

The Bible and Bioethics

Dealing with the problems of modern medicine

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Part One: Introduction to Bioethics - Scope of the Issue

Few of the moral issues which the Christian faces today are more complex or pervasive than those in medicine. There are so many different aspects to the issue. They involve the beginning and end of life, honesty, procreation, individual choice, paternalism, ethical systems, a confusing array of medical treatment options and questions about experimentation. These in turn have spawned a glossary full of technical terms which has become the working language for medical people, laymen, legal experts and ethicists alike. Living wills, pulling the plug, Roe vs. Wade, active and passive euthanasia, triage, extraordinary means, life support systems, in vitro fertilization, surrogate motherhood, sperm banks, implantation, genetic screening, right to die, therapeutic abortion, Karen Ann Quinlan, quality of life and informed consent have almost become household words and are no longer the sole province of medical manuals and court records.

As complex as the issue itself is the number of separate groups of people interested in bioethics. There are at least four distinct groups within the medical community itself. Doctors are forced to make tough decisions about life and death because of the advances in medicines and technology. Nurses often find themselves personally in conflict with the ethical conduct of the doctors or with the wishes of the patients and their families. Administrators have to balance the demands of government funding regulations with local pressure to fund budgets and pay for the ever-expanding technology of modern medicine. Add to this a growing field of specialized medical ethicists who try to reconcile a wide range of religious views with utilitarian humanist reasoning.

Anything this confusing is, of course, good material for the media and the politicians. Demonstrators take to the streets in the hope of having the media take their picture and the politicians legislate their moral viewpoint. All of these groups are prone to popularizing their brand of morality. Polls reflecting the general view of the populace on medical issues are regular fare in newspapers and news magazines. In the pluralistic atmosphere of our nation the legislatures and court systems have become the last resort for many medical-ethical conflicts. The court decisions on abortion and Karen Ann Quinlan were only the most well known. Courts have always wrestled with competency in mental health and geriatric cases. They continue to try to define prenatal viability, moment of death, and patient rights. They have also been called upon to make rulings about ownership of sperm banks and custody in surrogate motherhood cases.

Caught in the middle of this medical-moral morass is the humble parish pastor trying to bring comfort and direction to his agonizing and confused members. The choices his members must make from available options in medical technology sometimes seem to defy common sense application of Holy Scripture. In some situations three or more different scriptural directives seem to apply, and it seems impossible to offer clear, simple direction. It becomes even more difficult when families who sense the confusion in the matter demand that their pastor give them a definitive answer they can carry out with a clear conscience.

Pastoral Survey

From the answers given by Milwaukee area pastors in an informal survey a number of consistent patterns appeared. Most agreed that the most frequent biomedical issue they faced was the question of "pulling the plug." Distinguishing between ordinary and extraordinary means to prolong life and defining the moment of death was the advice they were most often called upon to give their

members. After this the most frequent counseling was given to families considering admitting their parents to a nursing home, hospice or other extended care institution. Third on the list, but mentioned by all those interviewed, were medical-ethical issues involved with reproduction, birth control and artificial insemination.

Two other things turned up in conversations with pastors who do a lot of counseling in bioethical matters. The first was the scarcity of materials on this subject. Some pastors said they had no resource for counseling medical-ethical problems outside of the Bible. Only a few pastoral conference papers have dealt with the bioethical questions, and most of these addressed the issues of organ transplants. One *Quarterly* article on active and passive euthanasia was written by Prof. Habeck (*WLQ*, Vol. 75, No. 1, Jan 78, pp56-61). Literally dozens of major works on bioethics have been produced by religious and secular presses of universities and medical schools. But not one of these approaches ethics from our Lutheran viewpoint or provides practical help for pastoral counseling in this area.

The pastors I polled were also concerned about making their own people aware of the religious element in their medical decisions. While members often seek out their pastors for the obvious circumstances of pregnancy or delivery, cancer treatment, nursing home placement or last hours counseling, there are many other medical-ethical concerns which families are approaching without pastoral help. These include artificial insemination, birth control, holistic medicine, honest with terminal patients and abortion. Some members neglect pastoral counseling because they know the church's position, oppose it and don't want to hear about it. Others fail to talk to their pastor because they don't stop to consider that there are religious and moral aspects to their medical decisions. Also, a number of nurses I interviewed said they would appreciate some formal education and direction from their church for the moral conundrums they daily face in their work.

Scope of Lectures

We are not going to be able to cover all the issues in medical ethics in five lectures. Most volumes on basic medical ethics issues are four to five hundred pages long. Nor are we going to be able to treat all the moral dilemmas in the area of health and medicine our pastors and their parishioners face. Missing from our treatment will be matters of holistic health care, including diets, lifestyle changes and preventative medicine. Discussion of dependency treatment for alcohol, drugs and other chemical addiction will be omitted. Birth control will be discussed only in connection with contraception pills and devices which are evaluated in life and death ethics. Discussion of pastoral counseling will be limited to what the pastor says to patient and family prior to death. Psychiatric treatment, including medication, is also beyond the scope of what we can consider in a few weeks.

What we will undertake is first of all a brief overview of ethical systems which are being taught to medical professionals and which are being used to establish right and wrong in biomedical decisions. It is necessary to become acquainted with the systems and their terminology in order to evaluate them in our upcoming lectures. After this we will briefly review our own approach to ethics. These two summaries will be a part of the first lecture.

In the next three lectures we will compare modern medical ethics to what the Scripture says in three broad categories: life and death issues, the good of the patient and decision making. In the fifth and last lecture we will consider some approaches to pastoral counseling in biomedical dilemmas.

Summary of Bioethical Systems

Since the times of the early Greek philosophers ethical systems have generally fallen into one of two categories. Deontological systems are duty oriented systems. They require that we judge the right or wrong of an action according to a duty. Deontology comes from the Greek words *deon* (requirement, need, duty) and *logos* (word or reasoning). Teleological ethics focus on the goal (*telos*) and decide what

is morally right on the basis of the end which is sought or accomplished. If the end is good, then rules should be set or changed to accomplish the goal.

We must start our investigation of both of these broad ethical categories, knowing that neither of them provides a comfortable setting for Christian moral decisions. Both deontological and teleological ethics depend heavily upon rationalism and subjectivism. For instance, one branch of deontological or duty oriented ethics is emotivism. We would think that ethical decisions based on emotions would fly in the face of duty oriented morality. But emotivism establishes duty on the basis of emotional reasoning.

Such ethics are not far removed from the thinking of Plato and Aristotle. They were popularized by Rousseau who promoted “common sense” as a moral guide.

The more conservative branch of deontological ethics is called voluntarism. In voluntarism the individual carries out his duty to moral rules or laws that have to some degree been formulated outside of himself. Immanuel Kant’s “Categorical Imperative” set the stage for today’s autonomism. Kant rejected God and society as sources for making laws for personal morality. The individual makes laws for himself (autonomism). He uses reason to establish those laws. Yet there was for Kant some restriction from the outside. His ethics differs from pure emotive reasoning by demanding any rule we make for our own actions be able to be applied to all men equally. These laws do not change according to the situation. Kant thought that men were capable of reasoning without self interest and that, although men reasoned their own rules, God would be pleased with them. Kant’s ethics are mostly rejected today because they are too stiff and formal and allow too little latitude in complex situations.

A more popular form of voluntarism today is positivism. This is the ethics for the conservative mind who doesn’t want to involve God in his decision making. It is perhaps the operative pragmatic approach of many doctors. Positivists accept the rules of the functional authorities in their lives. What the government, the institution, the profession or the “system” decide, that is law for them. When abortion was illegal, positivists would not perform one. Since it has been legalized by the state, authorized by hospitals and subsidized by the government they will now perform abortions. Positivism is the path of least resistance. It allows one to avoid moral arguments. You are always on the side of the majority or the party in power.

Another form of voluntarism is religious legalism. Roman Catholic ethicists criticize this approach as “blind submission to God’s will” (*Health Care Ethics*, p154). Generally these ethics are propounded by conservative Protestants. Paul Ramsey is the most prolific and respected representative of these ethics. His 1970 publication, *The Patient as Person*, is still quoted by ethicists of all different leanings. Ramsey’s books are probably some of the more profitable reading for our pastors. But even though his bottom lines will often correspond to our own, his approach to ethics is not identical. Ramsey embraces what is called the covenant tradition in which the faithfulness of God and man to each other is a model for the various relationships between persons in medical situations. Ramsey is conservative, but spends most of his time quoting and evaluating legislative and judicial material. He speaks without apology about quoting Scriptures, but none of his writings go deeply into developing biblical principles.

Surprisingly existentialism is classified as a form of deontological ethics. It is a form of voluntarism in that it holds that the individual has a duty to a certain order. But in the case of existentialism the order does not come from a rule above. The act itself in which the person is involved provides the duty for his actions. Life’s situations form the laws for moral good. “Existentialists believe that it is up to the individual confronted by the absurdity of the world and its injustices to create their (sic) own values” (*Health Care Ethics* p156). Existentialism was popularized by Sartre and “Christianized” by Bultmann.

Teleological ethical systems are also divided into those which set moral values on the basis of rules and those which feel the act itself determines right and wrong. Since Vatican II Roman Catholic

ethicists have splintered off in many directions. There are still a few who could be called religious legalists. But most Catholic ethicists today either follow the natural law direction of Aquinas or the more liberal proportionalism. Natural law ethics, or prudential personalism as one advocate calls it, is the popular Roman combination of religious legalism and teleological situationalism. It is the moderate view which denies the total depravity of man and the loss of the image of God in the fall. It holds that God has given us laws and that we must obey them as the church has interpreted them. But they insist that God wants us in turn to interpret and apply his law according to the “intelligence and freedom” which “remain a part of our human nature even in our fallen state” (*Health Care Ethics*, p154). The more liberal proportionalists deny that there are any general absolute principles which determine the good or evil of an action apart from the circumstances in which they take place. Proportionalists claim that they are not to be confused with humanistic utilitarians, but the distinction is very subtle. Charles Curran is an outspoken proportionalist who has recently been censured by the Vatican.

Probably the most popular ethical system in our country today is consequentialism. First articulated in popular form by Jeremy Bentham and John Stuart Mill, consequentialism holds that moral rules should be determined by the consequence of the action. What brings the greatest good to the greatest number of people must be right. This kind of ethics is also called utilitarianism because it makes rules on the basis of the usefulness or utility for bringing good from the action. This is certainly humanism. What is subjectively judged to be “good” for the race must be right for the individual.

Consequentialism or humanistic utilitarianism was “Christianized” by Joseph Fletcher in the 1960s. Fletcher’s situation ethics added love to the utilitarian ethical formula to make it more intoxicating for religious consumption, but he subtraced the general rules which utilitarianism set up. Each act in its own circumstances and with its own consequences may demand a different moral response imposed by the highest law of love. For this reason Fletcher’s ethics are often labeled act utilitarianism as opposed to the rule utilitarianism of consequentialism. Because Fletcher’s ethics left people facing their dilemmas with no specific direction, Fletcher was later forced into making some generalized moral rules.

In subsequent lectures we will see how each of these ethical systems approach specific bioethical questions.

The Bible and Bioethics

All philosophic ethical systems are antithetical to biblical ethics. A Christian does not determine what is morally good deontologically or teleologically. One need read only a few pages of some religious legalists to see that we cannot stand on the same ground as they do. We do not believe that performing a duty to a rule, even a rule from above, makes an action morally good. Deontology is contrary to the very nature of the Christian who according to the new man has been freed from all coercion from the law of any kind (Ga 5:1; Ro 8:15).

Nor can we ever establish moral right and good teleologically. Even determined the propriety of eating the fruit on the basis of consequentialism. “When the woman saw that the fruit of the tree ‘was good for food and pleasing to the eye, and also desirable for gaining wisdom, she took some and ate it’” (Gn 3:6). Since the fall we cannot objectively measure what is good for ourselves in any given situation, let alone determine what is best for the human race.

In the strict sense, then, there can be no such thing as a Christian ethical system. At least not if the term implies a system of reasoning by which we determine for ourselves what is right by a sense of duty to rules or an evaluation of the situation and its consequences. “No one is good—except God alone” (Mk 10:18). He is the *Summum Bonum*. Apart from God no devotion to duty is good. Apart from God no act in good, no matter how “good” the circumstances and consequences of it are. That’s why Jesus said, “Apart from me you can do nothing” (Jn 15:5). If there is to be any good—even in

medical treatment and care—it will not come from a system dominated by sinful man’s evaluative reasoning. If there is to be good, there must be a channel from the good God to sinful man.

That channel is faith. “Without faith it is impossible to please God” (He 11:6). It is the presupposition of faith that distinguishes Christian ethics from all philosophical systems. How important it is for the pastoral counselor to remember this when talking to a family about pulling the plug. How essential it is for the conscience of a woman who must place her aging mother into a nursing home. How critical this is for a young couple struggling with the options of birth control and family planning to know that the gift of faith from God precedes any moral good. Before we do our duty to a rule and before we judge any action by its consequences, there must be faith, or our best efforts will be sin (Ro 14:23).

Our confessing fathers clearly understood this concept of Christian ethics. They wrote, “Therefore, of works that are truly good and well-pleasing to God, which God will reward in this world and in the world to come, faith must be the mother and source” (F.C., Thor. Dec. IV, 1f9, Triglotta, p941). Luther prefaced each of the commandments with the sine qua non of Christian ethics: “We must fear and love God that...” Without the faith through which God channels the merits of Christ to us, we cannot do anything meritorious. Without justification there is no sanctification, nothing holy, nothing morally good. Our catechism reflects this Christian ethical principle when it speaks of the ability to do good works: “I am able to do good works because the Holy Spirit gives me a pure heart in which Christ lives by faith” (p200).

Faith is a matter of the heart. Only through faith can the disposition of the heart be right. By nature, Jesus says, “Out of the heart come evil thoughts, murder, adultery, sexual immorality, theft, false testimony, slander” (Mt 15:19). But through faith made is made a new creature (kai ktisee, 2 Cor 5:17). Now God can call for what is ethically good from our hearts. Jesus says, “A good man out of the good treasure of his heart brings forth good things” (Mt 12:35 NKJV). “Whatever you do,” St. Paul writes, “do it from the heart as to the Lord and not to men” (Col 3:23).

Thus a Christian ethics cannot be merely a legal sorting of applicable principles and rules from Scripture. All moral good proceeds from the predisposition of faith. This is why Christian ethics can never be separated from Christian dogmatics. The whole counsel of God must be presented by the pastor or counselor seeking to bring forth the right action. Even when philosophic ethics lead a doctor, nurse, patient or family to make a decision identical to that which a Christian makes, the action of the unbeliever will be unethical in the eyes of God. “For the works which pertain to the maintenance of external discipline, which are also done by, and required of, the unbelieving and unconverted, although commendable before the world, and besides rewarded by God in this world with temporal blessings, are nevertheless, because they do not proceed from true faith, in God’s sight sins, that is stained with sin, and are regarded by God as sins and impure on account of the corrupt nature and because the person is not reconciled to God (F.C., Thor. Dec. IV, 18, Triglotta, p941).”

This must give pause to Christian who make it their chief aim to reform society and devote their major efforts to making legislation conform to biblical standards. At best such efforts produce a civic righteousness which the unbeliever will boast to no avail at the left hand of the Judge. The pastor who counsels in medical matters must also keep this unique aspect of Christian ethics in mind. His counsel is not primarily a duty to figure out the right thing to do. His first thought is to lead the patient and his perplexed family to act out of faith. The arrow of the message of the church must always be pointed at the heart rather than the actions. Not only do we fail to produce any real moral good by aiming at actions and applying laws. By our misguided efforts we squelch the freedom from the law we have through faith in Christ. “The only thing that counts is faith expressing itself through love (Ga 5:6).”

So in our application of Christian ethics to biomedical issues we make no apology for resorting to Christian dogmatics. In fact, it is only in the sense that it relies on systematic biblical theology that Christian ethics can be called an ethical “system.” It is not a system of humanly reasoned rules, laws,

decisions and applications. It is the source and motive of the right action as well as the definition of the right moral action we receive in Scripture's balanced presentation of law and gospel.

Dogmatics is normative for Christian ethics in two important ways. First it keeps Christian ethics from becoming deontological, or duty oriented. It does this by setting the message and motivation of the gospel of Jesus Christ over against religious legalism. It sets forth faith and the disposition of the heart as the *sine qua non* of what can be considered good. It does not allow duty to the law to become the measure of moral action, and thus it preserves Christian liberty. Second, dogmatics keeps Christian ethics from becoming teleological or utilitarian by setting the message and impact of the law over against situationalism and consequentialism. Dogmatics demonstrates the complete loss of the image of God in man through the fall over against the ideas of partial loss taught in Roman and Reformed ethics. The law reflects back to us the presence of the old man and his working even in those who possess the new man by faith. Dogmatic development of law tells us not only that dutifully following the rules does not please God, but also that we don't possess the ability dutifully to follow the rules.

The law and gospel in Christian dogmatics also sets human reason in its proper place in ethical decisions. It tells reason that since the fall it is not a fit organ for determining what is the greatest good for itself, let alone for the whole human race. It's natural knowledge of God is dim at best and at worst is scaled over with the hardening of conscience. All the appeals of philosophical ethics to reason, then, incorporate an inherent weakness into such systems which make them inadequate for determining what is good in the eyes of God.

But there is a place for reason in Christian ethics. Under the gospel the Holy Spirit uses our reason as the instrument for receiving his word. According to the new man the Christian's reason is a receptor by which the word and will of God is communicated to us. (See Siegbert W. Becker, "The Place of Reason in Lutheran Theology," *WLQ*, Vol 67, No 2, Apr 70; and "Reason as Instrument," *WLQ*, Vol. 70, No 1, Jan. 73.) Yet such reason receives without rebellion against what it hears. It happily receives the message of Christ and looks to learn the will of God to return thanks to him.

The object of illumined reason is God's revealed message of Holy Scripture. There God reveals the righteousness of Christ which alone can make anything we do righteous. There God reveals his holy will. These two purposes of Scripture are clearly set forth in the classic passage from Paul's Second Letter to Timothy: "From infancy you have known the Holy Scriptures, which are able to make you wise for salvation through faith in Christ Jesus. All Scripture is God-breathed and is useful for teaching, rebuking, correcting and training in righteousness, so that the man of God may be thoroughly equipped for every good work (3:15-17)." This verse and many verses from Psalm 119 leave no doubt for the Christian that his search for the ethical good begins with his search of Scriptures.

In the weeks to come we will examine the suggestions of philosophical ethics in the light of Scriptures on a number of biomedical issues.

Part Two: Life and Death Issues

Bioethical Approaches

Medical technology and the proliferation of health care facilities have forced us to make some hard choices among many options in matters of life and death. At the very base of the problem is the difficulty of defining when life begins and ends. Making the problem more difficult is the advancing technology which allows us to keep alive premature babies and endlessly delay death for the aged. Should we keep alive premature babies who are hopelessly deformed or diseased? Should we use heroic measures to keep our elderly alive when death seems imminent? Cancer treatment can pose even more confusing options. How far must we drive how many times at what expense to what degree of sacrifice for family members for treatment that inevitably brings disfigurement and pain with no

promise of cure? Is it moral to administer pain-killing drugs which will bring relief from suffering but which will also most certainly hasten the moment of death?

Two philosophical ethical systems approach these tough questions. from two different sides. Teleological ethics focus on the intended goal or actual results of our actions and determine right and wrong on that basis. Teleological ethics thus measure life qualitatively, emphasizing the comparative value of life. Utilitarians do not see life as an absolute value, but as a relative value. This kind of ethics was reflected in the Supreme Court decision regarding abortion in which children were pragmatically assigned a relative value depending upon their prenatal maturity. This same kind of relativism is a part of the argument of those in many states arguing for the legalization of euthanasia. One scientist says in regard to the aging that “we should comparatively evaluate human lives in their declining trajectories—slowing some, hastening others” (quoted by Ramsey, *Edges*, p150).

This kind of thinking as taken over the field of medical ethics in recent years. Joseph Fletcher, the situationalist, also argues for subjective judgment on the issues of life and death. He writes, “The ethical principle is that pregnancy when wanted is a healthy process, pregnancy when not wanted is a disease—in fact, a venereal disease. The true ethical question is not whether we can justify abortion, but whether we can justify compulsory pregnancy” (quoted by Jones, *Brave*, p165). Fletcher argues for the same relativistic measure of life on the other end of the spectrum: “Doctors who will not respire monsters (sic) at birth—the start of life—will not much longer have any part in turning people into monsters at the end of life” (*Euthanasia*, p70).

Subjectivism and situationalism have led goal oriented ethicists to coin any number of new terms to help them describe and evaluate the circumstances and consequences of their decisions. The first set of terms have to do with establishing the beginning and the end of life. To justify their refusal to care for diseased or deformed infants and to deny reasonable treatment for those with painful terminal illnesses they speak of quality of life judgments. In making these judgments they consider a premature infant’s worthiness of receiving treatment on the basis of its viability or potential humanity. This in turn involves them in defining meaningful life and personhood. Of course, all these definitions are subjective, and each level more so than the other. In this utilitarian atmosphere spare embryos from IVF (in vitro fertilization) can be destroyed because they lack personhood. Experimentation on mentally retarded children has already been justified by the utility of meeting scientific objectives for the greater good of the race. The end justifies the means.

Qualitative terms are also formed by teleologists for the end of life. Euthanasia is one such term. Utilitarians like to expand the definition of euthanasia to include any decision on treatment and care for those who are close to death, ill without hope of recovery at any age, and even for the care of premature and newborn infants who are in need of treatment but without hope of a “meaningful” life. This wide definition of euthanasia gives them the opportunity to rationalize comparisons between turning off the respirator for a dying elderly patient and refusing treatment to a badly deformed newborn. In this area the terms active and passive euthanasia have been coined. Active euthanasia is the practice of purposely hastening or causing death by treatment or medication. Passive euthanasia describes the decision not to prolong the dying process. Both active and passive euthanasia can be voluntary or involuntary. Voluntary euthanasia describes a situation in which a patient knowingly agrees to the giving or withholding treatment or medication which will cause or refuse to slow the coming of death. Involuntary euthanasia occurs when the physician, institution, guardian or family member makes a decision for a patient who may or may not be capable of making one on his own.

The other approach to life and death issues is deontological. This duty oriented ethics often arrives at the same judgment we might make as Christians, but its means of arriving at decisions differs from ours. Much of deontological ethics today is as rationalistic as that of utilitarianism. We must remember that many deontological thinkers are neither Christian nor religious. Kant’s categorical imperatives do not necessarily coincide with divine imperatives. Existentialism’s duty ends up being

duty to self. There also seems to be little motivation behind positivism's willingness to go along with the law of the land, the will of the majority or the standard operating procedure of the institution besides the self interest of staying out of controversy and avoiding having to make tough moral judgments.

The deontology we are most interested in, however, is that of the so-called religious legalists. In the wide sense these include groups like the Moral Majority and other Evangelical and Fundamentalist bodies. But there has been relatively little material on medical ethics published by these groups. An interesting new book, *Brave New People*, by D. Gareth Jones is an exception. Evangelicals objected to its publication in this country because the author shows the influence of qualitative thinking in his applications to abortion and treatment of deformed newborns. Fundamentalists seldom see ethics as a discipline separate from theology. Most of their writing on medical ethics comes in the form of pamphlets, tracts and periodical articles. Much of Roman Catholic bioethics remains legalistic. Even the moderate and some of the more liberal Catholic ethicists rigorously follow the law in matters on which the church has made decrees, such as abortion, contraception and care for the terminally ill.

Roman Catholic ethicists

include Charles Curran, Richard A. McCormick, Bernard Haring, Benedict M. Ashley and H. Tristram Engelharoc. Paul Ramsey, a Presbyterian is by far the most prolific author among Protestant ethicists. He has worked and written on medical ethics from the sixties until the present day and is highly respected among both religious and secular ethicists. Only Martin E. Marty among Lutheran theologians has done any major writing. Like the Evangelicals Lutherans have done most of their publishing in tracts and periodicals.

Because of their duty oriented propensity for making rules; religious legalists of all kinds have fallen into the trap of the utilitarians and deontological rationalists. They begin with the medical situation and try to assign biblical definitions to the circumstances. Roman Catholic ethicists, for example, worked out the terminology of ordinary and extraordinary treatment for the dying. The terminology, when it was first phrased, reflected the technology available for life support at the time. The problem inherent in these terms is that they require continual updating and further definition. What was extraordinary in heart technology and terminal cancer treatment only a few years ago is ordinary today, and patients and their families can no longer refuse it in good conscience. Although the terminology was devised to help Christians make decisions in difficult situations, it necessarily falls into the category of act utilitarianism. Certain methods or means in themselves become right or wrong. There may be times when Christians in good conscience may want to use means that might be classified as extraordinary.

Paul Ramsey rightly dismisses all the euthanasia terminology along with the word itself (*Edges*, pp153ff). But he goes on to substitute for them his own set of terms. The urge to make rules and force biological information into theological terms affects all the religious legalists. The thrust of the popular anti-abortion argument, for instance, has been to prove from the Bible first that God deals with individuals before birth as humans, then that conception is the beginning of life, and then to apply the command not to murder to the unborn.

Another approach of religious legalists has been to establish what life is instead of when life begins. Ramsey takes a very strong stand against abortion. But he bases his stand on the sanctity and dignity of the person (Jones, *Brave*, p169). Then, of course, he is forced to make another rule and decide when this sanctified, dignified life begins after all. For Ramsey there is no biblical argument to determine this and he resorts to a biological distinction. He believes that the beginning of life is the blastocyst stage (60-100 cells). So while Ramsey rigorously opposes almost all forms of abortion, he sees nothing wrong with IUDs (intra-uterine devices) and "morning after" pills which destroy an egg after conception.

Evaluation of Bioethics Approaches

It is not difficult to evaluate any approach to ethics which denies the existence of God. Regardless of the mechanics each of these systems in some way substitutes the will of man for the will of his Creator. It may make use of human emotions, human reason, human pleasure or even the vague subjective idea of the good of the human race. But that is all human. It ignores or denies the natural depravity of man. It relies on "natural law" or an imperfect natural knowledge of God. It preaches love without attention to the disposition of the heart. It should not be surprising that such systems brazenly propose a morality that shocks the Christian conscience.

What may be more difficult for us to understand are the weaknesses of legalistic religious systems. We are naturally drawn to them because they are religious. They acknowledge the existence of God. What is more appealing is that at least to some degree they acknowledge the divine will as revealed in Holy Scriptures. Finally, what is most attractive about them is that they agree with us against humanism about what is legally correct.

But the weaknesses of these systems in life and death issues are also obvious. The first is their concession to rationalism. In Roman Catholic life and death ethics rationalism is present in three ways. The willingness of conservative Catholics to follow the interpretation of the church in matters which the Bible has not spoken is a public confession that the imperfect mind of man is exalted above what the perfect mind of God has revealed in his Word. The church's absolute requirement that abortion not take place even to save the life of the mother is an example of that. The second evidence of Roman rationalism is its resort to Thomas Aquinas'"natural law" in matters not specified by the church. The dependence of natural law ethics on a human reason supposedly not lost in the fall is contrary to Scripture and unnecessarily binds consciences. Also in Roman theology there is an increasing tendency to mix teleological rationale with duty oriented ethics. Ashley and O'Rourke in *Health Care Ethics*, a publication of the Catholic Health Association, call this mixed approach to ethics prudential personalism. They define it in this way: "For prudential ethics, morality ultimately is not a matter of obeying rules, but of intelligently seeking appropriate, concrete behavior by which to achieve human, personal and communal goals" (pp153, 164). The humanistic, utilitarian and situational leanings of these ethics are clear from their explanation of the term prudential: "We accept this means-ends type of ethics wholeheartedly and we use the term prudential because it indicates the practical, goal-seeking character and even the situational and contextual character of this ethics" (p163).

But we cannot find a shelter in today's protestant ethics either. The concession to rationalism may be less obvious in protestant ethics, but it is there. The attempt to establish the value and dignity of human life on the basis of the remnant of the image of God in natural man is a part of it. But there is another weakness evident especially in the effort to replace humanism's subjective terms with a religious set of subjective terms. That weakness is a tendency to go away from Scriptures rather than closer to it when resolving difficult and confusing problems. James F. Childress, like Paul Ramsey, is a fairly conservative Christian bioethicist. Like Ramsey he deplors utilitarian terminology. But also like Ramsey he substitutes his own terminology which leads him no closer to resolving tough issues. He writes, "Attempts to formulate satisfactory criteria of 'quality of life' or 'meaningful life' have been notoriously vague and inconclusive. One possible starting point is... that we consider 'the potential for human relationships.' Where this potential is totally lacking, the obligation to care does not require treatment" (*Priorities*, p45).

A third weakness of religious legalism is the natural consequence of the first two. We might call this weakness the wedge. Christian ethicists are losing ground. It is not just that they are losing ground to secularists and humanists. Given the atheistic bent of our society, such a retreat would not be surprising or necessarily an indictment of Christian ethical systems. It could simply be a sign of the last days of the church. No, the real problem is that Christian ethicists seem to be losing ground to themselves. Reliance on rationalism and edging farther and farther from Scriptures have led them

closer and closer to utilitarian thinking in their own work. The more they rely on reason and reasoned definitions—even those that begin with legal principles from Scriptures—the more a wedge is driven between their rules for moral conduct and the revealed will of God.

The Search for the Principle

In the first lecture we spoke of the role of faith in Christian ethics. If we want to establish what is right and wrong in the sense of what pleases God and what does not, we must begin with the disposition of the heart. In the ethical issues of life and death the need to focus on faith is most critical. The proliferation and complication of technologies and medicines has drawn every other ethical system to focus on the works of man. The idea seems to be that the more man learns how to apply medicine to preserving life, the more man's reason should take over in deciding how to make moral applications of his growing technology.

This is a faithless ethics. How does having faith change our approach? Faith looks first to God as the giver of all good things (James 1:17). That means that we look at the advances in medical technology as a gift of God. We see them as a trust by which God gives us greater opportunities to seek his glory (Col. 3:17). We consider that the more God blesses us, the more we want to look to him for guidance in using those blessings. If we forsook human reasoning and looked to God for answers when medicine was less confusing, how much more won't we look to God in faith and trust for guidance when matters become more confusing.

We have been operating with simple scriptural rules and laws in life and death issues. Be fruitful and multiply. Love your neighbor as yourself. Help and befriend him in every bodily need. Do not murder. But now God—through the advances of medical science—is presenting us with the possibility of having children in circumstances where before he had withheld that blessing. He is allowing us to reduce pain and extend life in situations where before there was no recourse but to suffer the pain and expect imminent death. Now the Christian must do some evaluating. But let's remember what has changed. God's blessings to us and opportunities for service have changed through increase. God's will is the same. If we are confused, it is because our faith-filled search of his will has not kept pace with his blessings.

We have been forced before to plunge more deeply into the Scriptures and to search out God's will to learn how to please him. David Kuske notes how getting away from the rules and searching for the principle was the approach we used in faith during the controversy over fellowship and again in regard to the role of man and woman. He writes, "Whenever a question arises about God's will in regards to a certain aspect of a Christian's life, there is always a tendency for us to think in terms of rules instead of a general principle" (*WLQ*, Winter 85, Vol 82, No 1, p19). Also in the biomedical issues of life and death we must try to avoid this tendency to make situational rules or a deontological law governing every circumstance. We must wean our people from seeking simple answers which will relieve their consciences and in the process excuse them from seeking God's Word to strengthen their faith and provide them with his changeless will.

But what is the principle underlying the rules and laws that God gives about life and death? By creating the world God made clear the relationship between the Creator and his creatures. God brought every living thing to life. The power he demonstrated in creating all things out of nothing (*creatio ex nihilo*) by his word, he perpetuated (*creatio continuata*) by his word in his command for them to reproduce after their kind (Gn 1:12,22,28). To man God showed from the beginning that the power to initiate life included the power and right to withhold it or terminate it. The tree of life and the tree of the knowledge of good and evil (Gn 1:9,16,17) were a divine instruction to the creature man in the state of perfection that the Creator was the author of life and death and that this power was closely connected with the relationship between man and God. After the fall God exercised his right over life both by threatening the sentence of death and by withholding it according to his gracious pleasure.

The principle is that God alone has the right and the power to initiate and terminate life. This principle is enunciated throughout the Old Testament by the inspired writers. Perhaps it is most clearly stated in Deuteronomy 32:29: "See now that I myself am he! There is no god besides me. I put to death and I bring to life, I have wounded and I will heal, and no one can deliver from my hand." This principle of God's power over life and death was not looked upon merely as a rule for moral conduct. It was received by faith as a part of the attributes of God. Hannah recognized this by faith in her prayer of thanks for God's reprieve of her barrenness: "The Lord brings death and makes alive; he brings down to the grave and raises up" (1 Sm 2:6). The king of Israel was forced to acknowledge that life and death was out of his realm of authority when Naaman came to him to be healed. He said, "Am I God? Can I kill and bring back to life?" (2 Kgs 5:7). The Psalms contain frequent expressions of faith in God's power over life and death. God is called "the stronghold of my life" (Ps 27:1) and "the fountain of life" (Ps 36:19; cf Dt 30:20). In Psalm 66 the fact that God "keeps our soul among the living" (v9 NKJV) is a reason for praise and thanksgiving. (Cf also Ps 139.)

The right and ability to bring life and death to his creatures remains uniquely God's. When Satan requested control over Job, "The Lord said to Satan, 'Very well, then, he is in your hands; but you must spare his life'" (Job 1:6). Solomon casually acknowledged this control of God over life in Ecclesiastes when he talks about the days of man's life (5:18; 8:15). He quickly adds that they are days "God has given him." Faith looks to God in life and death and says, "My times are in your hands" (Ps 31:15).

Although this principle of God's control over life and death is received and trusted by faith, natural knowledge of God forces even the unbeliever gudgingly to admit it. St. Paul appealed to that knowledge in the Athenians when he told them at the Areopagus, "He himself gives all men life and breath and everything else... For in him we live and move and have our being" (c 17:25,28). Faith embraces this principle in practice as Paul did when he approached death. He wrote to the Philippians, "I eagerly expect and hope that I will in no way be ashamed, but will have sufficient courage so that now as always Christ will be exalted in my body, whether by life or by death. For to me, to live is Christ and to die is gain" (Php 1:20,21).

Application of the Principle to Beginning of Life Issues

The most compelling issue at the beginning of life for us today is the matter of abortion. We know that it is wrong, but perhaps we have been drawn into some unnecessary argumentation by the religious legalists. Scripture has been used to try to prove that conception is the beginning of human life, that "human" emotions and activity begin in the womb, and that God's command not to murder extends to life from the point of conception. All of these are certainly legitimate points of biblical argument, but they may also be the long way around.

We cannot deny either that we have been drawn into the subjective and qualitative arguments of the humanists. Films that show how "human" fetuses look inside the womb are qualitative arguments for the presence of life at that stage. Or they are subjective appeals to the emotions of the viewers to deplore the destruction of such "human" looking beings. Such arguments are not, of course, sinful or wrong in themselves. But they open the door for the legitimacy of the same kind of arguments by utilitarians and situationalists. They can show the many ways in which fetuses do not resemble human life. They can use the same kind of subjective emotional appeal to deny life support to prenatals and newborns with terrible, unhuman deformities.

Now consider the simple principle that stands behind all that God says in Scriptures about conception, life in the womb, initiating life, terminating life and murder: God alone has the right to initiate and terminate life. In his continuing creation activity God has chosen conception as the means of initiating life. He has not established any other point in prenatal or postnatal development as his

means. Abortion is wrong at any stage from conception onward because it interferes with or countermands God's initiation of life. It is a faithless denial of God's right and power. We can call it murder without argument when we interpret the Fifth Commandment in the light of God's right to begin, maintain and end life.

According to this principle it is sinful to use birth control devices or prescriptions which interfere with God's means of creating life. The process of in vitro fertilization which fertilizes many eggs in separate tubes and then destroys all of the fertilized eggs except the one implanted in the mother would have to fall under the same judgment. Efforts to withhold or deny life saving treatment to babies before or after birth because of disease or deformity would be immoral unless God has made it clear that he himself is imminently withdrawing that life. More on some of these issues will be discussed in a future lecture.

Quantitatively life is life, or it isn't life. When we look to God as the author of life, he establishes how he creates life, not how much of life he made. The quality of life is left to his wisdom and justice. Quantitatively God creates life by conception. The Lord enabled Ruth to conceive (Ru 4:13). At the beginning Eve confessed, "With the help of the Lord I have brought forth a man" (Gn 4:1). Would Abraham and Sarah have doubted who brought life through conception? Or Hannah, or Elizabeth, or Mary? Life is a quantitative gift of God through conception. If we destroy what God creates through conception, we make ourselves God. What we do cannot be good in an ethical Christian sense. Lord, give us faith to accept you as the Giver of life.

Application of the Principle to the End of Life

While we have been generally and closely agreed on issues at the beginning of life, end of life issues have been much tougher. That is because, while God authors life in one way, through conception, he may choose any number of ways to end life. It is also more difficult because God tells us what happens when we die but not when we can observe this happening. The soul leaving the body (Ec 12:7) is not subject to an observable medical definition.

By keeping in mind the principle that God alone begins and ends life, we can be better guided in confusing situations. Too many good Christians think only in terms of the Fifth Commandment when caring for loved ones during their last hours. All they can hear in their conscience is, "Thou shalt not kill." They don't want to live with the thought that they participated in murder in any way. Even when their pastors try to ease their consciences, they make their decision to pull the plug with some guilt.

When we remember that God alone ends life, we can plead the Fifth in a different manner. Then it says, Don't stand in the way of God's right and power to begin and end life. When it is as clear as it can be by error-prone human standards that God wills to take a soul to himself, we can actually be impeding his will by prolonging the agony of death. We can wrongfully resist his power to end life by pridefully asserting the power of human technology in the face of the imminent and inevitable. What is worse is that families sometimes possess the selfish motive of fabricating against reasonable hope some extra time to say and do things for our loved one that we sinfully neglected earlier. We may cause needless suffering to relieve our consciences.

Acknowledging that God also has the power to end life must not gradually edge the Christian into qualitative or situational judgments. The judgment we make in faith is not whether a life has enough meaning to be saved, but whether or not God is seeking to end the life. Voluntary active euthanasia is a euphemism for suicide. The fact that God may call upon us or a loved one to endure terrible suffering or endure a vegetative state is not coincidental with his will to end life. Only faith in God's wisdom, justice and mercy can keep us from thinking qualitatively about life. The matters of voluntary (living wills) and involuntary passive euthanasia must be committed to God in faith and

acted on in good conscience according to the principle that he returns men to dust (Ps 90:3). (See Habeck, "Euthanasia," *WLQ* 1978, Vol 75, No 1.)

The Christian who clings in faith to the principle that God alone is the giver and taker of life will be shocked at the results of qualitative, subjective and situational morality in life and death issues. Hitler's doctors performed horrible experiments in the name of qualitative improvement of the race. They killed many who did not measure up to the standards of what they defined as humanity. It is not an illegitimate comparison to accuse humanistic situationalism and consequentialism in America today of using Hitlerish subjectivism. The principle that God alone decides who is going to die and when leaves qualitative judgments in the wisdom of God. We should not feel constrained to provide biblical evidence of the "good" or the "quality" that can come from lives in empty, waning years, enduring terrible deformities, in vegetative states, or in the process of bearing seemingly interminable pain. Any rules we make for teleological consequences will fly in the face of a divine logic which can be accepted only by faith. We trust that a good God will produce for his eternal purposes from each life he creates until the time he has set to call it from this world.

Other applications will be made in regard to life and death issues in the weeks to come as we discuss the good of the patient, making hard decisions and directions for pastoral counseling.

Part Three: The Good of the Patient

Bioethical Approaches

In Mark 5:24-26 we read, "A large crowd followed and pressed around him. And a woman was there who had been subject to bleeding for twelve years. She had suffered a great deal under the care of many doctors and had spend all that she had, yet instead of getting better she grew worse." Perhaps this capsulizes what is wrong with the approach of the medical community to patient ethics. Doctors are not always right. Doctors cannot always help. Doctors with the best of intentions can make decisions not in the best interest of their patients.

Yet any patient must surrender a certain amount of will and independence just in coming to a doctor. One ethicist summarizes it in this way: "That patients occupy a dependent role with respect to their physicians seems to be true historically, sociologically, and psychologically. The patient is sick, the physician is well. The patient is in need of knowledge and skills 'the physician possesses, but the physician does not need those possessed by the patient. The patient seeks out the physician to ask for help, but the physician does not seek out the patient. The patient is a single individual, while the physician represents the institution of medicine with its hospitals, nurses, technicians, consultants, and so on" (Munson, p193).

There are three subjects which ethicists deal with in the area of the good of the patient or the relationship of the patient to others who have to care for him. In our consideration we would want to include all those who might be called upon to make a decision for the good of the patient, including his family and spiritual counselor. The first of these subjects is called paternalism. One textbook defines paternalism as "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being coerced" (Quoted by Mappes, Zembaty, p33). Another summarizes, "Paternalism is the view that 'Father knows best'" (Munson, p191).

Another area of concern for the patient is honesty. Do doctors and families always have to be completely honest with a patient? Is it right to tell a patient severely depressed from recent surgery that the surgery was ineffective and another surgery will soon be needed? Wouldn't it be better to leave better impressions about the initial surgery until the patient has recovered from his depression? Another ticklish aspect of honesty is the propriety of the use of placebos. May a doctor use a placebo—basically

a fake pill—to allow a patient to believe he is being medicated with the hope that psychologically the patient may better his own condition?

A third area of concern in the patient's good is confidentiality. Is there ever a time when a doctor or family member is justified in revealing a patient's secrets. Family members may know something about the patient which the patient hasn't revealed to the doctor, but which if revealed might help the doctor diagnose and treat the patient. Doctors often have personal secrets, sins, even crimes revealed by the patient in confidence to them to assist their diagnosis and treatment. May a doctor ever reveal such secrets? Revelation of patient confidentialities are sometimes demanded in a court of law. Sometimes they are requested for tracing the source of disease by government health agencies. They might also be needed for evaluation by consulting doctors on the case.

A utilitarian approach to these questions of a patient's good sees little moral tension in the situation. Utilitarianism holds that "If a physician believes that she can protect her patient from unnecessary suffering or can relieve his pain by keeping him in ignorance, by lying to him, by giving him placebos or by otherwise deceiving him, then these actions are morally legitimate (Munson, p199)."

It seems that most ethicists today steer away from the radical conclusions of utilitarianism. Followers of Kant's Categorical imperatives demand honesty because lying is not a rule which can be applied equally to all people in all circumstances. Followers of John Locke and John Stuart Mill are utilitarians, but they argue against lying at will on the basis of the independence and self-determination rights of the patient. Mill argues that it is not right to interfere with a person's wishes even when it is for his own good, unless failure to intercede will bring harm to others (Mappes, Zembyk, p34).

It is ironic that many who refuse to allow the right to the physician and family to lie whenever they feel it is needed nevertheless do so on the basis of utilitarian thinking. In *Nursing Life* the head nurse from Mt. Sinai, Miami Beach, argues that nurses should always tell their patients at least as much as they want to know. But she bases her argument on teleological assessment of supporting polls and charts delineating positive and negative consequences for the patient. Doctors themselves justify the use of placebos ("placebo" is Latin for "I will please") for a number of utilitarian reasons. "Physicians are acutely aware of the uncertainties of their profession and of how hard it is to give meaningful and correct answers to patients. They also know that disclosing uncertainty or a pessimistic prognosis can diminish benefits that depend of faith and the placebo effect. They dislike being the bearers of uncertain or bad news as much as anyone else. Sitting down to discuss an illness with a patient truthfully and sensitively may take much-needed time away from other patients. Finally, the patient who demands unneeded medication or operations may threaten to go to a more cooperative doctor or to resort to self-medication; such patient pressure is one of the most potent forces perpetuating and increasing the resort to placebos" (Hunt, Arras, p281).

James F. Childress is a fairly conservative ethicist. He says that on the face of it paternalism is always wrong. But he allows for the use of interference, lying and breaking confidentiality under certain justifying circumstances. The circumstances must be that the patient is incompetent to make the decision for himself and that that decision he makes will cause himself harm. Even then paternalism is justified only if the incompetence and the potential harm outweigh the individual's right to independence. Such an ethics can accept a court's decision not to force a Jehovah's Witness to accept blood transfusions for himself, but to require that they be given to his children.

It is interesting to see the knots into which humanistic utilitarianism ties itself when wrestling with the questions of the patient's good. On one side is the pressure to allow a person to judge right and wrong from circumstances and consequences. On the other side are the rights of the patient to judge right and wrong for himself from his circumstances. The patient's right to know of his condition and treatment conflicts with the supposed right of the doctor and family to withhold information when they

judge teleologically this will harm the patient. The patient's right to decide clashes with the doctor's superior knowledge, experience and objectivity. The patient's right to decide also often runs counter to the family's wishes, conscience or religious beliefs. Living wills drawn up at a time when there is no threat of death can confuse more than clarify what the patient has decided when complicated options of treatment present themselves as death approaches. Utilitarians also of course demand the right of the patient to privacy. This proposed ethical right was made a legal right by the Supreme Court in striking down state statutes limiting abortion. In a sense it rejected state paternalism on behalf of the unborn in favor of the right of the mother privately to decide what she wanted to do with her own body. Finally, the right to die incorporates other patient rights when they are applied to treatment of terminal patients. This right of the patient often conflicts with a doctor's efforts to do everything possible to maintain life, even in a purely mechanical way. The right to die also has implications for voluntary active and passive euthanasia.

All of these patient rights are included in the concept of patient autonomy. Patient autonomy implies self-determination and requires informed consent. Many secular ethicists speak of respect for the patient. But here too the lines are hard to draw. Ethicist Terrence F. Ackerman argues that doctors must interfere with patient decisions at times in order to maintain "real respect" for the patient and his needs. He says that a patient is not just a well person with a disease. "If as I believe illness renders sick persons as 'qualitatively different,' then respect for personal autonomy requires a therapeutic interaction considerably more complex than the noninterference strategy (Mappes, Zimbaty, p70)."

Paul Ramsey is the most distinguished Christian ethicist. His book, *The Patient as Person*, deals primarily with the matter of the good of the patient. Ramsey utilizes what is called the covenant theology approach to the ethics of the doctor-patient relationship. He compares the way God deals with men according to his covenant with them to the way men deal with each other. He explains, "We are born within covenants of life with life. By nature, by choice, or need we live with our fellowmen in roles or relations. Therefore we must ask, What is the meaning of the faithfulness of one human being to another in every one of these relations, This is the ethical question" (p xii).

But Ramsey's covenantal theology is one that is based on rules or principles which govern the relationship. He views God's covenant with man as a two-way covenant and thus patterns his human relationships according to legal principles. Even his concepts of grace apply to law rather than to faith. He writes, "The practice of medicine is one such covenant. Justice, fairness, righteousness, faithfulness, canons of loyalty, the sanctity of life, *hesed*, *agape* or charity are some of the names given to the moral quality of attitude and of action owed to all men by any man who steps into a covenant with another man—by any man who, so far as he is a religious man, explicitly acknowledged that we are a covenant people on a common pilgrimage" (pp xii-xiii).

Generally religious ethicists urge a cautious common sense approach to the relationship of the patient to his doctor. Catholic ethicists encourage a discrimination which combines the decrees of the church with the situational realities. "To make this discrimination requires each person according to his or her gifts and situation to engage in prayer, study and reflection so as to note the signs by which God makes himself know to the Christian community. Taken one by one these signs may not be completely convincing, but their convergence can lead to a secure conviction that this is the Word of God" (Ashley and O'Rourke, p64).

Evaluation of ethical approaches

The commendable aspect of the state of secular and religious ethics today on the good of the patient seems to be its awareness of the problem. "Available studies (cf. R. Blum, 1964; Freese, 1975; Levin, 1975) of the actual competency of physicians in practice commonly turn up alarming percentages (from 30 to 50 percent) of physicians whose competence is substandard, while a similar percentage of hospitals do not meet minimal accreditation standards. Again estimates show that a high

percentage of surgery (50 percent in some hospitals) is unnecessary and explainable only by incompetence or greed. Finally the same studies show that among professionals, physicians rate highest in drug addiction, alcoholism, and psychological disorders. When this is added to the growing evidence that a considerable percentage of physicians have an income well in excess of members of other professions, choosing a reliable and competent physician and a high-quality hospital is a risk” (Ashley and O’Rourke, p74). In the face of this reality it is important to question the motivation of the paternalism of the medical community and demand frankness in the matter of patient rights.

Criticism of modern ethics’ approach to patient good comes in regard to how it goes about solving the problems. Although blatant utilitarianism is mostly rejected, it is rejected only for the sake of conflicting pet humanistic axioms about the autonomy and freedom of the individual. If the utilitarian opts in favor of institutional paternalism on the part of doctors in principle, it has lost its case against state paternalism in laws protecting the life of the unborn. The moral unfeasibility of utilitarianism is exposed whenever it is applied to two or more parties acting with the same subjective approaches.

Another criticism of popular ethics on the good of the patient is that it seems more than usual asean on the issues. Rules seem always to conflict. General principles seem to be lacking. Situationalism abounds. Common sense is the only bottom line. What makes this area especially difficult to resolve is that there is not only a conflict of options, but a conflict of interest among those who must choose among options. There seems also to be among ethicists an uneasiness in not being able to provide motivation for acting in the patient’s good. Selfish motives are present in the attending physician, the family and the patient himself. It is an area where even secular ethicists come close to mentioning sin.

Religious ethicists seem to have missed the chance to pounce on a wonderful opportunity here. The best of them (Ramsey, Haring) seem oblivious to the existence of the soul. They talk about covenants between men, meaningfulness, freedom, and even spiritual meaning. Haring writes, “The example and advice of the doctor and the nurse guide the patient’s relatives and friends as they try to harmonize loving concern, trust, truthfulness and authentic peace in order to maximize the patient’s exercise of freedom (p125).” He writes as though the Roman Catholic Christian does not know the meaning of death and must search for it with the doctor. “Theology cannot deny the value of such a sincere quest. It may be precisely in this sincerity and courage to keep on searching that man transcends himself in the direction of God (p127).” Ramsey bases much of his ethics on the sanctity of life, but his definition of sanctity seems to lean more toward inviolability in connection with the covenant relation than with a holiness stemming from the connection of the soul with the body. In *The Patient as Person* Ramsey devotes almost all of his time dissecting legal opinions and practical cases and explaining technical advancements. Only in his preface does he get close to making a clear connection between his theology and his ethics. He writes, “The sanctity of human life prevents ultimate trespass upon him even for the sake of treating his bodily life (p xiii).”

The notable Christian ethicists all have close connections to the medical community. They seem embarrassed even to mention the gospel of Jesus Christ or the faith that receives it. There is absolutely no soteriological flavor to their writings. Jesus is mentioned only as an example of caring for human bodily needs (e.g. “Jesus as Model,” Ashley and O’Rourke, p164). Christian ethicists have failed to fill the gaping void left by the confused secular ethicists.

The search for a principle

Perhaps even more in the area of the patient’s good than in the area of life and death issues the search for an all-encompassing principle is critical. It is not enough for Christians to say love your brother as yourself, love your father and mother, don’t lie, be a good Samaritan and don’t hurt or harm

your neighbor in his body. It is true the believer according to the new man wants to do all the things contained in God's law. But because there is an old man with imperfect knowledge problems remain. It is difficult to know how to honor your father and mother when they are patients pondering whether or not to submit to the paternalistic efforts of their physician. When your neighbor has lost his ability to think clearly, it is sometimes difficult to tell whether withholding information is loving or lying. Something must guide him through the muddy field of bioethical casuistry toward making a decision to the glory of God.

Of course, nothing will be good if it does not proceed from faith. God reveals himself in his Word through faith not only as the Creator who has control over life and death. He reveals himself in Scripture as the Savior God who desires the good of those to whom he has given life. Faith understands and 'trusts that no one desires the good of the patient more than God. "He forgives all my sins and heals all my diseases" (Ps 103:3). In that confidence of faith we have the kernel of principle that can guide our efforts for the good of the patient. The principle is that God desires the good of man according to body and soul and that in our love for our neighbor we are to seek our neighbor's good according to both body and soul. The confusion in medical ethics today when dealing with the good of the patient comes from the mechanical separation of body from soul. It is the naive approach to man as though he were only body and mind with no spiritual dimension, as though he could be treated in body and mind without reference to the good of the soul.

Faith that rests on Jesus does not separate the body from the soul. The prophecy of Isaiah that the blind would see, the deaf hear, the lame walk and the dumb speak (Isaiah 35:5) was fulfilled literally by Jesus for the good of the body and figuratively for the good of the soul of man (Mt 11:4-6). Jesus healed the paralytic whose sins he had forgiven to convince the teachers of the law that the power of the Savior God extended simultaneously over the physical and the spiritual (Mark 2:1-12). Jesus himself was born and lived body and soul (Ga 4:4), suffered and died body and soul (Lk 23:46; Jn 19:30), and rose body and soul (1 Pe 3:18). He did this to save us body and soul (1 Cor 5:5; Ro 8:11,23; Php 3:21; 1 Th 5:23).

Faith is confident that God desires and works for the good of man body and soul (Ro 8:28,32). Faith trusts that the directives God thus gives in his holy Word will lead him to love his neighbor body and soul. When our neighbor is an unbeliever love will strive to impress upon him that the spiritual ramifications of his medical predicament take precedence over the physical. "Do not be afraid of those who kill the body but cannot kill the soul," Jesus said. "Rather be afraid of the one who can destroy both body and soul in hell" (Mt 10:28). When dealing with a brother in faith, we will encourage him as St. John did Gaius: "Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well" (3 Jn 2). A Christian's neighborly love is never a mere exercise in mechanical decision making from a cold, detached physical morality. It seeks the good of the patient in the context of faith, looking to see how service to the body can serve both body and soul. It seeks to bring the unbeliever to faith and to preserve the fellow believer in faith.

Application of the principle

By faith the Christian works on the principle of God's desire for good for the whole person, body and soul. This is not only a principle of pastoral counseling in medical matters. It is how believing relatives and friends seek the good of a patient. God's laws about physical care and concern for others are interpreted in casuistry in such a way that the good of the soul, the creation or sustaining of faith, is served.

That this is not a vague subjectivism is clear when we remember that faith does not work in a vacuum. It is surrounded by and receives God's revelation in Holy Scriptures. It uses the circumstances around it not to develop morality situationally, but to deal in knowledge when it applies the objective truth of God's Word. We do not put implicit trust in the doctor or the medical establishment. Our

implicit trust for our good is placed in God, and the doctor and the medical establishment are a part of what we must judge and decide how they fit into what is best for us body and soul. Scripture must not be assigned and confined to an adjunctive role of comfort for the soul of the patient whose body is sick. It has a directive value in prescribing what is good for families, doctors and patients who are wrestling with hard decisions.

Perhaps the most obvious direction Scripture gives for the good of the patient is the prescription of consistent honesty. God is a God of truth. Jesus said that he is the truth and that the Father's word is truth. For the good of body and soul he gives us the "gospel of truth" (Ga 2:5). Faith was born and grew on the truth. It cannot express itself in any other way. The opposite of truth is iniquity (1 Cor 13:6) and cannot be ethically good. The devil is a liar and the father of it (Jn 8:44; cf. 1 John 3:8). So every believer wants to speak the truth to his neighbor (Eph 4:25).

In the context of the principle that God desires the good of body and soul, we can see why speaking the truth is so important for the good of the patient. Good psychology is not only a matter of the mind. It involves the soul. People who are sick need to prepare themselves spiritually whether they know it or not. Their illness may be God's way of drawing them closer to him (He 12:1-13). They need to know as much as possible what the condition of their body is so they can prepare their body and soul. The lack of frankness and truth by family and doctor often keep the pastor away from the bedside or compromise the directness of his spiritual applications.

Telling the truth is an absolute that cannot be compromised. But telling the truth in itself is not morally good if it is done apart from faith. The believer doesn't just tell the truth. He speaks the truth in love (Eph 4:15) in order to build up the church. Speaking the truth to hurt someone is not ethically good. Patients may of themselves or through medication be in a confused state in which tactlessly stated truth may hurt them. Still the alternative is not lying, but speaking the truth with the simplicity and clarity that can best serve the needs of the soul.

Speaking the truth always and always in love is how God served all people, body and soul. We must not swerve from our resolve to serve our fellowman in the same way. Utilitarian thinking may devise many subjective arguments as to why truth will not serve in one situation or another, but faith trusts a God of truth. Sometimes the truth hurts. We have all been hurt in some ways by the truth. But God's concern for our bodies and souls shows that what may hurt the body in the short run serves body and soul in the long term. Nor should we defend our telling the truth on utilitarian consequentialism. Polls and outcomes may substantiate that patients want the truth and that it helps them. Faith knows that from God and acts to please a God who says it is right and good.

Confidentiality is closely connected to truth-telling. Maintaining a confidence is remaining true or truthful to your promise not to reveal secrets. "A gossip betrays a confidence, but a trustworthy man keeps a secret (Pr 11:13)." But there are aspects of truthfulness involved in receiving information in confidence in the first place. Doctors, pastors and friends of patients must let it be known that they will not receive information of a criminal or immoral nature without urging the patient to make the matter right before God and man. When confidential information - harms another human being it flies in the face of love not to reveal the information on the principle of confidentiality. It is sin to reveal a confidence, but is also sin to promise confidence when such a promise assures harm to others. (Cf. Mt 14:6).

Evaluating patient rights over against paternalism must also be done knowing the principle that God cares for body and soul is behind his moral rules and laws. A patient certainly has the right to refuse treatment, but his evaluation of whether he wants the treatment must come from a concern for both his body and soul. A patient has a right to privacy, that is, the right to make a decision without the paternalistic concern of the medical community or the state, but a believer's right to privacy is an exercise of obeying God rather than man. A patient has a right to die, but he does not exercise that right over against God's desire to do good for his body and soul by establishing for him a time of grace.

Christians especially should cherish what humanists describe as the ‘rights’ of patients. But we would define them as the Christian’s freedom to act for the glory of God without constraint from those who may be acting contrary to the wishes of God. We would refuse the kind of paternalism that forces unnecessary expense and pain from unproven medical procedures or mechanically simulates life’s functions for the sake of professional pride or cost-effective frequent use of technological machinery. We would refuse and resent the paternalism of the state which required sterilization or forced the acceptance of unethical standards in connection with the acceptance of state-run health programs.

Yet paternalism is not wrong in itself. There are times when Christian doctors, families and pastors would interfere and deny or counsel him not to exercise rights which were not in accord with the principle of good for body and soul. A mother who claims her right to privacy as a justification for abortion would have to be told that the right over her body belongs to God (1 Cor 6:19,20) and that she is cutting off the time of grace for another body and soul to which God has begun life through conception (Gn 9:5,6). Pastors would advise members of their congregations not to make living wills that do not explicitly guard against voluntary euthanasia and leave the door open to active euthanasia to avoid pain and suffering. Not we, but God has the right over life and death. We would encourage fellow Christians to accept advice from physicians whose treatments and medications are God’s gift to them for the extension of their body and soul life (1 Tm 4:4,5).

There is something more that the believer does for the patient good than be honest, guard confidentiality and guide paternalistic efforts according to God’s will. As the Christian is moved by faith to seek the will of God so he knows that loving his neighbor body and soul means leading him to act from the same motive of faith. If we are honest in revealing to a cancer patient the hopelessness of his situation, we will be there at his side with gospel assurances to help during his stages of denial and resignation. The elderly will not merely be asked to accept entrance into a nursing home as an inevitability necessitated by their health care needs. They will be encouraged by the gospel of Christ to see their change as an opportunity to give glory to Christ in a new setting. Mothers contemplating abortion will not make an ethically correct decision—even when they choose not to have an abortion—unless they see children under all circumstances as a blessing of God to be raised in his knowledge and for service to him.

The answer in specific cases do not come easily. But Christians who are guided in faith by the principle that God wants us to love and care for our neighbor body and soul have something which modern ethicists, philosophical and religious, do not have. They have an arrow to point their way in the application of general laws and rules in casuistry. We aren’t restricted only to the arguing of which rule supercedes the other. We do not have to weigh consequences whose good we cannot really judge before we come up with an answer. We don’t have to measure our love for our neighbor with a subjective idea of good. We will love our neighbor with the trust that God’s rules were designed for the good of the patient body and soul.

Part Four: Making Hard Choices

Bioethical Approaches to Decision Making

Because of what doctors and their technology are able to accomplish Christians are being invited into or forced into making some difficult decisions. Would you be willing to have the heart of another human being implanted into your chest if the alternative were certain death within days or weeks? Would you be willing to ask your sister to donate a healthy kidney to you in order to prolong your life a few more years? How would you counsel a young couple who had tried for years to have a child, were hopelessly low on an adoption list and wanted to consider in vitro fertilization? Do you know enough of the process to guide Christian consciences to a godpleasing decision? Would you advise for or against the use of a sperm bank and artificial insemination if the husband of a happily

married couple was sterile? Could you provide compelling reasons for not considering surrogate motherhood to that couple if the wife were unable to conceive? What will you do when your mother cannot care for herself, needs nursing and medical attention you cannot give her in your own home and is dead set against being admitted to a nursing home? What choice would you make if your cancer-stricken wife required a promising new treatment beyond what your insurance and personal resources could afford?

Actually all these circumstances in real life are more problematic than can be described in a simple sentence. And they are no longer far removed from the everyday life of our congregation members. A large number of our people face cancer treatment options. Involuntary nursing home placement is a frequent occasion for pastoral counseling. Artificial insemination and in vitro fertilization procedures are now being advertised by local hospitals. Some pastoral counseling is being done in this area, and one would have to expect that much more could be done.

Perhaps the best summary of ethical approaches to decision making is presented by James F. Childress in his 1981 publication, *Priorities in Biomedical Ethics*. He starts by describing the teleological approach. "The first model is consequentialist. It emphasizes the values of scientific knowledge: the conquest of numerous diseases, the increase in life expectancy, and the improved quality of life. The basic ethical design of this model is balancing benefits against risks... The major imperative of the consequentialist model is, 'Achieve good.' Some extreme versions of this model imply that ends justify means, perhaps even to the extent expressed by the late labor organizer, Saul Alinsky, who held that "those who worry about means in relation to end usually wind up on their ends with no means at all (p53)." Teleological ethics would usually transplant the organ if at all possible for the sake of learning more about transplants. If parents wanted a child, it would ignore the possible moral implications of the means used to achieve pregnancy. It would opt for the most experimental and expensive forms of cancer treatment for the sake of gaining data on future treatment. Teleological ethics would usually commit questionable cases to nursing homes or hospices and work out patient and family anguish through social services after the fact.

The second ethical approach to decision making that Childress summarizes is the duty oriented one. He writes, "Over against this consequentialist model is the deontological model of ethical reflection. For this model, some acts, attitudes and policies are right apart from their effect or consequences... In this perspective, to act against a person's wishes or without the person's consent is to treat that person as a means to some private or social good. Such acts violate that person's fundamental rights. In this model the freedom of the subject, not of the biomedical professions, is critical (p53)." We should take careful note of Childress' words about deontology in decision making. Although Childress, Ramsey and other religious ethicists today fall into this category, the deontological model does not necessarily insure a biblical or Christian approach to decision making. Much of the emphasis of today's duty oriented ethics is on a duty to allow the individual to make up his own mind without pressure from the medical community and without pressure to consider the consequences of his actions. This is Christian ethics only if the individual exercising his rights is a Christian making his decisions on the basis of God's will.

A third approach to decision making ethics is a combination of the first two and seems to be the one which Childress himself endorses. It is called pluralism. Childress explains, "The starting point of the pluralistic model is a presumption that can be overridden under some circumstances... I think this model is closer to the way we actually think and reason in this area. Criteria that operate in the pluralist model apply to some extent in other areas, such as the justification of war. The reason is simple: the same or analogous criteria are used whenever we encounter situations that involve conflicting values, duties or obligations" (p54). Pluralism is perhaps the best way to describe the actual operating ethics of the medical community today. It is probably also the course to decision making taken by patients who do not receive Christian counseling. In a recent textbook, Robert T. Francoeur tries to describe this

decision process. “Initially three elements, A) our fixed world view, B) our emerging desires and concerns, and C) our ideals, personal relationships and experiences combine to create our personal values. These values are then given social expression in our laws, cultural values, and institutions. But science and technology also impact on our symbols and institutions... Filtered through our social institutions and symbols our personal values are expressed in a particular lifestyle. The way we live as individuals then feeds back and impacts on our social and physical environment. The interaction between our personal lifestyles and the environment feeds back to us as individuals. As a result we experience physical, biological and social constraints” (*Biomedical Ethics, A Guide to Decision Making*, p22. See accompanying chart).

Evaluation of Bioethical Approaches

The best way to describe the state of philosophical bioethics today is to say that it is in a state of confusion. All secular textbooks simply present all the possible alternative ways of coming to a decision without really showing in a simple way how to make choices. There is an emphasis on the mechanics without reference to morality. Religious views are acknowledged and analyzed but are simply incorporated as one small part in a pluralistic thinking process.

Religious ethicists do not do much better. Childress toys with pluralism. Paul Ramsey allows for some end-means argumentation. He says, “The end justifies the means, but not all means” (Quoted by Childress, *Priorities*, p54). Martin E. Marty shows his pluralistic stripes when he explains how he enlisted help for the book he coedited. “In this book another range of specialists has been called in: historians, philosophers, theologians, and ethicists. I want to talk about them and their world, their approaches and methods, their disciplines and what these have to offer” (*Health/Medicine*, p31). D. Gareth Jones speaks strongly against consequentialism in IVF research. He writes, “It is essential to realize that the way in which information is obtained is more important than the information itself. If information is obtained unethically, it will in all probability be applied unethically” (*Brave*, p115). At the same time Jones does not take an absolute stand against the systematic destruction of fertilized eggs in the laboratory after implantation to achieve pregnancy, and his position on abortion becomes situational when applied to cases of prenatal deformity.

With the exception of Jones published ethicists today make no specific reference to Scripture. Secular ethicists keep their distance from the Bible by lumping it with “religious preferences.” Religious ethicists draw from broad biblical themes such as love, covenanting and individual personhood but never quote passages. Ramsey and Marty pit such words as “religious traditions” and “protestant traditions” against consequential ethics, but they lend no substance to these traditions for decision making in particular cases. One gets the impression that ethicists hold themselves aloof from any form of casuistry, deeming it beneath the scope of their setting high ethical standards. At the same time they fail their own calling in not providing even the basic framework on which practical applications and decisions can be made.

The Search for a Principle

In the second lecture we suggested a principle from Scripture for life and death issues. That principle is that God has the power and the right to begin and end life. In the last lecture we suggested that since God created man body and soul decisions regarding the good of the patient must take into consideration how God had made man. But what principle could possibly lie behind decision making in various biomedical situations? Even from a Christian view there seem to be many different moral requirements which pull one in more than one direction at the same time.

Perhaps we can take our cue in the search for a guiding principle from the failure of the philosophical and religious ethicists of our day. Either they fail to consider God at all or they fail to look closely at what God has to say. But God demands that his creatures acknowledge him. He

demands more of those who acknowledge him than that they loosely admit that he has some preferences. God demands, in fact, that man be fully and perfectly accountable to him body and soul. “It is God’s will that you should be holy,” (1 Th 4:3) Paul says. Jesus said, “Be perfect, therefore, as your heavenly Father is perfect” (Mt 5:48).

The legal principle, then, in making hard choices is that God holds us body and soul fully accountable to himself. In bioethics as in any other matter we want to know all we can about what God has said is right and wrong. We want to obey God rather than man. Instead of dealing in broad themes and general vagaries, instead of simply throwing up our hands and saying God doesn’t have much to say on this point, we want to allow ourselves to be driven to his word.

Accountability to God sets its own limits. Faithfulness in the study of God’s law will stop us from pushing the law farther than God has given and explained it. This caution is also very much in place in bioethics. We don’t want to make for laws the commandments of men.

Nor does application of everything God has to say rule out any consideration of the consequences of our actions. Carefully evaluating circumstances and consequences is necessary in order to know exactly what law of God applies to our decision making. This is not consequentialism or situationalism. We do not justify immoral means by looking at the possible outcome of our action. Rather we learn from God what means is moral in that circumstance.

It is especially important for pastors who counsel members in difficult biomedical situation to remember Scripture’s corollary to the legal principle of his requirement of accountability. What he requires, he provides. The perfection he demands, he grants through the righteousness of Christ. The importance of this gospel in counseling should be obvious. In spite of our earnest study of God’s law, in spite of our careful evaluation of our options, and in spite of our careful decisions, we are going to make mistakes. We are going to misapply God’s law. We are going to misjudge the consequences of our decisions. Or we may make what God considers a good decision and not have the humanly evaluated results to verify that it was the right choice. We will sin. We will think we have sinned when we may not have. We need to know that we have a gracious God and that his blessing, yes, eternal life itself, does not depend on our following of the law. Only with this confidence can a man perform a work that is ethically good.

Application of the Principle to Some Hard Choices

The one subject in bioethics which has prompted some papers in our pastoral conferences is organ transplants. Especially when heart transplants first became a regular news item, some questions came to mind. Does receiving another man’s heart bring with it any aspect of the donor’s personality? Does the horrible complication and expense justify the relatively short extension of life that transplants promise? Should an accident victim’s family feel queasy about donating to another man a part of a body which God will raise in the resurrection? What about the artificial means of keeping the donor alive until the heart can be removed?

Although the Bible often mentions “heart” as a part of a man’s personality, the seat of his emotions, the controller of his will, a place of receiving knowledge and even the receptor organ for faith, it does not identify this with the organ in our chest which pumps blood to the rest of the body. There is no biblically warranted fear of a soul or personality transfer in an organ transplant. Nor will a God who made man from the dust of the ground have any difficulty putting us back together with the right parts on the day of judgment. It is a tremendously difficult thought to conceive of our heart beating in the chest of another or the heart of another beating in our chest. The heart is an extremely close identification of our physical and spiritual nature. Yet to donate a heart or to receive a heart is morally little different than to lay down one’s body and life for another or to have another lay down his life for you.

Other aspects of heart (and other organ) donations and transplants should receive more consideration. The disposition of our spiritual heart is the first consideration in an ethical matter. If there is lingering doubt in the conscience about giving or receiving organs that cannot be dispelled by Christian counseling, the procedure must be delayed. What are the thoughts of the family waiting for a donor? Are they hoping somebody with matching tissue type will die? Have they looked to the spiritual needs of the hopeful donee in the event that the operation cannot take place? Is undue pressure being put on a family member, such as in the case of a kidney transplant, to donate less than willingly to a dying sibling? Is a potential donor holding back out of conscience questions of propriety or out of simple selfishness. The pastoral counselor is always concerned about the motives of those in his care.

Another area in which Christians will want to carefully weigh what Scriptures have to say is artificial means of conceiving and bearing children. The various subpoints in this area include in vitro fertilization, sperm banks, artificial insemination and surrogate motherhood. In vitro fertilization (IVF) is a procedure in which the mother is first stimulated with hormones to produce eggs. The eggs are then withdrawn from the woman's ovary through an incision in the abdomen with a laparoscope, a fine needle. The three to six eggs withdrawn from the mother and combined in a test tube (in vitro) with the husband's sperm and a nutrient solution. After fertilization the eggs are allowed to divide and multiply for forty to sixty hours until there are four or eight cells. These cells (the embryo) are then transplanted back to the mother (embryo transplant = ET). The remaining embryos are then destroyed or given over for genetic research. The success rate of IVF and ET ranges from 20-38%.

The procedures for artificial insemination and surrogate motherhood are probably better known. Artificial insemination is the fertilization of the egg by the father's sperm or by the sperm of a donor from a sperm bank. This is done artificially when the wife naturally produces fluids with acids that destroy the husband's sperm before they can reach the egg. The sperm of a donor from a storage bank is used when the father is impotent or his sperm count is too low. Surrogate motherhood is the artificial fertilization of a woman other than the wife with the husband's sperm.

There are two ways to evaluate the issues involved in this area. One is according to mechanics, the other according to attitude. Some of the mechanics involve no problem, others are questionable, and some involve sin. There seems to be nothing wrong with artificial insemination when the sperm of the natural father is used to help the natural mother conceive. There could be some question as to how the sperm is obtained from the father. Many times this is done through masturbation. Pope Pius XII opposed artificial insemination on the grounds of natural law. Helmut Thielicke opposed it on the same basis. The argument is that God ordained that children should come through the union of one flesh, and the intervention of the laboratory destroys that natural intimate union. If Christian consciences are bothered by this thought, they might want to refrain from artificial insemination and bear the burden of childlessness with godly patience. But is it scriptural to push this argument to burden consciences which are not bothered by it? Artificial insemination does not rule out the intimacy of the sexual union between the husband and wife, nor is it likely to destroy the affection they have for each other. God blesses us to be fruitful and multiply and he speaks of the union of one flesh, but not in the same breath. To absolutely connect these is not a direct application of Scripture but an extension of it. It is this kind of thinking that has also led Rome to declare the bearing of children the primary purpose of marriage and the only purpose of intercourse (See Hans Kirsten, "Birth Control as Ethical and Pastoral Problem," *WLQ*, Jan 68, Vol 65, No 1, pp24-42). This argument, if pressed, could also be applied to organ and corneal transplants and most artificial means of preserving and sustaining life.

IVF and ET technology pose a more serious problem. The destruction of fertilized eggs or their use for research projects jolt the Christian conscience which equates such procedures with abortion. A booklet published by a study commission of LCUSA frankly evaluates the pros and cons of but leaves the decision to the reader. Here a natural law concept could be argued for the use of IVF even when embryos are destroyed. This suggests that God begins life by a fertilized egg inside the mother, so

those fertilized artificially outside the mother are not truly of God's initiation. Apart from this, it must be noted that not all IVF and ET procedures are mechanically wrong. Many if not most clinics take only two or three eggs from the mother and transfer all the fertilized eggs back to her. On the other hand many clinics which follow this procedure as a rule make an exception when it can be ascertained that one or more of the embryos is abnormal.

But there are other concerns for married couples and their pastors to consider when seeking to overcome the inability to conceive children. Although God does not singularly connect intercourse with the blessing of children, he does clearly say that sex and the bearing of children are blessings to be received in the bond of marriage. The concept of insemination from a donor sperm bank is one from which a Christian couple will shrink back. The same is true of surrogate motherhood. Attempts to draw comparisons between these practices and adoption are not legitimate. In adoption the child is not the natural offspring of either spouse. Both husband and wife receive the child as their own on the same basis. There is not the guilt, the second-guessing, or the resentment that often results when one of the spouses is the natural parent. This kind of lovelessness is a common problem in second marriages in which one or both of the spouses have brought along children from a previous marriage. Attitude and consequences must be given weight along with God's design for the blessing of children when making hard choices in having children.

Attitude and disposition of the heart are so important. In this area of bioethics the end, bearing children, is certainly justified. But the end does not justify the means. God does withhold the wonderful blessing of children from some couples, and they must not think that any means of attaining that blessing is right. Christian resignation and cross-bearing are legitimate topics of counseling in such matters. If God has withheld a good end and disallows the possible means, doing God's will and accepting God's will are the same thing.

Very likely the most common difficult decision which Christians make in the field of biomedical ethics has to do with the commitment of a relative, usually a parent, to a nursing home or other extended care facility. The same options apply to cancer treatment for a child or medical care for a spouse. Some of issues involved in these matters were discussed in the previous lecture on the good of the patient. There we discussed it on the basis of considering the spiritual as well as the physical good of the patient. Here we want to consider it on the basis of taking into account all of the things God has said about particular circumstances.

Biomedical advances have made this a more complicated issue that it was many years ago. Caring for parents in their declining years was a one dimensional moral issue. God has told us to honor our parents (Ex 20:12; Dt 5:16; Eph 6:2). We have always interpreted such honor to go beyond mere obedience in the home during childhood years. Simon and Andrew told Jesus about Peter's mother-in-law's illness so Jesus could heal her (Mark 1:30). In the midst of his own personal extreme anguish on the cross Jesus made provision for his mother's care (Jn 19:25-27). Adult Christian children regularly took their parents into their own homes and cared for them until death.

What has complicated this matter is the advanced technology for the care of the elderly, most of which must be administered by professionals. Taking a parent into one's home may no longer be the best way to honor one's parents. When specialized nursing home or hospice care can extend relatively healthy and active life for months and even years, home care may actually do a disservice according to the Fifth Commandment. There can even be selfish factors involved in keeping a parent at home against better advice. There may be a desire to preserve an inheritance intact, or children may fear speaking directly and honestly to their parents about their physical needs for fear of being considered unloving.

Another moral factor in the decision for nursing home placement is the matter of priority in family obligations. When one marries, one leaves his father and mother to be united with his spouse (Gn 2:24). Although this does not relieve one of the duty to honor his father and mother, it loosens the

relationship with parents in favor of duty to spouse. There is always a little tension when parents and in-laws live in the home. But when this tension threatens the marriage (quantitatively) and not merely irritates it (qualitatively), it may become a moral requirement to find other care for the parent even if the need for professional medical care does not demand it.

Still it is important not to deal with nursing home placement only on the basis of applying moral rules. Love for our fellowman also means dealing with him as a redeemed soul. Sometimes love endures all things. Sometimes love will rejoice in the truth and require direct, frank, honest discussion. A Christian pastor will often be called upon to moderate such discussion. He must do more than evaluate the situation and sort out the applicable rules. He will motivate with the gospel, speak of forgiveness, encourage forgiveness among the parties involved and strive to get all the participants to make their hard choices out of faith in Jesus.

In the preceding discussions of organ transplants, procreation technology and nursing home placement one factor has been omitted. Because it affects all of these and many more areas of biomedical decisions we will discuss it separately here. That is the matter of the cost of treatment. By cost we do not merely mean financial costs. There are many other sacrifices which patients and their families have to make. Mental anguish and worry, loss of time, disruption of family life, endless transportation and conscience pangs over tough decisions are also a form of medical expense. How much do we have to pay before the cost of helping and befriending our neighbor in every bodily need infringes on our moral obligation to regard our own body as God's temple (1 Cor 6:19) and to provide for his own relatives, especially for his immediate family (1 Tm 5:8)?

There is never an easy or simple resolution to making hard choices in the area of cost. Doing everything possible for the physical good of the patient will always seem like a sacrifice and a challenge to caring for one's own and one's family needs. Being concerned about one's own well being when a spouse or child is dying always seems to have a tinge of selfishness even when God's moral rules allow or command it. The resolution of this most difficult problem lies first of all in following the principle in hard choices and in relying in faith upon the promises of God to forgive what we do wrong. The principle is that God demands absolute accountability of us to himself. Making tough choices without searching Scripture, without talking with spiritual friends and relatives, without seeking the counsel of your pastor disallows to the conscience the plea of ignorance when the wrong decision is made. Christians want to be honest about the situation. They want to know everything God says about how they can please him in each circumstance. They pray for the faith without which they cannot please God. They ask for direction in doing the right thing. And then they come before God's throne in confidence that what they did not do right will be forgiven.

In the last lecture we will discuss the role of pastoral counseling in concentrating on motive, acting out of a clear conscience, leading people to work with principles and providing preemptive counseling and education for the congregation.

Part Five: Pastoral Care and Counseling

Motive, the Distinctive Element in Christian Ethics

The pastor's work of counseling in the area of medical ethics is complicated by a number of factors. There is the press of time in his own schedule. Add to this the press of time that often comes from the urgency of the situation. Families usually wait for crisis before they think of asking for the pastor's help. The cancer is advanced, and the options of treatment confuse them and lead them to search for spiritual help. Or, an elderly patient has been told she must leave the hospital within a short time because government or insurance funds have run out. Or, father's vital signs have diminished and would vanish without the use of the respirator.

The pastor's work is further complicated by the fact that those he counsels, sometimes even the strongest and best of his members, do not see his counseling role as he sees it. Most often members are asking for a legal judgment of their situation. And they want it quick. They have not searched their Scriptures. The pastor should do that. They are not looking for motivation, strengthening of faith or a review of God's gospel promises. They just want to do the right thing. And even this demand for a legal judgment is requested on their own behalf without reference to the spiritual good of the patient.

The urge to function as a judge, arbiter, rule-maker and interpreter presses the pastor from the outside and the inside. It solves the time problem because you can render your decision and go quickly on your way to other things. It satisfies those you are counseling because they wanted a quick decision so they could feel good about what they decide. Everybody's happy and the right thing has been done.

But the Christian pastor must take a higher road. The pastor's work is "to prepare God's people for works of service, so that the body of Christ may be built up until we all reach unity in the faith and in the knowledge of the Son of God and become mature, attaining to the whole measure of the fullness of Christ" (Eph 4:12,13). What our members do or decide will not be works of service, will not be ethically good, will not give glory to God unless we nurture faith and provide knowledge. Or, as we teach from our catechism, a work for the glory of God is also coincidentally a work done out of faith and according to God's law. Getting people to do the right thing without the right motive is no gain for the Christian pastor. He has not accomplished what God has sent him to do.

Pastoral counseling is the use of Scriptures to bring people to the point where they want to know what God wants. This means a careful review of the situation and a discussion of what has been done and decided to this point. The pastor then uses the law to point out weaknesses and sins. Did we wait too long before we turned to God? Did we act for the spiritual good of the patient? Were we honest? Did we trust the doctor more than God? Did we search God's Word for his will? Are we still wrestling with our trust in God's goodness? Have our decisions acknowledged God as the Lord of life and death? The pastor will want to pose questions which have to do with the element of faith as well as the technical right and wrong of medical decisions. Already in his application of the Second Use of the law the pastor wants to lay a foundation for his counseling the spirit as well as the mind and body.

Correction of sin necessarily involves speaking the gospel. To forget, presuppose or bypass the specific comfort of forgiveness in Jesus Christ relegates the pastor to the role of a secular, philosophic advisor. Merely to encourage people to stop doing wrong and begin doing right is legalism and rationalism. God kills and God makes alive. He wounds and he heals. But no one really understands or appreciates that truth unless he has been killed in the flesh and made alive in Christ. He will not hold these principles to his heart until his own wounds have been healed by the wounds of Jesus. Families may call you in only to make a judgment on the specific problem at hand. But your work is to open all the sores of the past, biomedically related or not, and wash them in the Fountain of Life. Whatever sin or hurt has not been healed will stand in the way of accomplishing the ethical good in a particular bioethical situation.

There are certain outward indications that the law and the gospel are working in the hearts of counselees. One is that they ask, or at least are willing to accept, that a more thorough search of God's will in Scripture be undertaken. The willingness not to push for a quick answer is a sign that people are acting in faith to please God and not just demanding a legal opinion. Another indication is their willingness to make their own decision on the basis of your scriptural counsel. This shows that they now know that their decision must proceed from faith in their own hearts and not on the basis of the faith and knowledge of a trusted counselor. Pastors must get over being flattered by people who are willing to accept their advice on the basis of their personal respect for them, and encourage their people with the gospel to make their own decisions with the confidence of personal faith in Jesus Christ. Then motive will become the distinctive element in their bioethical counseling.

The Search for Principles

That still leaves us with making a specific decision in a particular case. And that is never easy. Yet in the context of faith there is a different view toward the difficulty of making hard choices. Faith trusts the situation to be an opportunity to give glory to God rather than as a burden to be borne with an unsure conscience. Even if the complexity of the issue appears as a testing and fiery trial, there is the trust that God is faithful in not tempting you beyond what you can bear (1 Cor 10:13) and the joy that you are sharing in the sufferings of Christ (1 Pe 4:12,13).

Acting out of faith does not mean that our decisions become situational. The complexities of each situation are themselves invitations to seek the will of God. When our search of the Scriptures turns up many different rules and laws which seem to apply to some degree and which seem to our imperfect reason to conflict with one another, that, too, is another invitation to faith to carry its search further. We begin to look for the reason why God gave his laws, his motive in giving them, and the way he himself has interpreted and applied them. This is what we call the search for principles. Several have been suggested in these lectures. The principle that God begins and ends life helps us understand and apply the Fifth Commandment at end of life situations. The principle that God wants us to love our neighbor according to body and soul helps us to understand his requirement for honesty in seeking the good of the patient. The principle that God holds us fully accountable to himself body and soul sends us exploring his Word before we act out of ignorance or apathy when making hard choices. But the opportunities in the field of bioethics that God sets before us are more and more numerous and complex. The careful search for principles goes on as long as our faith is put to the test and as long as our old adam keeps us from knowing the perfect will of God in each situation.

Conscience and the Application of Principles

In counseling his members to apply scriptural principles in faith the pastor seeks to get each Christian to act on good conscience. What is conscience? In spite of his own health dilemma and the poor counseling he received Job had a good conscience. He said, "I will maintain my righteousness and never let go of it; my conscience will not reproach me as long as I live (27:6)." But consciences can also be bad. Paul speaks of false teachers "whose consciences have been seared as with a hot iron (1 Tm 4:2)."

Everybody has a conscience. The Romans were told that even unbelievers have one (Ro 2:15). The conscience is man's awareness, or consciousness, of his relationship to God. In the unbeliever the conscience can only feel relatively good in proportion to his keeping of the law. The believer's conscience, however, can be confident of its righteousness and thus its relationship to God through the promises of the gospel. The intimate connection between faith and a good conscience is demonstrated by Paul's words to Timothy that he hold on to faith and a good conscience (1 Tm 1:19).

But a good conscience in the believer can also be hurt by sin. Sin weakens or destroys faith. Thus also the Christian in making ethical decisions must listen to his conscience. Paul urges the Romans to obey the government not only out of fear of punishment, as the unbelievers' consciences would urge them to do, "but also because of conscience" (Ro 13:5), that is, out of a believing conscience. Paul told Felix that it was his faith that led him to keep his conscience clean (Ac 24:14-16). Leaders in the church especially "must keep hold of the deep truths of the faith with a clear conscience (1 Tm 3:9)."

So particularly in the complicated issues of medical ethics the pastor wants to lead his members to act on the basis of a good conscience. This means that he wants to explore the attitudes and knowledgeability of the conscience before he attempts to give appropriate counsel. His first concern is that his members not act against a properly informed conscience. They may know the right thing to do and yet be hesitant to carry it out because of the great sacrifice, or expense involved. They may want to be dishonest to a dying relative about the seriousness of his condition, even though they know he needs

time to prepare himself spiritually. They may continue to care for a mother or father in the family home even though the parent needs medical attention because they do not want their inheritance lost in a few months to nursing care. They know better and the pastor will seek to get them to act out of faith to listen to their conscience.

The other side of the issue occurs when the one we are counseling knows what he wants to do but is acting out of an ill-informed conscience (1 Cor 8:7). A family member may feel guilty about pulling the plug even when vital signs are absent because he thinks this is murder. A young girl may be sure abortion is the right approach because she is convinced that lovingly preventing her parents' shame is a higher moral principle than taking the life of an undeveloped fetus. Children often justify caring for their parents at home on the basis of the Fourth Commandment even when such care is destroying their marriages and attention to their own children is done great harm. A pastor must patiently educate an erring conscience. And before does, he will want to review the gospel promises to insure the willingness of the counselee to receive such instruction with a heart of faith.

Then there is the conscience in a hurry. We will run into a lot of these in our fast-paced society. With pragmatic businesslike hurry it lunges into a decision without carefully evaluating the circumstances and without knowledgeably applying God's will. Sickness and death are accepted too matter-of-factly. "There isn't anything we can do. Just tell the doctor to go ahead and do what he thinks best. When your time comes, it comes." A pastor will have to counsel that such an approach can be both faithless and illegal. It smacks of fatalism. There may be a lack of loving body and soul attachment to the sick or dying patient. Such a conscience does not seek to make use of the situation to give glory to God but to get the problem over with so it can go back about life without encumbrance. Counselors might consider the words of St. James, "if any of you lacks wisdom, he should ask God, who gives generously to all without finding fault, and it will be given to him. But when he asks, he must believe and not doubt (1:5,6)." Sometimes strong and direct law has to be applied to the conscience in hurry. We will be accountable to God for our actions. It is a moral problem and not just a medical problem. We cannot shift the problem from the "in" to the "out" basket without confession, faith and an ethically good decision.

Because of the bewildering complication of some biomedical situations and because of the many moral commands to weigh and evaluate, the conscience of those we counsel will often be in doubt. What makes it more difficult is that we as counselors may ourselves have some doubt about what is the best thing to do. But if we are not sure that what we are doing is right, we should not proceed. St. Paul indicated this in regard to eating food offered to idols: "But the man who has doubts is condemned if he eats, because his eating is not from faith; and everything that does not come from faith is sin (Ro 14:23)." Yet the situation Paul spoke of is not an exact parallel with most bioethical situations. In the case of eating food offered to idols it could be established that the eating of itself was not wrong. Doubting consciences could be reassured of that, and once the doubt was removed they could eat with confidence. When pastors can give such assurance, they can also lead doubting consciences to act out of conviction that their actions are not condemned by God. Many times, however, the doubt comes from not being sure that we know or understand all that God has spoken on the issue or being uncertain that we are properly applying what he has said. Such doubt is not so easily removed. The pastor will want to review what in Scripture he knows to have a bearing on the case. He will want to remind those he counsels of the clarity and sufficiency of Scriptures and the wisdom of God in revealing what he does and how much he does. He will want to emphasize that the motive of faith and the desire to follow the will of God is the most important aspect of the ethically good. He will encourage prayer prior to the decision and comfort with forgiveness after the decision if doubts return. After all, faith is not the trust that we can perform good works without the taint of sin, but the confidence that the blood of Christ removes the taint and receives even our imperfect works as good works only for Jesus' sake.

Preemptive Counseling and Education

The discussion of many different attitudes of the conscience reminds us of the many different members we have in our congregations. All are at a little different stage in the development of their faith and knowledge. Some are completely unaware that decisions they have made in regard to health and medicine affect their relationship to God. Others' consciences tell them that there is right and wrong involved, but they are too busy or indifferent to seek out spiritual advice for their decisions. Many make life and death decisions in regard to procreation with erring consciences influenced primarily by unbelieving friends and worldly propaganda. Others are conscience-stricken over matters about which God himself does not bind them.

A pastoral approach to bioethical problems which only waits until the most conscientious Christians seek out advice in crisis situations seems not to be the best way to shepherd the flock. The changes in genetic and birth control technology, the deteriorating ethical standards of medical professionals, the cost effective approach of medical institutions, the options in cancer treatment, the increased cost and proliferation of medical plans and the complexity of end of life options make preemptive counseling among our membership a wise and practical effort. At the least our people need to know that God is certainly involved in decisions affecting something so personal as our life and health. At the most they need to study their Bibles for what God does and doesn't say, learn to interpret his law through principles, and appreciate faith in Christ Jesus as the initiating motive of ethical decision making.

I'm not ready to suggest a formal program for such education. The obvious opportunities come to mind: sermons, Bible classes, youth instruction, society meetings, newsletters, PTS, and special mailings and seminars. Of course, before we can instruct others, we must do some learning ourselves. In spite of the extreme practicality and need for awareness in the field of biomedical ethics, we have done almost no writing or studying in our circles. Pastoral study clubs and circuit meetings and pastoral conferences would be suitable forums in which to share and expand on what we glean from personal study.

And let's not forget to give special attention to the medical professionals in our congregations. The proliferation of the health care business has meant the employment of ever-increasing numbers of people. It might be interesting to learn just what percentage of our members work for health care institutions and agencies. Doctors, nurses, practical nurses, technicians, lab assistants, social workers and hospital administrators are only a part of the picture. There are many other workers who are employed by related agencies. Health insurance underwriters, administrators and salesmen must also make bioethical decisions. Others are engaged in the engineering, design, production and sales in the booming field of medical equipment. Still others are involved in the research and clinical application of new technologies in reproduction and life extending methods.

All these people have consciences which carry the burdens of the workplace back to their homes. Many of them make decisions every day which affect the life and health of others. The ones I have talked to are not skeptical or resentful of the church's interest in medical ethics. They are simply unaware of it. They would welcome Bible study and instruction as a practical tangent to the real everyday concerns in their lives. They not only want to know for themselves, but they want to have answers to give to people around them who seem to be even more confused than they are. The well trained consciences of the members of our congregation from the medical community could provide information and support in our pastors' efforts to learn more and teach more about Christian bioethics.

Speaking Peace and Comfort in Christ

Counseling in medical matters presents pastors with unique opportunities for serving the spiritual needs of their people. As frightening and confusing as sickness and death can be, they are

nevertheless powerful tools in the hand of God to make people reflect on the real issues of life. Nothing shocks even the most hardened heart into looking away from the material pursuits of the world like the personal pain, uncertainty, the economic burden and the realization of mortality that serious illness and death bring. There is a willingness to receive the Word of God that seems not always to be present when you are sitting on a padded pew dressed up in suit and tie.

Sickness and death are reminders of sin. Pastors will realize that it is that intensified awareness of sin on the part of the patient and his family, whether conscious or unconscious, that sometimes makes them overly concerned about doing exactly the right thing in bioethical dilemmas. They sense that it was sin that brought them to where they are, and they don't want to make things worse by adding to the list. Children who neglected parents for years become intensely concerned about making just the right decision when their parents near death. When we see children with birth defects, cases of childhood cancer, unexpected death or the frightful deformities caused by auto accidents, we too may be tempted to ask with the disciples, "Who sinned, this man or his parents...(Jn 9:2)." The pastor will be empathic. He may have to remind people at times that trouble is not always a direct result of specific sins. But in any case he will want to make sure that decision making is not motivated by a fear of making things worse, the hope of appeasing God for past sins, or the belief that doing things right from now on will avoid future illness. To be empathic the pastor must be a good listener before he becomes a good speaker. He will want to learn from those he counsels whether they are receiving the difficulty as a punishment from an angry God or a chastisement from a loving God. If they can see it only as punishment, he will want to explore their consciences and speak of forgiveness. If they see the dilemma as a chastisement and as an opportunity to grow in faith and glorify God, he will reaffirm their confidence and proceed to exploring the Bible principles which apply to the difficult decision they must make.

The situation changes when those you counsel include a mixture of those who are your members and those who are not. If the patient or some of the family members will not receive your advice, it is best to counsel those who are your sheep out of their presence. You will have to deal with the medical dilemma itself and then advise on how they can share their decision with those who may not agree with it. You will want to be sure that your members not only understand what God has to say about the problem but that they are comfortable in explaining it to the patient or other family members. When the patient or disagreeing family members make it impossible for your counselees to carry out what they consider to be God's will in the matter, the pastor will have to be present at their side again to offer comfort and encouragement. God commands us to witness his will to the world. He does not hold us responsible when our faithful witness to him is refused.

In biomedical ethical dilemmas as in all areas of counseling Christ is the bottom line. If there is confusion, Christ offers direction in his word. If there is doubt about the love of God, Christ is himself the embodiment of that love. If there is temptation to take the path of expediency, Christ has defeated the devil for himself and us. If there is doubt that a sovereign God can commiserate with us in our human condition, we can remember that Christ was born of woman and was tempted in every respect we are. If there are guilty consciences, he forgives sin. If we feel that we are left alone in our decisions, we can trust his promise that he is with us always. If we cannot understand how his will applies to our situation, we have access through him before the throne of God to ask for wisdom. If questions remain for the old man after the new has acted in the confidence of faith, Christ is yet there cleansing away what is sin in our motives and actions and presents our bioethical decisions before the Father as completely righteous good works done to his glory. When there is weariness for the pastor or the patient in the continuous and confusing barrage of tough decisions, it is still the Christ who offers temporal comfort who has earned and promised eternal peace. In a sinful world with sinful people we can look forward only in Christ to that time when "there will be no more death or mourning or crying or pain (Re 21:4)." And, we might add, no more hard decisions about how to avoid them.

BIBLIOGRAPHY

- Ashley, Benedict M., and O'Rourke, Kevin D., *Health Care Ethics, A Theological Analysis*, Catholic Health Association of the United States, 1982.
- Bonhoeffer, Dietrich, *Ethics*, New York: Macmillan, 1964.
- Biomedical Ethics Reviews*, Clifton, New Jersey: 1983; 1984.
- Childress, James F., *Priorities in Biomedical Ethics*, Philadelphia: Westminster, 1981.
- Downing, A.B., *Euthanasia and the Right to Death*, London: Peter Owen, 1969.
- Ehlert, Werner, *The Christian Ethos*, Philadelphia: Muhlenberg Press, 1957.
- Fletcher, Joseph, *Situation Ethics*, Philadelphia: The Westminster Press, 1966.
- Francoeur, Robert T., *Biomedical Ethics, A Guide to Decision Making*, New York: John Wiley & Sons, 1983.
- Geisler, Norman, *Ethics: Alternatives and Issues*, Grand Rapids: Zondervan, 1971.
- Habeck, Irwin J., "Euthanasia," *Wisconsin Lutheran Quarterly*, 1978, Vol. 75, No. 1.
- Haring, Bernard, *Medical Ethics*, Notre Dame: Fides/Claretion, 1973.
- Hunt, Robert, and Arras, John, *Ethical Issues in Modern Medicine*, Palo Alto: Mayfield Publishing Company, 1983.
- In Vitro Fertilization (Study Material and Guidelines)*, LCUSA Division of Theological Studies, 1985.
- Jones, D. Gareth, *Brave New People*, Grand Rapids: Wm. B. Eerdmans, 1984.
- Koop, C. Everett, *The Right to Live, the Right to Die*, Wheaton, Illinois: Tyndale, 1976.
- Lau, David, "Matters of Life and Death—How Can a Christian Decide?" *Journal of Theology*, September 1984 and June 1985.
- Mappes, Thomas A., and Zembaty, Jane S., *Biomedical Ethics*, New York: McGraw Hill, 1986.
- Marty, Martin E., and Vaux, Kenneth L., *Health/Medicine and the Faith Traditions (An Inquiry into Religion and Medicine)*, Philadelphia: Fortress Press, 1982.
- McHugh, James T., *Death, Dying and the Law*, Huntington, Indiana: Bishops Committee for Pro-Life Activities, National Conference of Bishops, 1976.
- McLean, Sheila, and Maher, Gerry, *Medicine, Morals and the Law*, Hampshire, England: Gower Publishing Company, 1983.
- Ramsey, Paul, *Ethics at the Edges of Life*. New Haven: Yale University Press, 1978.
- Ramsey, Paul, *Fabricated Man - The Ethics of Genetic Control*, New Haven: Yale University Press, 1970.
- Ramsey, Paul, *The Ethics of Fetal Research*, New Haven: Yale University Press, 1975.
- Ramsey, Paul, *The Patient as Person*, New Haven: Yale University Press, 1970.
- Smedes, Lewis B., *Mere Morality - What God Expects from Ordinary People*, Grand Rapids: Wm. B. Eerdmans, 1983.
- Vaux, Kenneth, *Biomedical Ethics - Morality for the New Medicine*, New York: Harper and Rowe, 1974.