

EDITORIAL

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Bioethical issues lie at the center of what it means to be human and how to live faithfully in a medically, scientifically, and technologically advanced world. Because of this, bioethical reasoning must be both intellectually rigorous and deeply attentive to the human person. Isolated intellectual work is insufficient, and humility is necessary to deal faithfully with such deeply personal questions. As Augustine wrote:

To [Jesus], my dear Dioscorus, I wish you to submit with complete devotion, and to construct no other way for yourself of grasping and holding the truth than the way constructed by Him who, as God, saw how faltering were our steps. This way is first humility, second humility, third humility, and however often you should ask me I would say the same, not because there are not other precepts to be explained, but, if humility does not precede and accompany and follow every good work we do, and if it is not set before us to look upon, and beside us to lean upon, and behind us to fence us in, pride will wrest from our hand any

good deed we do while we are in the very act of taking pleasure in it.¹

Among the intellectual virtues, humility is understood as “proper attentiveness to, and owning, one’s intellectual limitations.”² From a Christian perspective, humility requires the genuine pursuit of truth out of love for God and others rather than for personal pride or self-righteousness. Because of this, as CBHD seeks to foster a *distinctly Christian* conception of bioethics, we value the pursuit of intellectual humility through dialogue and a communal pursuit of truth.

This issue of *Dignitas* represents just such a dialogical approach in several important ways. First, the article by Cayla Bland and Scott Rae characterizes interdisciplinary dialogue, using the fields of psychology and bioethics to protect the rights of whole persons in end-of-life care. David Croy continues the discussion on the use of Normothermic Regional Perfusion (NRP) in organ transplants, furthering points Adam Omelianchuk raised in his 2025 [guest editorial](#).³ Finally, Rebecca Martin and David Ramirez approach Bryce Asberg’s [article](#) (2025) on palliative sedation with an applied

lens, refining his points based on their practice as medical professionals.⁴

Also included in this issue are several book reviews. Heather Zeiger provides a review of Carl Elliot’s *The Occasional Human Sacrifice*, a book that explores why some allow unethical practices in medicine and what prompts others to work to restore justice for patients. Bryan Just reviews a proposed counter-history of bioethics in Robert Baker’s *Making Modern Medical Ethics*. In *Eggonomics*, medical anthropologist Diane Tober reports on the commodification of donated eggs and the women who contribute them, which Megan Best generously summarizes. Finally, Joy Riley evaluates Mary Roach’s journalistic and popular exploration of removable body parts in *Replaceable You*.

David Croy’s guest editorial continues the work of Adam Omelianchuk’s 2025 article. Normothermic Regional Perfusion (NRP) is the rather new practice of circulating blood through organs in a deceased donor in order to improve organ health in preparation for transplantation. As Omelianchuk’s original article suggests, in the process, some techniques involve restarting circulation of blood through the heart while keeping the flow to the brain clamped off. This brings up major ethical concerns regarding our

definition of death and whether a person who is not technically dead but experiencing a collapse of consciousness might be made a candidate for donation and reduced to their function as a means of “organ harvesting.” Omelianchuk thus argued for “ethical parsimony,” asserting that if less controversial methods exist that are effective (which they do), then they should be chosen over ethically complex options.

Croy continues the conversation on the ethical controversies tied to NRP (specifically, Thoracoabdominal Normothermic Regional Perfusion or TA-NRP), focusing specifically on ethical challenges in the determination of death. He discusses the difficulty in identifying the point of death, describing it more as a process rather than a clear arrival. For brain death to be officially determined, a person’s whole brain must be declared deceased. The development of TA-NRP complicates this ascertainment. The Universal Determination of Death Act defines death as “the *irreversible* cessation of circulatory functions or the *irreversible* cessation of whole brain function including the brain stem” (as cited in Croy). However, TA-NRP procedures merely require a determination of death by circulatory criteria. Advocates of TA-NRP defend the procedure by suggesting that the intent of restoring circulation matters—the goal is not to bring the person back to life. Croy challenges this argument, asserting that there should be no difference between a patient who is resuscitated and brought back to life on purpose—and who is therefore afforded the rights of a living person—and a patient who still experiences “stable hemodynamic parameters, oxygenation, and heartbeat,” yet who is determined “dead” and stripped of such rights. Thus, Croy argues that the dead donor rule must be upheld and protected. He writes, “certitude in the donor’s death is vitally important for compassionate reasons, for ethical and legal reasons, and for maintenance of public trust.”

Cayla Bland and Scott Rae unite to integrate family therapy and ethics to provide a model for end-of-life care that can benefit attending healthcare providers, social workers, or pastors in such situations. They offer a fictional case of an elderly gentlemen in the ICU, lacking an advance directive, without his primary decision-maker (his deceased wife), and with tense familial relations between his

four children and two siblings. With treatable but incurable cancer, the man faces an indeterminable amount of time with a likely low quality of life, and the family must decide whether it is in his best interest to pursue aggressive treatment. The reactions of each are varied, with a range of responses from the suggestion for physician-assisted suicide to the pursuit of treatment to extend his life.

In order for this family to come to a robustly Christian conclusion that honors the dignity of their father/brother, they must first deal with their family dysfunction. With an understanding of family life-cycle changes—a developmental framework that underscores the stressors that come about when changing familial dynamics require the taking on of new roles and being flexible in how one participates in the family system—the ethicist is better equipped to help the family turn toward one another in both unity and difference in the decision-making process. To do this well, it is helpful to also understand common aspects of family processing, including cohesion (familial emotional bonds), flexibility (rigid vs. flexible family interactions), and communication, which moderates the other two. Finally, Bland and Rae discuss relational ethics, or those beliefs within family systems as to whether the family unit, and each member within the family, adequately upholds the standard (whether cultural or theological) for relational interaction. These beliefs lead to a spectrum existing on an axis between trustworthiness and destructive entitlement. Throughout the article, the authors apply this developing knowledge to their opening case study.

Once the family dynamics have been addressed (which may require outside therapy), Bland and Rae suggest they turn to wrestling with the ethical issues involved. Addressing the issue of informed consent, physician-assisted suicide would not be an option, since the patient is unconscious. Here, it is also helpful to keep the family system information in mind as the ethicist or healthcare professional wrestles through a theological approach to their decision-making. After analyzing several key biblical passages, the authors suggest an approach that honors human dignity and affirms God’s control of both life and death. This communicates to the family that death need not always be medically resisted, and futile

treatments may cause more emotional or physical suffering for the loved one. Further, to choose futile treatment may be making the theological assumption that our earthly existence is the highest good to be pursued. In conclusion, the model that Bland and Rae propose takes seriously patients as whole people, contextualized in a particular family system and yet in pursuit of a higher moral good.

As the final dialogical article in this issue of *Dignitas*, Rebecca Martin and David Ramirez extend Bryce Asberg’s arguments by revising them to fit a real-world clinical care context. Asberg’s 2025 piece uses the Hippocratic Oath to evaluate the use of palliative sedation for existential suffering, finding it an inappropriate treatment and arguing instead for psychosocial restoration in such cases. Martin and Ramirez center their nuanced approach to Asberg’s points around two core questions: (1) Can one diagnostically create a clear distinction between physical and existential suffering? (2) How can a clinician therapeutically address existential suffering when there is little time and many other symptoms?

In addressing the first question, the authors cite the interconnectedness of physical and existential suffering. As an example, they note a child who was experiencing intense pain that was not responding to typical medicinal interventions. Yet, when doctors brought the child a puppy, her pain scores and use of such medication dropped exponentially. They further cite those who experience hallucinations at the end of life or combat veterans with PTSD; the question remains: Where does the physical end and the psychological begin? Expanding their second question, if indeed we could clearly diagnose existential suffering, and such a patient also had no clear cause for physical suffering, how do we provide therapeutic treatment substantive enough to meet such psychological needs with the short time patients are in palliative care? Once again, with the experience of combat veterans, such trauma is quite complex, and end-of-life hallucinations in connection to such experiences are unlikely to be alleviated by brief psychological treatment.

As an alternative to address such real-world issues, they support the use of respite sedation, “the use of sedative agents for a brief, time-limited period (usually 24–48 hours)

aimed at alleviating physical symptoms such as pain, nausea, and agitation, followed by sedative weaning and return of consciousness thereafter.” Such a therapeutic approach aims to break the cycle of anxiety and then return the patient to a state of consciousness. Ultimately, issues such as existential suffering and palliative care raise the question of what the purpose of medicine is. How can Christian physicians steward

their knowledge of the whole person and the therapeutic process to care spiritually for patients in the midst of both physical and existential suffering?

We at CBHD are grateful for our authors who engage some of the most complex questions facing healthcare professionals and ethicists alike. They do so with intellectual rigor, epistemic humility, and constructive

critique. We invite continued dialogue on these issues and in response to those questions that matter most for living faithfully in our complex MedTech world. In line with this, our next issue of *Dignitas* will engage the intersection of being human, human health, and the use of Artificial Intelligence (AI). This will also serve to introduce the theme for CBHD’s 2027 annual conference on AI and bioethics.

References

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