to others, capable of rationality in a measure at least sufficient to support some initiative. When these things are absent, or cannot ever come to be, there is neither a potential nor an actual person. To be a person is a lot more than just to be alive. . . . The fact that a biological organism functions biologically does not mean that it is a human being." Bernard Bard and Joseph Fletcher, "The Right to Die," *The Atlantic Monthly* 221, no. 4 (1968), 62-64.

14 Fletcher, *Morals and Medicine*, 201; emphasis mine.

15 Ibid., xix; emphasis mine.

16 Thomas Aquinas, *Summa Theologica*, trans. Fathers of the English Dominican Province (New York: Benzinger Brothers, 1947), Ia.29.3

17 Luther as quoted in W. Robert Godfrey, "A Question of Transition" in *Scripture and Truth*, D.A. Carson and John D. Woodbridge, eds. (Grand Rapids: Baker, 1992), 227.

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ACADEMY OF FELLOWS

LONDON CONFERENCE ON HUMAN DIGNITY

BY DÓNAL O'MATHÚNA, PHD, CHAIR OF THE ACADEMY OF FELLOWS

The conference "Human Dignity in Bioethics: Universal or Useless?" brought over 50 delegates from all over Europe to London in September 2011. The topic was prompted by Ruth Macklin's 2003 editorial, "Dignity is a Useless Concept."[1] Macklin has called for discussion and debate on dignity to ensure the concept is more than a slogan.[2] The London conference aimed to contribute to this discussion.

The conference was hosted by the Centre for Bioethics and Emerging Technology (CBET) at St. Mary's University College, a Catholic university in London. CBET's mission is to examine the ethical and social dimensions of emerging technologies, particularly nanotechnology (www.smuc.ac.uk/cbet/). The conference was organized in conjunction with the Anscombe Bioethics Centre (previously called the Linacre Centre for Healthcare Ethics), the Catholic University of Leuven, Belgium, and the Scottish Council on Human Bioethics. The latter's director, Calum MacKellar, is a Fellow in CBHD's Academy of Fellows, which was also represented by Dónal O'Mathúna and Agneta Sutton.

The conference opened on Friday evening in the stately rooms of St. Mary's University College. After official welcomes, Prof. Raymond Hide, an eminent British physicist and cosmologist, discussed the importance of dialogue between scientists and theologians, especially around bioethics. He shared intriguing insights from his membership in the Pontifical Academy of Sciences. In the keynote address that followed, Dr. David Kirchhoffer from the Australian Catholic University noted how the critique of human dignity can strengthen our understanding of the concept. Human dignity, he believes, is too often used as a trump card to end discussions, rather than as a means to explore deeper issues. He finds Stephen Toulmin's approach helpful in challenging bioethics to become more than a moral calculus.[3] Kirchhoffer uses a hermeneutical interpretative account to address broader issues of meaning and interpretation.

Saturday began with Prof. Geoff Hunt, director of CBET, who explained why the conference was also addressing biodiversity. Dignity often focuses on the status and treatment of humans, but has implications for creation theology. Both 'having dignity' and 'being dignified' are important, and the latter needs more attention. Human flourishing depends on the complex web of life, and there is nothing dignified about exterminating other creatures. This led into a fascinating lecture on biodiversity by Dr. David Plackett from Denmark's Risa National Laboratory for Sustainable Energy. The beauty and diversity of nature were shown, along with examples of the devastating consequences of human choices. He recalled the words of Theodore Roosevelt: "When I hear of the destruction of a species, I feel just as if all the works of some great writer have perished." Christians then should be helping protect the works of the Author of creation.

The next plenary analyzed dignity in the context of law and public policy. Dr. Roberto Andorno, from the Ethics Centre at the University of Zurich, Switzerland, noted that dignity is not defined in law, but neither are other fundamental concepts like justice or freedom. Sometimes its guidance is clearer in what it prohibits than in what it promotes. In patient care, weakness and vulnerability helps us see dignity's importance.

The afternoon lectures started with Rev. Prof. Emmanuel Agius, Dean of Theology at the University of Malta and a member of the European Group on Ethics in Science and New Technologies. This body provides independent advice on bioethics to the European Commission (http://ec.europa.eu/bepa/european-group-ethics/). His lecture examined the challenges of embedding human dignity in E.U. policies on biotechnologies. Switching to clinical issues, Dr. Carlo Leget of Tilburg University, the Netherlands, discussed the place of dignity in care of the dying. His historical overview of dignity was helpful, and he used the work of Paul Ricoeur to provide a hermeneutical phenomenological analysis of dignity.

Sunday morning began with either Mass or a viewing of the Japanese film, *Departures* (2008). This moving and beautiful movie shows the dignity that an undertaker can bring to death. The care he expressed contrasts sharply with the

CONTINUED NEXT PAGE

undignified ways he is treated because he is an undertaker. Even in death, dignity can be promoted.

The conference ended with a lecture from one of the organizers, Prof. David A. Jones, director of the Anscombe Bioethics Centre. He explored the ancient idea of dignity as status and being worthy of honor. The idea of all humans having dignity owes much to Christianity. Even if this was not in the original concept, it is more fundamental. Christian notions of dignity are paired with dependence and wretchedness, which provide a response to claims that human dignity is "speciesist." Dignity reminds us of our common value and vulnerability, and the importance of including all humans in the human family.

Delegates were divided into four groups for small-group discussions between lectures. These provided time to address questions in more depth, and to get to know other delegates. This revealed wide diversity in discussions of dignity around Europe. The role of religion in European bioethics was discussed regularly. Christians are actively involved in European bioethics, yet uncertainty remains about the best way this can be done. Even at the conference, diverse approaches were taken in lectures, some using explicitly Christian language, while others not. This topic requires much further reflection and discussion, which CBET may be able to facilitate.

The conference lectures are available to download (http://extranet.smuc.ac.uk/events-conferences/human-dignity-in-bioethics/Pages/default.aspx). Conference proceedings will be published in a themed issue of *The New Bioethics*, an international peer-reviewed journal acquired by CBET. A follow-up conference is planned for 2013 to continue the development of fresh ideas and rigorous thinking in bioethics. Through the contacts made and renewed at the conference, collaboration is planned on research projects. Scope exists for members of the CBHD Academy of Fellows to contribute to such projects and work together to affirm the dignity of all human life.

1 Ruth Macklin, "Dignity is a Useless Concept," *British Medical Journal* 327, no. 7429 (2003): 1419-20.

2 Ruth Macklin, "Reflections on the Human Dignity Symposium: Is Dignity a Useless Concept?" *Journal of Palliative Care* 20, no. 3 (2004): 212-6.

3 Stephen Toulmin, "How Medicine Saved the Life of Ethics," *Perspectives in Biology & Medicine* 25, no.4 (1982): 736-50.

CBHD CALL FOR PAPERS AND POSTERS

Paper and poster proposals are now being accepted for our upcoming 19th Annual Summer Conference, *Reclaiming Dignity in a Culture of Commodification*, to be held on July 12-14, 2012, on the Deerfield campus.

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THE CENTER FOR BIOETHICS & HUMAN DIGNITY
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THE PHYSICIAN-PATIENT RELATIONSHIP: MORAL AGENCY IN BALANCE

SUSAN HAACK, MD, MA, FACOG
CBHD ASSOCIATE FELLOW, ACADEMIC INTERN

Watching a pendulum swing can be a monotonous activity, unless it is the ideological pendulum in which case it is both fascinating and

humbling. From fashion to politics our ideologies swing wildly from one extreme to the other, never coming to rest in a moderate position. The pendulum is apparently still in motion with regard to our understanding of the physician-patient relationship and informed consent, having swung from an understanding of that relationship as one dominated by absolute paternalism (paternalism-run-amok) to one dominated by absolute patient autonomy (autonomy-run-amok). Recent articles advocating the benefit and necessity of some degree of paternalism in the physician-patient relationship are evidence that the pendulum is still in motion. This indeed coincides with what many have understood to be true of the professional relationship all along: those who present for care are often suffering and vulnerable, consequently lacking full autonomy and control—and what they seek, in part, is someone to assist them in the relief of their suffering and restoration of their health. Two recent essays have approached the problem of medical decision-making within the physician-patient relationship from the perspective of a "means-end" evaluation. In an article entitled "What Health Care Providers Know: A Taxonomy of Clinical Disagreements," Daniel Groll explores the nexus of paternalism and autonomy in the context of disagreements over medical care by developing a "means-end" taxonomy in the form of a binary matrix for the evaluation of such disagreements between physicians and patients.[1] His taxonomy includes the concept of "medical accessibility"—nonmedical issues to which the medical resources and reasoning of the physician can be applied, at least indirectly if not directly. By means of this model, he demonstrates that physicians, by virtue of their knowledge and experience beyond "medical knowledge," have a significant contribution to make to the medical decision-making process. While such nonmedical guidance carries no medical authority, it can be legitimately offered even if it is not with the authority of a clinician. He grounds this perspective in the unique responsibility that physicians as professionals have to the patient and their well-being, a responsibility that is often ignored.[2] What Groll is implicitly acknowledging, however, is the truth of our common humanity, a truth grounded in our shared nature, our mutual embodiment, and our communal environment, a truth that resonates with the plight of the other, enabling our mutual compassion and concern.

Similarly, Steven Joffe and Robert D. Truog in "Consent to Medical Care: The Importance of Fiduciary Context," examine the issue of informed consent in the context of the fiduciary physician-patient relationship.[3] Defining "fiduciary" as one "entrusted with power…to be used for the benefit of another and legally held to the highest standard of conduct,"[4] they then distinguish two fiduciary models that are pertinent to the physician-patient relationship: fiduciary as agent and fiduciary as advisor. In the agency model the fiduciary acts paternalistically on the patient's behalf, serving their welfare on the basis of an overarching authorization.[5] In the more deliberative advisor model, the fiduciary offers information and guidance to patients but lacks authorization to act on their behalf without their specific consent. In an attempt to capture the ambiguities surrounding the responsibility for decision-making between physicians and patients, Joffe and Truog have also drawn a distinction between choices concerning "means" and those concerning "ends." They conceptualize shared decision-making as occurring along an inextricable means-ends continuum (as opposed to the matrix used by Groll) in which the patient is primarily responsible for determining the value-laden decisions about ends or subsidiary ends of their care while the physician has presumptive responsibility for determining the means to those ends. They also extend to the physician the responsibility of framing the decisions so that patients are able to appreciate the values and ends that are consequent upon their decision.[6] Moreover, this shared decision-making transpires in the thicker context of the fiduciary relationship that exists between the physician and patient, which, despite the relational asymmetry, entails a two-way flow of information and deliberation. Joffe and Truog contend that an agency-advisor interface is involved in every physician-patient interaction to some degree; it, too, is best understood as a continuum that changes over time and according to the medical circumstances, thus illustrating the dynamic complexity of the physician-patient interaction.

"Yet means-ends determinations are not without their limitations, for means frequently become the object of choice in medical care. If the desired end of a medical encounter is to postpone pregnancy, there are many means available to that end which are largely a matter of patient preference, and not the prerogative of the physician."

Both articles not only provide balance and clarity to the issue, but also refreshingly acknowledge the moral agency of the physician, an agency denied in the model of absolute autonomy. A physician is not merely an automaton, but a moral agent involved in a moral encounter, who must balance fiduciary responsibilities to the individual patient who has presented for care with contractual responsibilities for the health of the society they are called to serve.

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end which are largely a matter of patient preference, and not the prerogative of the physician. Alternative categories for distinguishing areas of responsibility within the professional encounter, whether one chooses "elective/non-elective," or "preventive/therapeutic," are subject to the same difficulty: they can provide only a vague sphere in which to mold our interactions. Relationships resist rigid taxonomies.

Over the past fifty years the concept of paternalism has developed very negative connotations, especially in medicine, despite the fact that the image of a father is not inherently a negative one. No doubt it is the converse image of the patient as a dependent, needy child to which many object; yet that is in fact the foundation of healthcare—caring for the vulnerable person in need. The challenge of the medical profession and professional relationships is to navigate this changing dynamic in the context of a prosperous society and a highly developed healthcare system. It entails recognition of the uniqueness of each encounter, a discernment of the degree of autonomy possessed by the person presenting for care, and the ability to alter one's approach to that unique individual in order to adequately meet their physical, emotional, and spiritual needs. Formerly, with limited medical resources, less patient access to information, and a more homogenous culture resulting in greater cultural consensus, a paternalistic physician-patient relationship was not inappropriate. But as technology has exponentially expanded healthcare options, as patients have gained greater access to medical information, and as the explosion of options has necessarily resulted in less consensus, the relationship between physician and patient also has had to undergo change. Physicians have had to increasingly assume an advisory role, assisting patients in the translation, interpretation and application of the information that they have acquired.

Yet there are some who believe that this role is still inappropriate. According to Robert Veatch every medical choice requires a value perspective—and health professionals have no expertise in the value dimension of medical care.[7] He believes that they are incapable of making judgments about what is good for a patient; therefore, the patient must be in charge of making all decisions.[8] However, if medicine were to abandon all conceptions of the patient's good, its moral *telos* would be replaced by the exigencies of a business transaction. While there have been many recent attempts to reimagine medicine according to a business model, the uniqueness of the fiduciary physician-patient relationship resists such reimagining. Interpersonal relationships based on a social contract theory result in a highly autonomous relational model that fails to acknowledge that human flourishing necessarily entails relationships with others. As relationships become contractual and decontextualized, the healing aspects of the relationship, dependent as they are on compassion, trust, and the experiences of our shared and vulnerable humanity, are irretrievably lost. Paternalism is replaced by disinterested depersonalization, dispassionate entrepreneurialism.

While the scope of medicine has been extended in recent years to include preventive care and enhancement, the primary focus of medicine is still healing and restoration. Consequently, patients present for care in various states of vulnerability, with limited knowledge, misinformation, misunderstood facts, fears, anxieties and denial, all of which coalesce to limit their autonomy. In this state of being, what they seek is expertise and care, not the exercise of their autonomy. The proper response to paternalistic indiscretions in professional relationships should be to correct those attitudes rather than restructure the entire relationship. The physician-patient relationship is a dynamic moral encounter between moral agents in which the relational parameters ought to be determined by the parties involved. Attempting to deconstruct and reconstruct the relationship through the imposition of unsolicited ideologies violates vital aspects of the professional relationship for it neglects the vulnerability of the patient as well as the obligations of the physician who is ultimately responsible for any choices made by patients that require physician participation. Furthermore, reconstructing the professional relationship on a framework of patient autonomy unjustly disadvantages the vulnerable who are most in need of care. The power differential inherent in the relationship needs to be acknowledged and respected, not denied or injudiciously abused. The terms of engagement should be determined from within the confines of the relationship, not dictated from without.

The swinging of this pendulum is a welcome event, for effective professional relationships are not located in the extremes of either autonomy or paternalism but in a dynamic equilibrium between these extremes, one that requires conscientious discernment and balancing. As a moral encounter, the physician-patient relationship varies over time with changes in age, maturity, experience, technology, and the extenuating circumstances of both parties. The respect for autonomy that is crucial to the physician-patient relationship is that which esteems the person who has presented for care in the midst of their compromised autonomy, and which seeks collaboratively to restore that person to autonomy and wholeness. The art of medicine is recognizing the role required in a given relational moment and shifting roles as needed to best accommodate the vulnerabilities of the person who has presented to you for care.

1 Daniel Groll, "What Health Care Providers Know: A Taxonomy of Clinical Disagreements," *Hastings Center Report* 41, no. 5 (2011): 27-36.
2 Ibid., 34.
3 Steven Joffe and Robert D. Truog, "Consent to Medical Care: The Importance of the Fiduciary Context," in *The Ethics of Consent: Theory and Practice*, eds. Franklin G. Miller and Alan Wertheimer (Oxford: Oxford University Press, 2010).
4 Ibid., 352.
5 Ibid., 353.
6 Ibid., 360.
7 Robert Veatch, *Patient, Heal Thyself: How the New Medicine Puts the Patient in Charge*, (Oxford: Oxford University Press, 2009), vii-viii.
8 Ibid., 3.

BIOFICTION

BIOETHICS IN NOVELS, SHORT STORIES, PLAYS, AND POETRY

Fiction is a powerful medium for raising issues and dilemmas in medicine, science, and technology. Readers are cautioned that these works represent a variety of genres and may not be appropriate for all audiences. If you have suggestions for inclusion in this column, please email us at info@cbhd.org.

Fiction Series:

Card, Orson Scott. Ender's Game Series (also referred to as *The Ender Saga* and *The Shadow Saga)*

Ender's Game (1985)
Speaker for the Dead (1986)
Xenocide (1991)
Children of the Mind (1996)
Ender's Shadow (1999)
Shadow of the Hegemon (2001)
Shadow Puppets (2002)
Shadow of the Giant (2005)
Ender in Exile (2008)

A sci-fi series for young adults. Amidst the evolving storyline the series raises a number of issues related to technology and the complexities of their personal and societal implications. (Topics: Reproductive Technology, Genetic Engineering, Human Enhancement, Artificial Intelligence and Personhood, and Radical Life Extension)

Novel:

Wilson, Daniel. *Robopocalypse: A Novel.* New York: Doubleday, 2011. [Interested readers who enjoy this volume may also like Daniel Wilson, *How to Survive a Robot Uprising: Tips on Defending Yourself against the Coming Rebellion* (New York: Bloomsbury, 2005).]

Robopocalypse chronicles the birth and escape of an artificial intelligence named Archos on through the robot uprising at zero hour and to humanity's passionate fight for liberation from the ensuing robotic oppression. (Topics: Artificial Intelligence, Cyborgs, Human-Computer Interface, Human Enhancement, Neuroethics, Personhood, and Transhumanism)

BIOETHICS AT THE BOX OFFICE: AN UPDATE

COMPILED BY CBHD RESEARCH STAFF

A recap of relevant materials that have premiered on the silver screen in 2011. Readers are cautioned that the films represent a wide variety of genres and may not be appropriate for all audiences. Viewers are encouraged to read annotations/synopses available through such websites as www.movieweb.com or www.imdb.com. For more backlists of Bioethics at the Box Office visit our website at http://cbhd.org/resources/reviews/movie-review.

Hanna (2011, Rated PG-13 for intense sequences of violence and action, some sexual material and language) Categories: Genetic Engineering/Gene Therapy, Human Enhancement

Source Code (2011, Rated PG-13 for some violence including disturbing images, and for language) Categories: Neuroethics, Human-Computer Interface, Research Ethics

A CHRISTIAN FRAMEWORK FOR ENGAGING IN SCIENCE POLICY

MICHELLE KIRTLEY, PHD
CONSULTANT ON BIOETHICS AND PUBLIC POLICY

Central to the mission of The Center for Bioethics & Human Dignity is an effort to analyze and interpret bioethical issues with a view towards cultural transformation. While several key Christian thinkers have rightly challenged the Judeo-Christian world to think broadly about the tools we use to engage culture, public policy, and science policy more specifically—whether upstream or downstream of broader cultural change—remains an important means of securing the common good and affirming the human dignity of our fellow citizens.

But what is science policy and how should Christians approach science policy? 'Science policy' includes public policy *about* science—federal funding for scientific research, clinical trial regulations, public health policy, or science, math, and engineering education policy. The term 'science policy' is also invoked to talk about how science is used to craft public policy, as in the case of using fetal pain research to craft abortion policy.

In order to develop a sound approach for Christian engagement in science policy, we first need to develop a framework for thinking about how to integrate faith with our view of science and our approach to political engagement.

The church has a checkered history of relating to the scientific community. Some of history's best known scientists—including Sir Isaac Newton, Michael Faraday, and William Thomas Kelvin—were themselves devout believers, and yet, some of the church's darkest moments involve the persecution of scientists thought to be at odds with church doctrine (Galileo being perhaps the most famous example).

Of course, science need not be in conflict with Christian faith. The entire universe is part of God's created order, and Scripture clearly speaks of God's desire to reveal Himself to us through creation. Science can be a means of glorifying God by reflecting His creative nature, revealing the beauty and complexity of his created order and providing tools for participating in His work of renewal and for achieving justice and affirming the dignity of all humanity. Christians need not fear scientific progress. "All truth is God's truth," as the saying goes (though this legitimate insight needs to be handled with care). Christians should be supporting and participating in scientific efforts to uncover truth about our world, working to ensure that science in the service of the common good, can flourish.

Integrating our faith with our view of politics is equally important. Political communities play a vital, God-ordained role in His work of redemption and renewal of all creation. Government exists to uphold public justice for all citizens, not to privilege Christianity or any other faith. Responsible citizenship includes helping to shape the political community to conform to the demands of justice and human dignity. Justice, while Christian in its origin, should be extended to all people, believers and non-believers alike.[1]

A Christian approach to science policy, then, includes several key principles. Because, as Christians, we have a high regard for the truth, science policy decisions should be evidence-based. Yet because we also have a keen awareness of our human limitations, policy decisions should involve mechanisms for transparency regarding the biases and conflicts of interest inherent in the application of scientific evidence to public policy. Science must be viewed as one of many tools used to develop policy but should not be seen as the final arbiter of policy debate. Data can be biased even at its point of acquisition and are always interpreted by fallible researchers, used to develop models that approximate, rather than mirror,

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reality. Even the most understood scientific principles and dogma are subject to revision, and so science must be used with caution and never in a vacuum.

Instead, science should be evaluated, among other things, in the context of the value our republic places on human dignity, public justice, and the common good. The role of the federal government is both to provide incentives (funding) and set boundaries around the pursuit of science to ensure that science serves the common good and upholds human dignity.

In the particular arena of bioethics policy, Christians, while working to ensure that our federal laws protect and affirm human dignity, should also be thinking strategically about how to enable science to flourish. We should encourage college students to pursue principled careers in the sciences. And policymaking should not be left to "professional" politicians. Fulfilling our God-given calling as citizens includes political engagement—whether through contacting political representatives, writing letters to the editor, or submitting public comments to the many proposed rules issued by federal agencies. In so doing, we will be making a small contribution to broader cultural transformation.

1 Adapted from principles outlined by the Center for Public Justice at www.cpjustice.org.

QUESTIONS?

Would you like to offer comments or responses to articles and commentaries that appear in *Dignitas*? As we strive to publish material that highlights cutting-edge bioethical reflection from a distinctly Christian perspective, we acknowledge that in many areas there are genuine disagreements about bioethical conclusions. To demonstrate that bioethics is a conversation, we invite you to send your thoughtful reflections to us at info@cbhd.org with a reference to the original piece that appeared in *Dignitas*. Our hope is to inspire critical dialogue between our readers and those who contribute material to this publication.

SAVE THE DATE! JULY 12-14 2012

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www.cbhd.org /conf2012

TOP BIOETHICS STORIES: OCTOBER - DECEMBER 2011 EDITION

BY APRIL PONTO, RESEARCH ASSISTANT

1. "**Even Compliant Parents Doubt Vaccine Safety**" by William Hudson, *CNN,* October 3, 2011.

> The study, published Monday in the journal Pediatrics, confirms that about 2% of parents living in the United States are refusing all vaccines for their children, and more than one in 10 alter the Centers for Disease Control and Prevention-recommended vaccination schedule by delaying or refusing certain vaccines. (http://tinyurl.com/83z4wd6)

2011 was marked by the most cases of measles since 1996. This is attributed, in part, to parents not vaccinating their children or delaying vaccination. Doctors believe parents are not following vaccination guidelines because many of the diseases have fallen out of public view.

2. **"Hormonal Contraception Ups HIV Risk in Women"** by My Health News Daily Staff, *MSNBC*, October 3, 2011.

> Hormonal contraception may make it easier for HIV to spread between heterosexual sex partners, according to a new study conducted in Africa. Women in the study who used hormonal contraception had double the risk of acquiring HIV or transmitting it to their male partners as those who did not use hormonal contraception. (http://tinyurl.com/3f2gepc)

Evidence suggests that women using oral or injectable contraceptives are more likely to contract and spread HIV to their partners. The reason for this is unknown, but doctors believe it may be the result of changes created by hormonal contraceptives in the lining of the cervix and vagina. Experts are calling for more research until any action is taken that might limit the use of hormonal contraception.

3. **"Egg Donor Compensation is to Triple under New HFEA Guidelines"** by Jane Hughes and James Gallagher, *BBC News,* October 19, 2011.

> The UK's fertility watchdog has agreed to triple the compensation given to women who donate eggs to help infertile couples to have a child. Experts believe this will encourage more women to donate, but critics warn it may create financial incentives. (http://tinyurl.com/63guwrt)

The Human Fertilization Embryology Authority, HFEA, has agreed to raise the compensation given to egg donors from £250 to £750 per donation. Many see this increase as fair and adequate compensation for lost wages during the course of the donation procedure. Others see it simply as paying women to donate their eggs. Due to insufficient numbers of donated eggs some couples have turned to other countries, such as Spain and the United States, which have more relaxed laws governing egg donation.

4. **"Animal Transplants Coming 'Soon'"** by James Gallagher, *BBC News,* October 20, 2011.

> Using animals as a source of organs for transplantation into humans was once one of medicine's next big things - a solution to transplant waiting lists. However, there have been problems with rejection - and recently stem cells have been grabbing the spotlight. But some researchers are now saying that transplants from animals "could soon become a reality", but not necessarily as originally expected. (http://tinyurl.com/6yb2dxe)

Although there has been much attention surrounding animal-to-human organ transplants, scientists now believe a better and more effective technology is transplantation of a small number of cells from pigs to humans as opposed to using a whole organ. To date, this experimental method has proven to be effective in patients suffering from type 1 diabetes, though further research is still needed.

5. **"Artificial Blood Could Be Used within Next Decade"** by Nick Collins, *The Telegraph,* October 27, 2011.

> Clinical trials using blood created from adult stem cells are set to begin within the next two or three years, raising the prospect it could soon become routinely used where real blood is unavailable. (http://tinyurl.com/5uesffk)

Although blood manufactured from adult stem cells is still an imperfect technology and cannot be used in every situation, it is a promising treatment for use in ambulances, war zones, and underdeveloped countries. Many hope that blood created from adult stem cells will help to alleviate issues of scarcity, and remove the risk of the spread of disease through contaminated human blood.

6. **"Mississippi's 'Personhood Amendment' Fails at Polls"** by CBS/AP, *CBS News*, November 8, 2011.

> The so-called "personhood" initiative was rejected by more than 55 percent of voters, falling far short of the threshold needed for it to be enacted. If it had passed, it was virtually assured of drawing legal challenges because it conflicts with the Supreme Court's 1973 Roe v. Wade decision that established a legal right to abortion. Supporters of the initiative wanted to provoke a lawsuit to challenge the landmark ruling. (http://tinyurl.com/bmhtkdg)

The ballot initiative sought to be the first of its kind to assert that life begins

at conception. Among the concerns expressed regarding this initiative were potential ramifications for in vitro fertilization and the Morning-After Pill. Similar initiatives are appearing in other states beginning in 2012.

7. **"Bedside Test Finds Awareness in Vegetative Brains"** by Malcolm Ritter, *MSNBC*, November 9, 2011.

> In recent years, scientists have learned that some patients believed to be in a vegetative state actually have some awareness and that they might be able to communicate. Now, a new study suggests a portable brain monitor can detect signs of this, perhaps making it possible someday for doctors to easily double-check the diagnosis at the bedside. (http://tinyurl.com/7ujtjmm)

By strapping a tight-fitting cap on a patient's head, doctors can determine brain activity using an EEG machine. In a test, three out of sixteen patients thought to be in a vegetative state showed signs of being able to listen and respond to cues. Patients found to have discernible brain activity may be given a chance at rehabilitation or a longer stay in a rehabilitation hospital.

8. **"Supreme Court Takes Up Challenge to Health Care Reform Law"** by Bill Mears, *CNN*, November 15, 2011.

> As expected, the Supreme Court has agreed to decide the constitutionality of the sweeping health care reform law championed by President Barack Obama. The high court agreed to hear two major questions: whether the law's key provision is unconstitutional, and if so, whether the entire law, with its 450 sections, must be scrapped. (http://tinyurl.com/7ne9pu8)

Led by the state of Florida, the largest challenge has emerged against the Patient Protection and Affordable Care Act (PPACA). Twenty-six states have joined with Florida and the case is expected to be ruled on by June. At stake is the provision for the individual mandate for coverage. Proponents of PPACA are confident that it is constitutional and will not be overturned. Opponents, however, argue that states should not be forced to expand Medicaid costs as well as force citizens to buy medical insurance.

9. **"Survey: U.S. Doctors Disagree on Pregnancy Start"** by Kerry Grens, *Reuters*, November 18, 2011.

> Most U.S. doctors believe pregnancy starts when the sperm fertilizes the egg, a survey shows, contradicting the position of a key medical group with a view that could potentially affect U.S. policy and laws regarding contraception and research. (http://tinyurl.com/7td8jck)

After polling more than 1,000 obstetrician-gynecologists, a survey led by CBHD Fellow Farr Curlin has shown that a majority of doctors disagree with the American College of Obstetrics and Gynecology's definition of pregnancy beginning at implantation. According to the survey, 57 out of every 100 doctors believe that pregnancy begins at conception. Respondents were given the option of pregnancy beginning at conception, implantation, or saying they were unsure.

10. **"Court: Some Bone Marrow Donors Can Be Paid,"** *The Associated Press,* December 1, 2011.

> A federal appeals court says some bone marrow donors can be paid, overturning a decades-old law that made such compensation a crime. (http://tinyurl.com/6m2mhrc)

New technology has made the process of donating bone marrow similar to donating plasma. With this change in bone marrow donation, the 9th U.S. Circuit Court of Appeals has said that donation of bone marrow is exempt from a prior law making it a felony. Those choosing to donate can now be paid.

11. **"'Morning After' Pill Will Stay Prescription-Only for Girls under 17"** by Miriam Falco and Jennifer Bixler, *CNN*, December 7, 2011.

> The secretary of Health and Human Services overruled Wednesday a Food and Drug Administration recommendation that would have made the emergency contraceptive pill Plan B One-Step available over the counter to girls younger than 17. (http://tinyurl.com/6v5magz)

In the U.S. the Morning-After Pill is available by prescription only to women under seventeen years of age. HHS Secretary Kathleen Sebelius overruled the FDA's request for the drug to be made available with prescription regardless of age. Proponents of the Morning-After Pill claim that politics are being placed above science and reproductive health. Those who agree with the HHS Secretary's decision cite that more education and greater emphasis on pregnancy prevention is needed.

12. **"DNA: The Next Big Hacking Frontier"** by Vivek Wadhwa, *The Washington Post,* December 8, 2011.

> Craig Venter, who led the research at Celera, announced a decade later, in May 2010, that his team had, for the first time in history, built a synthetic life form — by "writing" DNA. Christened Mycoplasma mycoides JCVI-syn1.0, also known as, "Synthia," the slow-growing, harmless bacterium was made of a synthetic genome with 1,077,947 DNA base pairs. (http://tinyurl.com/7w2rqdt)

Celera, a company that ten years ago announced they made a working draft of the human genome, has announced the creation of a synthetic life form. Researchers have predicted that in the future fighting disease might be as easy as downloading an app and modifying it to fit your needs. Others are voicing concern over the potential threat of bioterrorism and safety issues in this new development.

updates & activities

RESEARCH LIBRARY UPDATE

The Center continues to expand our research library holdings. Our library holdings are non-circulating to promote active scholarship in community and are available to CBHD staff, as well as students, faculty, and guests of the Center interested in doing research in our newly renovated study facilities.

If you are interested in donating books or other resources in good condition from your personal collection, please contact Michael Sleasman (msleasman@cbhd.org). CBHD is free to decide whether to keep the book in the library's collection, put it in a book sale to raise funds for the library, donate it to a student, or discard it.

MEDIA RESOURCES

CBHD.org on Twitter: @bioethicscenter

Bioethics.com on Twitter: @bioethicsdotcom

The Bioethics Podcast at thebioethicspodcast.com

Facebook Cause at causes.com/cbhd

Facebook Page at facebook.com/bioethicscenter

Linked-In Group at linkd.in/thecbhd

YouTube at youtube.com/bioethicscenter

The Christian BioWiki wiki.everydaybioethics.org

COMING SOON:
CBHD'S 2011 ANNUAL REPORT

STAFF

PAIGE CUNNINGHAM, JD

- Appeared in September on *American Conservative Radio* for an hour-long interview on "The 6 Reasons Why Bioethics Should Matter to Christians."
- Spoke in early October at Taylor University's Science Seminar Series on "Pleading Ignorance: The Foolishness of Avoiding Science in a Biotech World."
- Taught an enrichment class for Trinity alumni on "Back to School and Brain Boosters" during TIU's homecoming weekend.
- In October, attended the Christian Legal Society's national conference.
- In November, joined several CBHD interns in attending the Practice and Professionalism Symposium hosted by the Program on Medicine and Religion at the University of Chicago. CBHD Fellows Daniel Sulmasy, MD, and Farr Curlin, MD gave presentations at the event.

MICHAEL SLEASMAN, PHD

- In October, attended the annual meeting of the American Society for Bioethics and Humanities.
- Delivered the introductory comments for two sessions co-sponsored by CBHD at the annual meeting of the Evangelical Theological Society in November.
- In November, attended the annual meeting of the American Academy of Religion.
- Appeared in December on *The Katherine Albrecht Show* for an hour-long radio interview on "Bioethics at the Intersection of Technology and Humanity."
- Published two essays titled, "New Technology and Christianity" and "Postconservative Theology" in volume 3 of George Kurian, ed. *Encyclopedia of Christian Civilization* (Malden, MA: Blackwell, 2011).

EVENTS

- CBHD co-sponsored two sessions on bioethics at the annual meeting of the Evangelical Theological Society in November. In one session, CBHD advisory board member Allen Verhey, PhD, spoke on "Jesus as Paradigm for Dying Well." In the later session, J.P. Moreland, PhD, spoke on "Bioethics, Substance Dualism, and the Argument from Self-Awareness."
- CBHD is pleased to continue our participation in a strategic partnership with the Christian Medical and Dental Assocations (CMDA) and their bioethics initiatives. In early November, the Center continued our annual tradition of hosting the Fall meeting of CMDA's ethics committee. The committee is chaired by CBHD Senior Research Fellow William P. Cheshire, Jr., MD. Paige Cunningham and Michael Sleasman benefitted from participating with the committee members as the committee worked on developing position statements for CMDA.

ON THE CBHD BOOKSHELF

ARTICLES OF NOTE: **For those interested in knowing what books and articles the Center staff have been reading**

Bodurtha, Joann, and Jerome Strauss. "Genomics and Perinatal Care." *New England Journal of Medicine* 366(1): 64-73.

Boersma, Hans. "Hope-Bridled Grief." *First Things*, January 2012, 45-49.

Cohen, I. Glenn. "Medical Tourism: The View from Ten Thousand Feet." *Hastings Center Report* 40(2): 11-12.

Frankovich, Jennifer, Christopher Longhurst, and Scott Sutherland. "Evidence-Based Medicine in the EMR Era." *New England Journal of Medicine* 365(19): 1758-1759.

Hartzband, Pamela, and Jerome Groopman. "The New Language of Medicine." *New England Journal of Medicine* 365(15): 1372-1373.

ON THE BOOK SHELF:

Peterson, James C. *Changing Human Nature: Ecology, Ethics, Genes, and God.* Grand Rapids: Eerdmans, 2010.

Sterberg, Eliezer J. *My Brain Made Me Do It: The Rise of Neuroscience and the Threat to Moral Responsibility.* Amherst, NY: Prometheus Books, 2010.

Tenner, Edward. *Why Things Bite Back: Technology and the Revenge of Unintended Consequences.* New York: Vintage Books, 1997.

Turkle, Sherry. *Alone Together: Why We Expect More from Technology and Less from Each Other.* New York: Basic Books, 2011.