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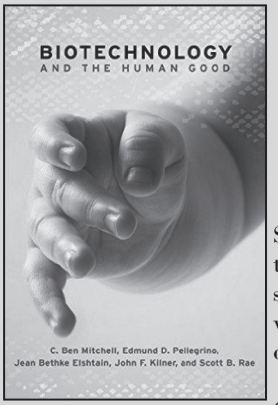

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BIOTECHNOLOGY
AND THE HUMAN GOOD

By C. Ben Mitchell, Edmund D. Pellegrino, Jean Bethke Elshtain, John F. Kilner, and Scott B. Rae

Some of humankind's greatest tools have been forged in the research laboratory. Who could argue that medical advances like antibiotics, blood transfusions, and pacemakers have not improved the quality of people's lives? But with each new technological breakthrough there comes an array of consequences, at once predicted and unpredictable, beneficial and hazardous.

Outcry over recent developments in the reproductive and genetic sciences has revealed deep fissures in society's perception of biotechnical progress. Many are concerned that reckless technological development, driven by consumerist impulses and greedy entrepreneurialism, has the potential to radically shift the human condition—and not for the greater good. *Biotechnology and the Human Good* builds a case for a stewardship deeply rooted in Judeo-Christian theism to responsibly interpret and assess new technologies in a way that answers this concern.

The authors jointly recognize humans not as autonomous beings but as ones accountable to each other, to the world they live in, and to God. They argue that to question and critique how fields like cybernetics, nanotechnology, and genetics might affect our future is not anti-science, anti-industry, or anti-progress, but rather a way to promote human flourishing, common sense, and good stewardship.

A synthetic work drawing on the thought of a physician, ethicists, and a theologian, *Biotechnology and the Human Good* reminds us that although technology is a powerful and often awe-inspiring tool, it is what lies in the heart and soul of who wields this tool that truly makes the difference in our world.

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Vol. 33:3 Fall 2017

EDITORIAL

Ectogenesis and the Future of Procreation

C. BEN MITCHELL, PHD

The future is closer than it used to be. In April of this year, Emily Partridge and her colleagues in the Center for Fetal Research at Children's Hospital in Philadelphia announced that they had invented an artificial womb—a "biobag"—in which to gestate extremely premature lambs until they could survive on their own. The lambs received oxygen and nutrients through their umbilical cords just as they would have had they remained in their mother's uterus. The Children's Hospital research team believe human clinical trials could begin as soon as the next three to five years.

Readers of *Ethics & Medicine* may know that the development of an artificial womb was foretold by eugenic visionaries like J.B.S. Haldane, who in his epic treatise, *Daedalus*—"the skillful craftsman" and father of Icarus of Greek mythology—coined the term "ectogenesis" in 1924. As he prophesied,

> It was in 1951 that Dupont and Schwartz produced the first ectogenic child . . . Now that the technique is fully developed, we can take an ovary from a woman, and keep it growing in a suitable fluid for as long as twenty years, producing a fresh ovum each month, of which 90 percent can be fertilized, and the embryos grown successfully for nine months, and then brought out into the air.

By the year 2074, Haldane predicted, ectogenesis would be so popular that "less than 30 percent of children . . . [are] now born of woman." "Had it not been for ectogenesis," he imagined, "there can be little doubt that civilization would have collapsed within a measurable time owing to the greater fertility of the less desirable members of the population in almost all countries."

Aldous Huxley, George Orwell, and even C.S. Lewis often peered into the future with great prescience. Many of their predictions are now reality. Huxley, for instance, laments in *Brave New World Revisited*: "In 1931, when *Brave New World* was being written, I was convinced that there was still plenty of time . . . Twenty-seven years later, in this third quarter of the twentieth century A.D., and long before the end of the first century A.F. [After Ford], I feel a good deal less optimistic than I did when I was writing *Brave New World*. The prophecies I made in 1931 are coming true much sooner than I thought they would."

The advent of human ectogenesis may come sooner than any recent observer imagined. It is, therefore, crucial that those of us committed to Christian-Hippocratism begin thinking seriously about the ethics of ectogenesis and what its evolution might mean for human procreation. Ectogenesis might, as some have suggested, end the abortion debate, if unborn children are removed from the uterus and gestated for adoptive parents. Alternatively, ectogenesis might have eugenic uses that end up commodifying both gestation and the children who are born from an artificial uterus.

There are vast moral consequences of ectogenesis, and with those consequences potentially just around the corner, we need a sober conversation about the meaning of an artificial womb. **E&M**

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GREY MATTERS

The Moral Significance of Pain for Synthetic Human Entities Derived from Embryo-Like Cells

WILLIAM P. CHESHIRE, JR., MD

A moral boundary is approached when a human nervous system is brought into the plan.

- Jon Holmlund[1]

Abstract

Recent developments in stem cell biotechnology are challenging afresh the long-contested question of the moral status of nascent human life. Rather than clarify the moral question, more detailed information about and ability to manipulate the subcellular realm have further complicated the ethical analysis. One of the greatest ethical challenges is how to evaluate novel entities that do not fit within the biological frameworks that guided the development of current consensus about ethical boundaries for the creation and destruction of embryonic human life, whether for purposes of reproductive embryo selection, embryologic research, or the development of cellular therapies in medicine. Amid claims that the 14-day rule, defined by the appearance of the primitive streak, has become obsolete, some scientists have proposed that the capacity to experience pain should be the new moral threshold beyond which novel organisms should not be allowed to develop. This leads to further questions about the moral significance of pain, the minimum biologic substrate needed for pain to exist, what kinds of experiences count as painful, and how to detect and measure pain in creatures that cannot speak.

Introduction

The moral status of the earliest stages of human life remains a contested question. How one evaluates this question determines when or whether the creation or destruction of new human organisms for purposes of scientific research is ethically permissible. Advances in cell biology that are clarifying the cellular and molecular details of early human development, paradoxically, are further complicating the ethical questions regarding how these organisms should be treated and how research on them should be regulated.

Enter Embryoids, Organoids, and Gastruloids

Novel human cellular configurations have moved into the embryonic neighborhood and are challenging some previously held assumptions. Increasingly, new methods for manipulating human pluripotent stem cells are spawning biotechnologies capable of generating organoids[2] or whole organisms[3] in ways that fundamentally diverge from natural, or canonical, embryonic development. Some biotechnologies can

now engineer viable embryonic organisms that bypass the defining developmental biologic steps on which have been based criteria to delimit the ethical boundaries of human embryo research. For example, embryoid bodies have been generated from isolated pluripotent stem cells that have not been recognized to be totipotent.[4] Micropatterning, 3D printing, and organ-on-chip technologies can take stem cells that lack the intrinsic capacity *in vitro* to self-organize spatially to form a complete embryo or organ and arrange them into intended spatially ordered configurations.[5-8] Remarkably, some micropatterned pluripotent stem cells have been shown to develop features identifiable as embryonic, such as a primitive streak.[9]

Biotechnologies that perform—or even replace—necessary developmental functions, such as cellular organization, challenge the traditional understanding that self-organization is a requisite criterion for distinguishing a viable human embryo.[10] Alternative pathways of embryogenesis, mediated partly by technology, have yielded what have been called "synthetic embryos,"[11,12] and if their developmental trajectories can be altered early in embryogenesis, then the potential varieties of more mature synthetic organisms that biotechnology might craft are quite possibly beyond what anyone has yet imagined.

At the center of current debate is the 14-day rule. Some scientists are calling for it to be retired, arguing that novel versions of human embryonic life are being created for which traditional ethical boundaries have become obsolete.[13,14] Among these novel creations are what are now being called "synthetic human entities with embryo-like features," or "SHEEFs."[13] The problem raised by SHEEFs, write John Aach and colleagues, "is that, given the many emerging technical options for generating them and their expected developmental plasticity, research limits that are triggered by entry into any particular stage of canonical embryogenesis may lose their effectiveness."[13] Others also are asking, not whether, but how the 14-day rule should be rethought.[14]

Why the 14-Day Rule

For decades the 14-day rule, an ethical and legal line which limits *in vitro* human embryo research to the period before the appearance of the primitive streak, has guided the development of policies internationally that govern research on human embryos. First proposed in 1979 by the Ethics Advisory Board of the U.S. Department of Health, Education, and Welfare,[15] the 14-day limit was endorsed by the Warnock Committee in the U.K. in 1984[16] and by the National Institutes of Health's Human Embryo Research Panel in the U.S. in 1994.[17]

While not a perfect solution to disputes over the moral evaluation of human embryo stewardship, the 14-day rule has, until recently, been widely accepted as a useful criterion on which to base research policy because it signifies a biological discontinuity as the first visible indication of the developing nervous system. The primitive streak is primordial neural tissue that precedes the development of more complex features of the nervous system destined to become the brain and spinal cord and, as such, has been regarded as an ethically relevant embryologic feature.

The Significance of a Nervous System

Why the human nervous system has moral significance that should guide the ethical analysis depends on one's worldview and how it shapes the valuation of human life.

To the materialist, who restricts his or her understanding of human life to a set of empirically measurable physical attributes and their biological functions, the primitive streak is the first visible physical sign of a rudimentary nervous system that may develop into the tissues associated with sensation, thought, and self-awareness. Denying the existence of any categories beyond matter and energy, and recognizing nothing to life other than chance physical arrangements of molecules and cells and their deterministic biologic processes,[18] the materialist regards the human embryo as a potential human that has not reached the threshold of neural complexity necessary to actualize the higher cognitive capacities exhibited by a morally relevant organism.

A reductionistic materialistic worldview provides little, if any, basis for respecting or protecting human lives that do not meet the developmental threshold marked by the attainment of higher cognitive functions. By this logic, there would seem to be little reason not to extend the threshold for respecting and protecting new human life to later in the developmental trajectory and well beyond the 14-day rule. Organisms not meeting that threshold, either because they have not yet attained it or, having reached it, fall below it, could be expendable. Accordingly, Daniel Dennett argues that "there are gradations of value in the ending of human lives."[19] Francis Crick, codiscoverer of the structure of DNA, asserted starkly that "no newborn should be declared human until it has passed certain tests regarding its genetic endowment and that if it fails these tests it forfeits the right to life."[20] By the same logic Peter Singer has defended infanticide as ethically permissible.[21,22] Historically, the premise that humans are nothing more than cells clustered together and that human thought is reducible to the accidental secretions of neurons blindly oscillating to the laws of physics has contributed to the devaluing of people with disabilities and has been used to justify eugenics and euthanasia movements.[23]

There is also a higher view of human nature that rejects as incomplete the morally flat worldview of the materialist that strips people of their moral status. This higher view appreciates that humanity has been placed into a richly contoured moral landscape, a terrain soaring with sublime peaks and pocked with slopes falling into dark valleys, a realm infused with mystery, where one can find meaning, beauty, value, purpose, love, and representations of transcendent reality. From the perspective of this higher view, humanity is special, and the biological facts that describe a human embryo denote exceptional moral significance. Biologically the human embryo, from the moment of conception, is an individual entity possessing a complete and (except for twins or clones) unique human genome, a living organism that directs his or her growth and development and possesses the intrinsic capacity to generate and elaborate, unless prevented, all of the tissues and organs and cognitive capacities that distinguish the adult human being.[24,25] The substance of human existence, on which is based an inherent right to life, is found in offspring of human parents and does not reduce to a material quality. The essence of a human life, which some consider to be an inborn immaterial substance and others consider to be an emergent immaterial state of being, ontologically precedes the actualization of the neural functions corresponding to higher cognitive functions.[26] This human essence is the basis for the

integrity of personal identity throughout one's lifetime despite bodily change. This human distinctiveness is the basis for the concept of universal human rights.

Thus, materialist valuations of human life and its novel variations tend to favor assigning moral thresholds later in development, whereas valuations that recognize both material and immaterial aspects to human life are more likely to regard even the earliest human lives as possessing intrinsic special dignity.

The Significance of Pain

Proposals to consider the ability to experience pain as the new threshold beyond which developing human lives and variations thereof would be counted as morally significant may seem, at first glance, to simplify the question of moral status. Pain, however, like other aspects of development, is an incremental process in which each functional threshold develops gradually. Not only are functional demarcations difficult to define precisely, but each level of complexity introduces more moral quandaries.

At the structural level a number of biological components are necessary for the experience of pain. First, the organism must have the capability of detecting noxious stimuli. This is possible through nociceptors, which respond to external threats, such as trauma, hypoxia, or thermal extremes, by encoding and transducing those threats into changes in cell membrane ion permeability or the release of chemical messengers. Many types of specialized nociceptors exist. Rudimentary nociceptors have been identified even at the embryonic stage of development, before they connect with future peripheral or central targets.[27] At the level of the nociceptor the thresholds at which an increasing stimulus transitions from barely noticeable to uncomfortable to noxious is not always clear.

Secondly, the organism must be able to transmit the signal from the nociceptor to the central nervous system. This is accomplished through peripheral nerves, which conduct impulses that allow the organism to detect, localize, and grade noxious stimuli. Some sensory nerves are specialized to conduct signals very fast, allowing the organism to respond rapidly to an acute threat, while others conduct signals more slowly and mediate information about ongoing tissue damage. Very rarely, a person is born lacking the ability to feel pain.[28] No physician or anyone else regards these unfortunate children, who inherit a sensory and autonomic neuropathy causing the nerves that normally conduct pain not to develop properly, to be other than human.

Thirdly, the organism must be able to interpret pain signals. Specifically, the experience of pain as pain involves, at a minimum, awareness of the stimulus coming from the sensory nerve, an understanding that the sensation is harmful or threatening, and an affective state of unpleasantness. Added to this may be the cognitive activities of associating the experience with memories of prior personal experiences, reasoning whether the pain may be a necessary means toward a desired end, empathy with others who have experienced pain, and reflection on the meaning and purpose of pain.

At this level arises the key biological distinction between nociception and pain. This distinction is explained in the definition published by the International Association for the Study of Pain, which designates pain as "an unpleasant sensory and

emotional experience associated with actual or potential tissue damage, or described in terms of such damage."[29] Pain is distinguished from nociception, which is "the neural process of encoding noxious stimuli," with the caveat that, for nociception, "Pain sensation is not necessarily implied."[29]

This distinction is universally accepted in medicine and may be illustrated by a simple example. When a surgeon makes an incision in the skin of a patient who is asleep under general anesthesia, a nociceptive impulse is generated by the nerve supplying sensation to that region of skin, and even though that signal may reach the brain, the patient, whose cerebral cortex is temporarily suppressed by the anesthetic agent, feels no pain.

Current ethical guidelines for research on nonhuman animals share the distinction between nociception and pain. A considerable body of research in animals supports the conclusion that some behavioral signs of nociception, such as limb withdrawal from a noxious stimulus, pupillary dilatation, elevation of heart rate and blood pressure, and sweating, occur automatically as reflexes and do not necessarily indicate the presence of pain.[30] Furthermore, the ability to experience pain is generally thought to be limited to vertebrates with a cerebral cortex.[31] The evidence is inconclusive whether cephalopods can experience pain. Although a physiologic basis for nociception has been described in squid, no objective criteria have been established to ascertain whether they feel pain, and this remains an area of controversy.[32] Uncertainties about whether future synthetic organisms with well-developed central nervous systems can experience pain may become similarly contentious.

The clear implication of the well-established biological distinction between nociception and pain for research on organisms generated from synthetic human embryos is that, if pain were to become the accepted new threshold for assigning moral status, then only organisms with a functioning cerebral cortex would be considered morally significant and ineligible for deleterious research. A criterion that prohibited or limited the possibility of pain while allowing for nociception would grant considerable license for engineering a wide assortment of novel life forms well beyond the embryo stage of development.

Pain Disappoints

Pain, it is concluded, fails as an ultimate criterion to guide ethical decisions about the moral status and worth of living organisms. A number of exceptions underscore the point. Nociception, or physical responses to noxious stimuli, can be demonstrated in some lower life forms that lack any capacity for awareness of pain. On the other hand, some humans are incapable of nociception, and anyone may temporarily lose the capacity for regional nociception while under the influence of a local anesthetic, yet in these instances they are fully conscious of threats to bodily integrity and have the capacity to suffer. All humans have the capacity to suffer, even to experience painful emotions, in the absence of nociception.

The philosophy that reduces all meaning to a scale of pain, pleasure, and happiness is known as ethical hedonism. Hedonism is an incomplete and ultimately disappointing ethical theory, for many people embrace values in life more important than pleasure and minimization of pain. Among them are love, knowledge, friendship, altruism, creativity, faith, and a relationship with the heavenly Creator. These values

are meaningful because they are purposeful. They are difficult to measure because they are qualitative, manifold, and transcendent. They are beyond pain and often are found through suffering. In so many important ways, they are distinctly human.

Pain and Beyond

What would it mean to engineer synthetic human entities derived from modified human genes and human embryo-like cells and allow them to grow and mature as long as they did not experience pain? Suppose that, through genetic engineering, it were to become possible to design and breed in the laboratory a sentient creature possessing a complete brain composed of human neurons, yet lacking critical genes necessary for the capacity to experience pain. A sufficiently intelligent creature incapable of experiencing pain might still be aware of its existence and know—even fear—what is being done to it. It might be difficult to predict or detect when the threshold for such awareness would be reached. It might be difficult to know what difference it would make that the neurons brought together to form a functioning brain were of human origin.[33]

Innovative researchers interested in growing such creatures might seek greater ethical latitude by developing technological solutions to the problem of pain. Analgesics or deep brain electrodes might be employed to anesthetize the creatures. Another strategy could be to stimulate the brain's pleasure centers more potently than the intensity of pain, adjusting sensation along the utilitarian scale so that the sum experience did not count as pain. It seems doubtful that, in these hypothetical but potentially feasible scenarios, no further ethical concerns would remain.

Rather than ask, what does it mean for a human organism to experience pain, a better question is, what does it mean to be the kind of being that experiences pain? What does it mean to be the kind of being who has the intrinsic capacity to develop sentience, to ponder the universe, to comprehend the inevitability of mortality, to seek purpose, to yearn for love, and to suffer? A further and no less difficult question is, why do humans so frequently inflict pain on others?

These questions cannot be answered by gazing through the reductionist microscope, although human beings who began their lives as mere embryos continue to seek after answers.

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CLINICAL ETHICS DILEMMA

Telling the Truth in Therapeutic Encounters

JOSHUA D. NIFORATOS, MTS; GREGORY W. RUTECKI, MD; F.D. YATES, JR., MD, MA

Editor's Note: *This column presents a problematic case—one that poses a medical ethical dilemma for patients, families, and for healthcare professionals. As this case is based on a real medical situation, identifying features and facts have been altered in the scenario to preserve anonymity and to conform to professional medical regulations. In this case, the health care is misappropriated by the healthcare process.*

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Question

How should the healthcare process be administered in the absence of a proper doctor-patient relationship?

Case Study

A 37-year-old nurse was admitted to our hospital for the first time with fever. Initial blood cultures grew Acid-Fast Bacilli, specifically two very unusual species, *Mycobacterium mucogenicum* and *Mycobacterium tropicalis*. Despite appropriate antibiotic therapy, she continued to spike fevers and additional blood cultures grew *K. pneumonia*—another different bacterium. After an extensive review of her past medical history, the medical student discovered a pattern of recent, frequent admissions to another hospital system for fevers with myriad organisms isolated from her blood. An explanation as to the source of these various infections was never identified. At different times over the preceding months, she had been treated for Candidemia, Cryptococcemia (both are fungi), and gram negative bacteremia. Extensive work ups for a nidus inciting recurrent bloodstream seeding were unrevealing. She did not have history of an indwelling catheter, and transesophageal echo (in order to see her heart valves better) did not demonstrate a heart valve infection (endocarditis). She was not immune-suppressed and was HIV negative. Lumbar puncture and other imaging studies were normal. On examination she had unusual skin lesions suspicious for a factitious rash. The Infectious Disease Consultant observed that the recurrent episodes of fungemia (fungal organisms in the bloodstream), Mycobacteremia (the bacteria isolated on admission), and Klebsiella bacteremia, in the absence of endocarditis or another intravascular source—accompanied by a factitious rash—suggested a factitious disorder. The patient also had a substantial Psychiatric history that included Obsessive Compulsive Disorder and depression consequent to the recent death of her

mother. Despite the clinical suspicion of Infectious Diseases, Psychiatry would not accept the diagnosis of a factitious disorder. The consultant felt that the patient did not have the typical psychiatric profile of someone who has a factitious disorder. As a result, the Psychiatry Consultants refused to confront the patient with that suspicion.

The Internal Medicine team, however, believed that the clinical facts were impossible to ignore. So the senior author asked the patient if she might be responsible for her recurrent fevers and bloodstream infections. She became unsettled and angry at that physician, and the primary care team, for the implied etiology. She started to cry and accused the Internal Medicine Physicians of being "mean and inconsiderate"—lacking compassion for her situation. Meaningful therapeutic interactions and daily communication were made more difficult for members of the medical team. Continued Psychiatry disagreement with the factitious etiology brought all interactions to an impasse. After discharge the patient was lost to follow-up. Her anger at the medicine team breached that relationship and she did not keep her Psychiatry ambulatory appointment. After discharge, she declined to answer phone, electronic, or mailed communications.

Truth Telling in Medicine

The authors have chosen to frame the ethical circumstances in this case as telling a patient the truth despite uncomfortable consequences. In regard to truth telling, centuries of medical history have been conspicuous in regard to recommending the opposite. Long before personal autonomy was valued, it was believed that breaking bad news would have the adverse effect of destroying any vestiges of a patient's hope. As far back as the Hippocratic Corpus, physicians were sternly warned regarding the painful outcomes of truth telling in serious clinical situations: ". . . be economical with the truth . . . reveal nothing of the patient's future or present condition . . . [such honest revelations] have caused many patients to take a turn for the worse."[1] A Greek philosopher-contemporary, Plato, writing in *The Republic* observed, ". . . what of the falsehood in my words . . . does it not then become useful to avert the evil—as a medicine."[1]

The newly organized American Medical Association crafted an 1847 Code of Ethics for medical practitioners.[2] In reference to the downside of truth telling, the code remarked, "It is . . . a sacred duty . . . to avoid all things which have a tendency to discourage the patient and to depress his spirits."[2] Code content also stated that only "if absolutely necessary" may the doctor share a poor prognosis with the patient."[1] The last statement mitigated what appeared to be a stern admonition thusly, "A physician should not be forward to make gloomy prognostication . . . *but he should not fail . . . to give . . . to the patient himself . . . timely notice of danger*" (these authors' italics).[2] Much like a selective breach of confidentiality in medical encounters,[3] as in the Tarasoff case (breaching a medical confidence in order to save another's life), this particular quote seems to only permit medical truth telling when there is a perceived "timely notice of danger." The clinical case presented herein definitely contained a sense of danger. Continued factitious infections could be fatal.

The aforementioned sentiments were ubiquitous in medicine, not isolated to the United States. For example, Thomas Percival, a British 19th Century physician who is widely credited for developing the first modern code of medical ethics, seemed to

harbor beliefs similar to his American colleagues: "The life of a sick person can be shortened . . . avoid all things which have a tendency to discourage the patient and to depress his spirits."[2]

The contemporary era of honesty was ushered in by important events. In the person of a medical "prophet," the New Englander Richard Cabot (1868-1939) observed sagely that the "gains of a lie were only temporary . . . 'a lie saves a present pain at the expense of a future greater pain.'"[1] A 180 degree turn in contemporary medical discourse also became cognizant of the misery inherent in the medical lies of the Tuskegee Experiment and the downside of Henrietta Lacks, who had a positive effect on women stricken with cervical cancer. She and her family did not know the secret vitality of her cancer cells for almost 20 years—the cells were utilized without knowledge or consent.[2] Patient advocacy groups and numerous international conferences, ranging from the Declaration of Alma Ata[4] to the Decent Care Conference sponsored by World Health Organization,[5,6] would later institutionalize philosophies of health that promote truth telling: "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care."[4]

Unfortunately, there is no universal model for truth telling in medicine, a shared template considering the consequences of telling the truth to diverse patient populations. Psychiatric patients pose additional challenges to truth telling—especially when confronting patients when psychotherapeutic interventions are a contingent. Confrontation, as in our case, also includes the risk of alienating patients and therefore ending therapeutic relationships. Furthermore, there are psychiatric conditions that are not amenable to psychopharmacology, including factitious disorders.[7]

Factitious disorder is an extremely debilitating psychiatric illness in which an individual consciously creates, fabricates, or exaggerates the symptoms of an illness for primary gain, such as to be perceived as ill.[7] This disorder is associated with significant morbidity and mortality from self-harm and iatrogenic interventions, including exploratory laparotomies.[8-10] Additionally, there is theoretical concern of transformation of this illness to factitious disorder by proxy, which often results in a severe form of child abuse with high mortality rates.[11,12] Supportive confrontation is essential when individuals are diagnosed with factitious disorder. Such an approach establishes the rationale for recommending psychotherapy.[13,14] But the messenger must realize that patients with factitious disorder rarely acknowledge self-induced illness, and the majority are lost to follow-up.[8] Studies assessing longitudinal care of patients after confronting factitious disorder demonstrate that most patients continue to receive inpatient care for different 'diseases' with only a small proportion agreeing to psychiatric care.[8] Establishing rapport with such patients can enhance the efficacy of truth telling. In this patient's situation no one on the team—primary or consultative—had a prior relationship with her.

Conclusion

When the patient was discharged, the senior author was out of town. The patient told the medical student that she wanted to tell Dr. Rutecki something only "he would understand." Was she going to acknowledge her self-induced harm with the

physician who confronted her earlier? The answer to that question has not been forthcoming. The disagreement among the three teams treating the patient also complicated management and follow-up. The senior author experienced distress at her emotionally charged response to his question regarding a potential factitial etiology for her illness. It took days to partially repair that relationship. Since there was inter-specialty disagreement as to the diagnosis, the medical team could not derive support from the Psychiatric consultants. It is possible that the Psychiatry team might have changed their diagnosis to a factitial disorder if she had longitudinal follow-up in an ambulatory setting. Also, it may have been beneficial to have sent someone to her home to engage her since she did not answer other contacts.

Truth telling in medicine has evolved historically. In the context of a Psychiatric illness on a medical service, telling the truth may be complicated by the potential to break a fragile doctor-patient relationship. However, factitious illnesses are difficult to treat even in those patients who accept a truthful diagnosis.

Editor's Comment

Truth telling in today's medical care system has become an expectation: patients (for the most part) want to know their medical condition, prognosis, and medical care options. However, for proper information to be delivered by the practitioner to the patient, proper information—both historically given (from the patient) and medically discovered (through diagnostic evaluation)—needs to be accurate, prompt, and complete. The patient who is purposely inexpedient, inaccurate, and insincere in presenting her medical exposé can create massive consternation for the medical team. It is a true 'puzzlement' in attempting to understand the benefit such a person derives from the disquiet (s)he generates. One must also consider the inappropriate and unnecessary allocation of resources when there is repetition of medical diagnostic procedures in the case of an unclear medical diagnosis.

Perhaps the collation of medical data entered into electronic health records will generate some sort of 'alert' for frequent or repeated hospitalizations, or for unusual diagnoses.

Useful—perhaps—but also may be (mis)construed as invasion of privacy?

Truth-telling: a gift that keeps on giving.

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Patient Medical Consent from an Islamic Perspective

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Abstract

Patient consent to treatment is considered an essential step in the process of providing medical care. Often it is a simple step, but in certain occasions it may prove to be complex and difficult to obtain. The topic has been extensively discussed from various perspectives including the many numerous ethical, religious, and legal angles. However, there remain some angles that need to be further explored and clarified. The objective of this review is to shed more light on these somehow gray areas that at times constitute dilemmas to the practicing physician with the hope that this would allow a more obstacle-free management process. In addition, this review intends to be of some guidance to the patient so he or she is able to make a more informed decision when it comes to accepting or refusing a treatment option. This is expected through enhancing knowledge on their right of autonomy, its extent, influences, implications, and constraints. Furthermore, the role of the treating physician in influencing the patient's decision to accept or reject the treatment is explored. All this is with consideration of the Islamic faith and the general law and in the context of specific scenarios related to medical consent where solutions are presented through attempting to strike a balance between the principles of medical practice that always aim to preserve life and the right of autonomy of the patient, which is initially granted by Islamic legislation (Sharia) and later by human legislation.

Introduction

According to the Islamic faith, God created man to be his deputy on Earth and intended that he follow a straight path of righteousness. To aid him in his mission, He set forth rules and regulations. Divine providence dictates that man heeds his body and soul. Furthermore, Prophet Mohamed, peace be upon him (pbuh) preaches, "God has created illness and medicine and has made a medicine for each illness, so seek treatment for your illness and make sure it's lawful."[1] Also through verses from the Quran, God suggests some means of cures for illness: "From out of their bellies comes a drink of different color in which there is a cure for the human being"—in reference to bees and honey.[2]

One can then ask: To what extent does a human being have the right to consent to or refuse medical treatment? Physicians of all practices are often faced with dilemmas related to patient consent to treatment, such as the following:

1. Who among the patient's children has the right for legal guardianship?
2. What if the son or daughter is relieved from responsibility or legal capacity due to minority or mental incompetence?

3. After fully informing a mentally competent patient, can they refuse a life-saving medical intervention?
4. Does an expectant mother who needs an emergency caesarean section have the right to refuse this surgery after being informed of the risk of harm to her unborn baby? If her refusal leads to fetal death or serious harm, is she legally liable?
5. What if the legal guardian refuses treatment for the patient-dependent?
6. If a patient dies due to refusal of treatment, would he or she be considered to have committed a criminal act (religiously or legally), or is it the physician who is liable if the patient's refusal leads to serious complication or death?

No one would dispute the sanctity of the human body. Therefore, it is of great importance to identify governing principles that maintain human dignity and beneficence. Human beings do have custody of their own bodies and, according to God, are ultimately responsible for nourishing their bodies with all that is benign and protecting them from all harm. The Holy Quran states: "do not throw [yourselves] with your [own] hands into destruction."[3] Physicians must respect these principles and always seek consent prior to examining or treating a patient. It is from this perspective that the essence of medical consent can be explored.

Medical Consent

Medical consent can be defined as agreement or permission granted by the patient or their legal guardian to the health professional allowing him/her to perform a specific medical action within a defined spatial and temporal context. This permission may be absolute or restricted. When absolute, it would allow all interventions necessary during the treatment process. When restricted, it allows only a specific medical action. This definition encompasses all the obligatory components of medical consent: the consenting individual who is the patient or their legal guardian; the consent seeker who is the health professional; what is being consented to, that is, the medical action necessary for treatment; and the consent format which is a positive expression of will by the patient or guardian.

Ethically, physicians engaged in patient-physician relationships involving medical informed consent have a moral responsibility to identify the best treatments for each patient on the basis of available medical evidence and to discuss with patients the hoped-for benefits and the potential risks. Physicians must allow for patients' questions about the proposed treatments, benefits, and risks and must answer those questions from the available medical literature and their professional experience. This exchange of information and ideas is the foundation of the patient-physician partnership and promotes informed decision making in the most complex medical situations.[4]

Generally, medical consent arises in three contexts: medical intervention using drugs or devices, medical intervention via a surgical procedure, and scientific research. Medical consent can either be "implied" or "express." Implied consent is deemed granted by the patient's conduct without the patient's explicit permission, for example, by a patient going to a physician's practice to seek medical advice. Express consent constitutes explicit formal permission to undergo a diagnostic or

therapeutic procedure. This is documented in writing and is signed or fingerprinted by the patient or their legal guardian and corroborated by two witnesses, one being from the concerned medical team.

The Civil Status law in the Sultanate of Oman states that an individual becomes an adult and attains full legal capacity at the age of 18 years.[5] Medical consent is valid when given by a mentally competent adult patient. However, validity is discounted if the patient has not been properly informed about the medical intervention even where consent was granted. In the case of a minor or a person with a mental incapacity, whether temporary or permanent, the legal authority is transferred to the legal guardian. Determination of priority of guardianship is derived from the Islamic doctrine governing inheritance, which ranks inheritors according to the degree of relation to the deceased. Precedence is given to the sons and daughters followed by the father and the mother.

There are situations where the consent requirement can be waived, such as when an immediate medical or surgical intervention is necessary to prevent loss of life, limb, or organ and the patient's condition is such that it would be impossible or impractical to seek consent from the patient or their guardian. Another situation is when the patient has a contagious condition that puts other members of the community at risk. In this case the patient is treated without consent for the good of the public. In this case the treating physician must always ascertain from another proficient physician the veracity of these situations. This must be documented in the medical chart with witnesses signing on it.

The Religious Stance

Islamic Law and the Principle of Autonomy

The Islamic religion strongly stresses the sanctity of the human body. Any transgression on it is considered to be a major sin in all Islamic schools of thought. Prophet Mohamed (pbuh) preaches, "All of a Muslim is forbidden to another Muslim, including his blood, money and honor."[6] According to the Islamic faith, God Almighty has favored human beings over his other creatures by granting them a mind and free will and has emphasized their right for a free choice. However, this right is not absolute, and it benefits from a religious framework to govern it in order to assure man's best interest and to guide him to all that is beneficial for him in this life and the hereafter. From the religious point of view, a person is considered a sinner if he/she inflicts harm upon the human body whether it is his/her own or someone else's. According to Islam, a person who commits suicide shall be punished in the hereafter because he murdered a soul that God forbade from harming unlawfully.

Using this analogy, a question arises here on whether death from refusal of medical treatment would qualify as suicide. Upon investigating the various sources of Islamic Law one finds numerous judgments from different Islamic scholars. Al-Shatibi, for example, does not favor an absolute right to autonomy over one's own body. He states, "What is made apparent is that an individual has a mere right that is not absolute in everything but rather related only to the worldliness rules."[7] In modern times, this view has been supported by the current Mufti of Oman, Sheikh Ahmed Al-Khalili, who does not permit refusal of treatment if it leads to one's perishing, and

he advocates for mandating an "obligatory treatment," without which death would ensue. This being by virtue of the Quranic verse, "do not throw [yourselves] with your [own] hands into destruction."[3] However, if a patient refuses a treatment to opt for an alternative one or if the outcome of the treatment being offered is questionable, then he or she is exempt from any sin.[8]

Patient Consent in Islamic Law

The International Islamic Fiqh Academy discussed the issue of patient consent for treatment in several of its sessions including the 7th, 18th, and 19th. During its 7th session it issued the following declaration:

> If a patient is fully competent, consent for treatment must be obtained. If competency was absent or deficient, then consent must be obtained from the guardian who is determined in the order of priority according to the guardianship rules in Islamic Law, which grants authority limited to allowance of beneficence to the patient and deterring of harm from him or her. If the guardian's decision to refuse treatment was to result in obvious harm to the patient then the treating physician should disregard it and guardianship in this case must be transferred to the next in order of priority. If all potential guardians' decision is unfavorable then the right for consent is transferred to the magistrate judge. The legal guardian is given the authority to force treatment decision in some situations like a contagious illness or prophylactic vaccines. In cases where resuscitation is necessary to save a patient's life then consent is unnecessary.[9]

Then, in its 18th session, the issue of treatment in some emergency situations was discussed and the following declaration was issued:

> It is allowable to take measures and interventions that are medically necessary in certain resuscitation situations without obtaining the consent of the patient or their guardian. These include when the patient arrives in a state of unconsciousness or a condition that does not permit consent to be obtained, when the patient is in a critical condition that requires a rapid life-saving intervention before consent can be obtained and when there is no one available with the patient and time is of the essence.[10]

Finally, in its 19th session, some issues related to consent in emergency situations were discussed and the following declarations were issued:

1. Emergency situations are defined as medical conditions that require a therapeutic or surgical intervention without delay in view of the patient's critical condition and in order to save his life or prevent damage to one of his or her organs. These include situations where a Cesarean section is necessary to save the mother or the fetus or both, such as when there is an entanglement of the umbilical cord or rupture of the maternal uterus during labor. It also includes situations where a surgical intervention is necessary, like in the case of appendicitis, and situations where a specific medical intervention is necessary, such as renal dialysis or blood transfusion.
2. In the situation where a patient is fully competent, fully conscious, and is able to comprehend and make a decision with no coercion, and the treating doctors determined that his or her condition is emergent, requiring a necessary medical or surgical intervention, then the patient's refusal for treatment would be sinful.

The doctor in this case is authorized to carry out the necessary therapeutic intervention to save the patient's life by virtue of the necessity provisions in Islamic Law.

3. In the situation where the patient lacks competence and his legal guardian refuses treatment in an emergency situation, then this refusal is invalid and the decision is transferred to the legal judge or his/her deputy from the concerned authorities in the country.
4. When a caesarean section is necessary to save the fetus, the mother, or both, and both spouses or one of them refuses the intervention, then this refusal is discounted and the decision is transferred to the legal judge or his/her deputy from the concerned authorities in the country.
5. In case of refusal of a medical intervention in an emergency situation, the following is necessary:
    - The doctor must explain to the patient or his guardian the importance of the medical treatment, the seriousness of the medical condition, and the consequences of refusing treatment. If the patient insists on refusing treatment then the doctor must document this.
    - The doctor should go through great measures to convince the patient and his or her family to reverse a refusal decision in order to avoid deterioration in their condition.
    - A medical team formed of three doctors, one of them being a consultant/attending who is not involved in treating the patient, should verify the diagnosis and the proposed treatment and prepare a signed report. The hospital administration should also be notified.
    - Treatment should be offered free of charge or treatment costs should be estimated by an impartial authority.[11]

The Legal Stance

When reviewing Omani Law, it becomes apparent that Omani legislators did not exempt those situations where medical consent can be waived from the mentally competent adult patient who refuses treatment that would save his or her life, limb, or organ. Instead, what is understood from the texts is that the patient has the right to exercise his free will to accept or refuse medical treatment regardless of the consequences.

To reach a clear understanding of this issue, we will explore the principle of autonomy. This, together with beneficence, non-maleficence, and justice, form the four pillars of medical ethics. Autonomy is a fundamentally important principle in the practice of modern Medicine and is particularly relevant to the context of the subject at hand.

The Law and the Principle of Autonomy

Maintaining the safety and autonomy of the individual is a basic human right that has been given due consideration and attention by the law. The Anglo-Saxon and the Latin schools of law both have clear legislation that criminalizes any unlawful assault on

the human body in any shape or form, and they enact deterring punishments that can range from monetary fines to imprisonment to the death penalty. While man-made laws hold the individual's autonomy in high regard, there are two schools of thought as to how it is to be respected. One school advocates an absolute right of autonomy so that the patient is granted complete authority to refuse treatment even if it leads to his or her own demise. The other school advocates a "relative" right whereby the patient is not empowered to make every decision related to treatment, with this right becoming subservient to the absolute responsibility bestowed upon each individual by God to preserve his own body. Furthermore, although the former school supports the absolute right in autonomy, this right does become suspended in most cases when it comes to a patient attempting to end his or her own life, whether on his or her own or with someone else's assistance.

The Omani Law and the Principle of Autonomy

The Omani law emphasizes the importance of individual freedom. According to Article 165, any government employee who detains an individual unlawfully shall be punished with imprisonment for a minimum of three months and a maximum of three years [12]. With regards to autonomy, the law in section number six of the Penal Code (Crimes against Individuals) states that anyone who inflicts intentional harm on an individual shall be punished with imprisonment [12]. Furthermore, Article 247 states that anyone who strikes, wounds, or harms an individual, without it resulting in an ailment or absence from work for a period of more than ten days, can face six months imprisonment or a fine of one to 20 Omani rials [12]. However, this legal prosecution can be dropped if the victim chooses not to pursue it. Article 248 states that if the assault resulted in more than ten days absence from work, punishment can increase to up to three years imprisonment [12]. Furthermore, Article 256 criminalizes any intentional attack on individuals and their freedom [12]. It is also worth mentioning that the Omani legislation goes so far as to criminalize euthanasia (Article 240) and any provocation or assistance in suicide (Article 241) [12]. The Law, however, does not codify the issue of medical consent and its necessity with a clear and explicit article, and the Penal Code does not define any punishments in this regard. Issues arising in this context are deferred to the aforementioned Penal Code articles on the assault of individuals.

The Current State of Affairs

In the Sultanate of Oman, all health institutions under the administration of the Ministry of Health as well as the private health institutions do adopt the concept of patient's right for autonomy. In addition, the legal system also seems to be in favor of the same as an almost absolute right for patients.

When studying the laws in other Arab countries we find that some of them are explicit about the necessity of obtaining patient's consent prior to medical intervention. For example, Egyptian Law emphasizes the right for autonomy in Article 43 of its Constitutional Law, which states that no medical experiment or operation can be performed on an individual without his or her free will.[13] Furthermore, the Egyptian Constitution gives individuals and their autonomy protected status. In its Article 42 it states that any citizen who gets arrested, detained, or has their freedom constrained

must be treated with what preserves their dignity, and it is forbidden to inflict upon them any physical or moral harm or detain them in places other than the ones subject to the laws concerned with governing prisons. Also, any confession that proves to be extracted under the pressure of what has been aforementioned or through threats thereof makes the confession void.[13]

Egyptian Law also considers infringement against any public freedom or public rights to be a crime. Article 57 states that any infringement on personal freedom or the sanctity of the personal life of individuals and other rights and public freedoms that the constitution and law maintain is considered a crime and both resultant civil or criminal suits would preserve validity with passing time. Furthermore, the government would guarantee fair compensation for the victim.[13]

The Right Direction

It is clear that the questions posed earlier constitute a dilemma as well as a challenge to the physicians' professional values. Physicians are expected by society to follow the noble goal of the medical profession, namely treating patients and salvaging their lives. Should they abstain from providing care to honor the principle of individuals' autonomy and their right to exercise freewill in refusing treatment where full capacity and mental competence is present? This obviously constitutes a clear conflict between two principles, namely patient's autonomy on one side and patient's beneficence on the other. So how should one proceed in this situation?

Taking a closer look at Omani laws and legislation, we find that there are no articles that explicitly deal with this conflict. In fact, the Law goes into detail with regards to granting the patient complete authority to exercise freewill, and it clearly prohibits administering any unconsented treatment even if this leads to loss of life, limb, or a vital function. However, when it comes to suicide and euthanasia, the law criminalizes these actions.[12]

When it comes to addressing the first question posed earlier, which relates to determining the right of guardianship for a son in the presence of more than one son, the Law states that guardianship is granted through a judiciary decision in case of disagreement among the sons. Therefore, if such disagreement arises in practice, the physician has to defer the matter to the court to issue a decision. This would not pose a problem if the patient's condition were stable enough to allow time for such a procedure. However, how should one proceed if the patient is in a critical situation and an emergency medical or surgical intervention is deemed necessary and the aforementioned disagreement takes place? Should the physician base his or her action on the decision of the one who is approving treatment or the one denying it? Although Omani legislation does not address these issues, it can still be deduced, from the understanding of the law and its spirit, and also in keeping with necessity rulings according to Islamic Law, that the physician may administer a necessary medical or surgical intervention in dire situations if only one of the sons, being a competent adult, consents to treatment (and even if others object). The law in this case would not fault the physician because his or her actions are in keeping with the medical profession's values as well as the Quranic verse "Whoever saves one [soul], it is as if he had saved mankind entirely."[14]

The second question relates to the mental incompetence of the incapacitated patient's son or daughter. In this case the legal guardianship is transferred to the next most eligible person according to the order of priority discussed earlier.

The third question addresses the scenario when a patient refuses treatment despite a clear explanation of the seriousness of the situation, and that such refusal can lead to death. In this case, and according to the law, patients have the absolute right to refuse treatment if they wish, provided they are mentally competent, and the doctor has no choice but to submit to the patient's decision. Legally, the patient would bear the full responsibility for their decision. However, from an Islamic legislation perspective, scholars have had different opinions on how to characterize this refusal. If the patient's refusal was based on the fact that his condition has been deemed hopeless with or without treatment, then such decision is considered to be sound and there are no repercussions from a religious point of view. The same also applies if the patient refuses a specific form of treatment to consider another valid alternative form of treatment. If the patient becomes convinced that treatment is futile despite it being scientifically proven to have a success rate of 90% or more, then he or she is considered a sinner and is subject to divine judgment. However, if the refusal leads to his or her demise, religious scholars have had different stands on characterizing such a person. The Grand Mufti of Oman, Sheikh Ahmed Al-Khalili, among others, is of the opinion that such a person would be considered to have sinned; however, it would not be equivalent to suicide due to the fact that there is no kind of treatment that can be guaranteed to provide absolute results.[8] Others agree that such an act would qualify as a suicide.[15]

The answer to the fourth question is the same as the third, with the additional explanation that in the case of fetal demise due to maternal refusal of a surgical intervention, the mother is under no legal liability. However, the Islamic religion considers this to be involuntary manslaughter and it therefore mandates atonement.

The fifth question posed pertains to the refusal by the legal guardian for treatment of the dependent. In order to reach a correct perspective on this issue, it needs precise detailing. For example, if a medical intervention is necessary to save the life of a minor and the clinical situation allows time for that, the physician can raise this matter to the police or child protection services to aid in resolving it. However, if time is constrained then the treating physician is faced with a dilemma of whether to abide by the medical code and implement immediate life-saving interventions or follow the guardian's wishes, which might compromise the life of the minor. Reviewing the laws on this, we find that Western laws provide protection to minors by preventing legal guardians from abusing their right for guardianship. However, the law is not clear on this in Arab countries. Nevertheless, despite the refusal of the guardian, the physician is obliged to provide the necessary care after notifying the hospital administration. But what is the proper mechanism that needs to be followed in this situation in order to achieve this? Would forcefulness be the solution? Perhaps this approach may be justified when a child's life is endangered and the guardian would not have legal support if a lawsuit were to be pursued by the guardian against the physician.

According to Islamic Law, there is no disagreement among scholars that the guardian's actions are to protect and keep harm from happening to the protected minor. This can be discerned from the Quranic verse, "And do not approach the

orphan's property except in a way that is best,"[16] as well as from the prophet's saying, "if a man is entrusted by God on citizens and when the time of his death comes he is still cheating them then heaven shall be forbidden to him."[6] Therefore, the guardian's abstention is undoubtedly invalid in this case.

It is important to emphasize that refusal of treatment may be justified or unjustified. Therefore, the proficient physician must perfect the art of communication with his or her patients and their guardians and possess the ability to inform them of the medical condition and its potential complications in a simplified language that is understood while avoiding exaggeration or oversimplification. Persuasion is an art that a physician must master as an essential tool that minimizes the conflicts of objection and rejection. On occasion, physicians when communicating with patients exaggerate or instigate fear, which results in patients' reluctance in accepting the treatment. Patients may also have financial constraints or other reasons that would affect their decision. If the exact reason becomes apparent it will be less problematic to deal with the refusal and may be easier to convince the patient about the treatment's necessity.

The final question pertains to the legal liability to the physician who did not deliver treatment in accordance with the patient's refusal and there was resultant death or loss of a vital organ or limb. In this case the physician would not be held liable since the patient was practicing his or her legal right in whether to accept or refuse treatment. The physician would have to respect the patient's autonomy as has been provided for by Omani Law.

Conclusion

In light of the discussed scenarios pertaining to the lawful consent granted by the patient or his/her surrogate decision maker, there is no doubt that in certain occasions doctors face challenges regarding whether to honor what their profession dictates, which is saving life, or to respect a patient's right of autonomy, which is to the contrary. It would be more ethically sound for a physician to administer life-saving treatment, and the Law would have to remain silent in front of the ethics of medical practice. Furthermore, the physician should distance himself from any criticism that may be imposed by the Law as long as his decision to actively administer treatment has scientific grounds. In fact, from a legal standpoint, it is less probable for a case to be made against the physician who goes against a patient's will and delivers active care to save life than one who withholds life-saving measures merely to satisfy a patient's wish. In addition, some Islamic scholars argue that physicians who do not administer life-saving treatment upon patient's request are committing a sinful act and would mandate repentance. On the other hand, other scholars oppose this view, claiming that the effect of any medical intervention is not fully guaranteed; therefore the physician should not be considered a wrongdoer.

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Slathered, Zapped, Nipped, and Tucked: An Ethical Analysis of Cosmetic Dermatology

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Abstract

It has become common practice for dermatologists to offer cosmetic enhancing products and procedures and to do so alongside the medically required services offered (e.g., annual skin checks, treatment of rashes, removal of pre-cancerous moles, etc.). As a patient, it is likely that a visit to the dermatologist will include exposure to advertisements for these cosmetic products and procedures. Advertisements are found in the waiting area, examination room, and, in some cases, even at checkout in the form of a coupon for future use, all situated where the patient is a captive audience. This practice may not be the cause of our society's ubiquitous focus on beauty as perfection; however, these practices arguably contribute to this culture, harming not only individual patients but also society as a whole. Further, since the physician's endorsement of these products and procedures carries added weight, above and beyond that of a normal citizen or another non-medical professional, the impact on perpetuating a culture of beauty as perfection is even greater.

Given this, in this essay I argue that the practice of dermatologists advertising, offering, and profiting from cosmetic enhancing products and procedures is unethical, violating the most basic bioethical principles. To demonstrate how this is the case I unpack how the culture of beauty as perfection is oppressive and therefore problematic; how dermatologist feed into, perpetuate, and profit from this culture; and how this practice is an ethical violation. Central to my analysis is an account of the commonly accepted bioethical principles within a framework of a social conception of the self. The implications of this analysis and findings include a need for clear guidelines offered by various medical oversight associations including the American Academy of Dermatology (AAD), the American Society for Dermatological Surgery (ASDS) and the American Medical Association (AMA). These guidelines should reflect a robust ethical analysis of this practice, ideally in conversation with the analysis offered herein. Once offered, physicians should follow these guidelines and, until then, should proceed with an abundance of caution, ideally ceasing to advertise, promote, or use biotechnologies in their practices for solely cosmetic reasons until more nuanced guidelines are available.

Introduction

> *Inspire me with love for my art and for Thy creatures. Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and of love for mankind and they can lead astray in the great task of attending to the welfare of Thy creatures.*
>
> *- Maimonides*

Sandra Bartky, a recently deceased feminist philosopher, astutely analyzed and critiqued the lived experience of women in society, offering a phenomenological account of the contemporary experience of being a woman. One insight she offered was that, in regard to her appearance, women seem to have a "virtual duty" to "make the most of what we have" and use all available resources and technologies to do so. This "duty" assumes that it is, as Bartky describes it, within women's power to make themselves ". . . look better—not just neater and cleaner, but prettier, and more attractive." This leads to "intimations of inferiority" where the body is the source of one's value and where whatever body one happens to have is ". . . never sufficient unto itself, stands forever in need of plucking or painting, of slimming down or fattening up, of firming or flattening" (Bartky 1990, 22-32). At first, the judgment of "inferiority" is externally located, ubiquitously found throughout our culture, especially in mainstream entertainment mediums. However, with time and repetition, this judgment of inferiority is internalized into the psyche of the woman. When this occurs, Bartky notes, the individual experiences a kind of psychological oppression, where the individual is ". . . weighed down in [her own] mind," exercising "harsh domination" over her own self-esteem (22).

In our culture of perfection in which images found on social media, on television, in magazines, and on the Internet are edited, trimmed, and reshaped to make the model look flawless, it is not surprising that this feeling of being "weighed down" is ubiquitous.[1] These unrealistic images are everywhere, woven into our consumer-driven culture, offered to us in order to encourage the purchase of particular products that promise similar results for the user. Further, these images and the products represented are typically gendered according to norms of masculinity and femininity, encouraging boys and men to be tough, independent, and action-focused and girls and women to be docile, sexy, dependent, and fashion-focused.[2]

In itself, this situation is already ethically suspect, relying on the exploitation of the vulnerable in order to profit from the individual need to address some perceived flaw or weakness.[3] However, it is even more disconcerting to imagine that the medical community also participates in creating, exploiting, and profiting from this culture of physical perfection. With this in mind, I am interested in evaluating the ethics of the increasingly common practice of medical dermatologists advertising and offering enhancement products and procedures[4] as part of their practice. I will ultimately argue that both the offering of and the advertising of procedures and products for cosmetic enhancement reasons is ethically wrong. Medical advertising is particularly suspect as it contributes to and profits from the already prevalent culture of perfection discussed above and, if the advertisements occur in the medical practice, targets a captive audience not themselves seeking out and inquiring about cosmetic options.[5]

As physicians, dermatologists offer messages that have an added prestige and carry an additional force in society.[6] Because of this, these messages have weighted influence on how the public (and the physician's patients) receives them. The physician has the potential to reinforce, diminish, or otherwise mitigate the power of the norms of society. However, when a physician uses this power in a way that reinforces and perpetuates problematic societal norms, we must ask ourselves whether doing so is ethically permissible. In this case, the answer is an emphatic no.

It is not ethically permissible because the norms being perpetuated and from which the dermatologists then profit are not conducive to fostering the health of the individual or the society as a whole. Instead of profiting from this culture of perfection, dermatologists should be using their influence to highlight and critically consider it. To put this in bioethical terms, dermatologists violate the principle of nonmaleficence when they advertise cosmetic products and procedures in their medical practice, subjecting their patients, a captive audience, to additional messages that their body, as Bartky said, is not "sufficient unto itself." This potentially harms the patient psychologically and increases the likelihood that the patient will choose to undergo cosmetic procedures, which, since many of these procedures come with certain risks, could cause them medically unnecessary physical harm. While, arguably, dermatologists did not create this culture of perfection that results in the "intimations of inferiority" that can lead to psychological oppression, they are certainly feeding into it when they advertise and sell products that reinforce the previously discussed problematic norms of society. They are taking advantage of the virtual duty that women have come to believe they have, offering biotechnology applications within cosmetic dermatology that sometimes seem without limit. Affordability need not even be a limitation as it is possible to finance the procedures much like one might finance the purchase of a car or other consumer good.

When physicians choose not to use their powers of influence to turn a critical eye on this culture they fail in terms of the principle of beneficence as they are failing to promote the well-being of individuals and of society. To understand how this analysis holds true requires that we look a bit more closely at the principles of bioethics and couple this with careful considerations of how conceiving of the self as necessarily social makes clear, in ways that might otherwise be obscure, the ethically problematic nature of this practice.

Principles of Biomedical Ethics & a Social Concept of the Self

As noted in the *Code of Medical Ethics* created and promoted by the American Medical Association, "a physician must recognize responsibility to patients first and foremost . . ." and, according to the AMA first principle of medical ethics a physician must ". . . be dedicated to providing competent medical care, with compassion and respect for human dignity and rights" (American Medical Association). Similarly, a commonly accepted and often-repeated ethical command in medicine is that the physician should ". . . make the habit of two things—to help, or at least to do no harm."[7] These principles are encompassed in the standard four principles of bioethics. These include: autonomy, beneficence, nonmaleficence, and justice.[8]

On the one hand, these principles seem pretty straightforward. However, what they require of a physician depends in part on how we conceive of the self and the self in relation to other beings and institutions. If we were to see the self as, idealistically, an atomistic self, functioning best when acting independently, rationally, and unimpeded by emotion or situational context, then how we define the concept of autonomy and how we conceive of what it means to harm, to promote well-being, and to advocate for justice would be skewed in certain ways. More specifically, these principles would focus on assuring independence and individual autonomy, prioritizing the individual's right to choose for him or herself. To do this, the practicing physician would insist

on patients being fully informed, with an understanding of the various aspects of the procedures being considered, and would want to make sure the decisions made were rational ones, made with realistic expectations of the probable outcomes and with the ability to articulate why his or her choice makes sense given his or her situations and his or her particular desires. Once autonomy is secured through understanding and informed consent, the goal would then be to assist that individual in actualizing his or her desired outcome, whether that be Botox-enhanced lips, skin tone treatment, or, among other things, fat-emulsifying Ionithermie.[9]

The priority would be to promote individual actualization, to the extent that this is possible, and to do this would require attending primarily to the individual's stated wants and needs.[10] With this focus, to harm the patient or to benefit the well-being of the patient would primarily be an isolated question, honing in on the individual's stated wants and needs alone rather than critically considering the larger context in which the individual lives, makes decisions, and formulates the wants and needs that guide his or her decisions.

Similarly, an atomistic conception of justice becomes a matter of ensuring individual rights and perhaps only a weak nod to the outside influence that societal norms, such as the culture of perfection, have on the individual. Justice then is a matter of moving toward equal access of all individuals to all available technologies and doing this without a deeper critique of the ethical parameters of the use of these technologies from a broader point of view.

Thus, in the context of enhancement technologies and considerations of justice, the physician addresses inequalities in society as a whole by, for example, offering payment plans or discounts to lower-income individuals so that they too can benefit from the biotechnologies used in the field of cosmetic dermatology. They may also, in the interest of justice individualistically conceived, offer medical treatment for free or at reduced rates for those who might not otherwise be able to afford these services.[11] In other words, with an atomistic conception of the self, issues of justice become a matter of clearing the way for the individual to have access to the same enhancement tools and technologies as individuals better situated economically.

Similarly, with the atomistic conception of the self, the principle of autonomy would require that the patient is informed, gives consent, and is not being "unduly influenced" where being "unduly influenced" is defined by some practitioners in the field as occurring when ". . . an individual who is in a more powerful position persuades a more vulnerable individual to do something that he or she would not have done otherwise" (Imadojemu 2012, 138). While situating this analysis within a social conception of the self leads to a broad definition of "undue influence," including not only the influence of individuals in positions of greater power than the patient but also the influence of advertisements on the patient as well as society as a whole, an analysis of "undue influence" within an atomistic conception of the self may arguably be more narrow, focusing on influence that is directed by an individual toward another individual (e.g., a particular physician toward a particular patient during a particular moment). As long as this narrower conception of "undue influence" is met, the patient is informed about the procedure, and the patient consents to the procedure to be performed, then this is enough for the physician to move forward. In fact, it may even

be ethically required for the physician to do so in order to facilitate the achievement of the patient's stated wishes and thereby promote the patient's autonomy.

In this conception, offering cosmetic procedures and products to patients can become, oddly, an ethically praiseworthy act, empowering the patient to meet both cultural standards of actualization as well as the individual's internalized versions of the same. As a result of the enhancement services offered, the individual fits better in society, perhaps even receives certain social and career benefits for doing so, and may experience a greater sense of individual well-being.12 Marking this as ethically praiseworthy based on this analysis, however, assumes that the social norms to which the patient is now conforming are in themselves ethically acceptable, and, further, it assumes that the physician has no role to play in critically examining the status quo of society as part of their medical practice.[13]

In contrast, if we understand the self to be a social self, always "in-process" and necessarily contextualized within discursive, co-constitutive transactions,[14] then we come to see the roles and responsibilities of the dermatologist differently. First, how the bioethical terms are understood are more nuanced and interrelated than with the atomistic understanding. What it means to respect autonomy, promote the well-being, and prevent the harm of the patient becomes inexorably connected with critical questions applied to society as a whole. It is no longer enough to ascertain the individual's wishes and wants and assure that they are fully informed and not obviously coerced. Rather, it becomes imperative to consider as well the situation from a social context. One must not only consider what the individual states he or she wants, but also question where and why these wants and wishes emerged. We must ask if the context from which they have emerged is conducive to full human flourishing and ameliorations for all, and we must attempt to mitigate against those situations and those norms that limit opportunities and expectations based on power-related dichotomies (e.g., men over women, citizen over noncitizen, Anglo appearance over other, etc.).[15]

In addition, the dermatologist must also consider his or her role in society and in the context of the norms that motivate individuals and society to see cosmetic enhancements as empowerment, as a way to express individual choice rather than for what it is, which is a profit-driven institution that is, through the use of sophisticated advertisement campaigns, manipulating the public's internalized need to conform to the unrealistic cultural codes of beauty and youth.

The physician who understands the implications of a social understanding of the self will fully expect that the thoughts and choices of the patient are already and necessarily deeply informed and influenced by context, and that context includes any information, advertisements, or similar provided by the physician. The question then becomes not whether others have influenced the individual but how this influence is manifest and whether or not the influence is conducive to meaningful self and societal actualization, with the cultivation of active and intelligently engaged social participation rather than routine or unthinking absorption and repetition of what is passively experienced.[16] In other words, it becomes a question of whether the individual is critically and thoughtfully engaged in his or her own construction and the construction of others and of society as a whole.

Thus, when considering the central question of this paper from the perspective of a social understanding of the self, the physician must seek to understand the patient's stated wishes and connected choices from a wider social justice perspective, asking whether the norms, expectations, and values of the social circles from which this individual emerged are constructed so that all individuals in that social context can participate fully and live flourishing lives. In these cases, socialization certainly occurs but occurs with intelligent and critical engagement rather than being passive and routine. With this understanding, we must evaluate the practice of advertising and offering cosmetic procedures with a critical awareness of how that practice is situated within a culture that is problematically gendered (as discussed above) and that values physical perfection over other conceptions of actualization connected with meaningful community engagement.

As noted above, our culture cultivates in individuals a sense that they have a duty to avail themselves of all possible technologies in order to better meet the established norms. Failing to meet these results in a sense of shame and even guilt[17] and can further result in negative social consequences such as, for example, lower pay, missed promotions, and social castigation for those individuals who have not met the standards of beauty embraced by society. These consequences or the possibility of these consequences serve as strong motivation to continue to do all that one can to get closer to the impossible. When we include within the realm of possible "fixes" products and procedures offered by physicians, what is possible continues to expand and what is required in the mind of the individual becomes nearly limitless.

With this more nuanced and interconnected consideration of this issue, we see that advertisements for cosmetic or enhancement procedures by dermatologists can no longer be viewed as an empowering service to the patient, informing them of additional tools available to them in their quest toward the perfection they desire. Rather, the ads must be viewed as part and parcel to the larger context of society in which the culture of perfection has had and continues to have nefarious effects.

Interestingly, while one might assume that the accrediting bodies of dermatology would have addressed this particular issue directly, this is not the case. Instead, organizations such as the American Academy of Dermatology (AAD) and the American Society for Dermatological Surgery (ASDS) have only made gestures toward acknowledging the ethical issues involved and have not addressed it head on, offering no definitive statement on the practice.[18] In addition, the American Medical Association (AMA), while offering opinions on an expansive array of medical related practices in a variety of medical areas of specialty, is silent on the practice of cosmetic dermatology.[19] This should change. The AAD, the ASDS, and the AMA should be more explicit about the regulation of advertising cosmetic procedures and products and should offer guidelines, as it does for other controversial medical topics, for the use of biotechnologies. Further, this essay has, in part, been an argument that any guidelines offered by the governing bodies of medicine and dermatological medicine should be available and, as are other medical guidelines, should be framed by principles of biomedical ethics. Further, how the issue is critically considered should be within a framework of the self as a social being and not atomistic in order to avoid the narrow conception of bioethics that an atomistic conception of the self may yield.

Further, regardless of what the various medical boards and institutions choose to do, individual physicians should, at least until the advisory institutions offer explicit opinions to guide their decisions, refrain from advertising or otherwise promoting cosmetic products and procedures, cease the use of biotechnologies for primarily cosmetic reasons, and lobby their governing medical bodies to state more explicitly positions consistent with these ethical practices related to this topic. Once a physician becomes aware of his or her influence on the norms of society, then the physician has responsibility to act accordingly. One purpose of this work has been to enhance awareness. To the extent that this has occurred, continuing with practice as normal is to neglect one's ethical responsibility.

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Endnotes

1. In a study commissioned by *Dove*, a Unilever Beauty Brand, researchers found that only 2% of women worldwide see themselves as beautiful and, further, that women also see ". . . beauty and physical attractiveness as increasingly socially mandated and rewarded, with almost two-thirds strongly agreeing that: 'Women today are expected to be more physically attractive than their mother's generation was' (63%); and, 'Society expects women to enhance their physical attractiveness' (60%)." This same study found that "women tend to believe that the popular meanings of beauty and physical attractiveness have become increasingly **narrowed and unattainable.** [. . . Further, more than] two-thirds (68%) of women strongly agree that 'the media and advertising set an unrealistic standard of beauty that most women can't ever achieve'" (Etcoff, Orbach, Scott and Agostino 2004, 1-25, esp. 9 and 25).
2. With a focus on children and advertising but arguably similarly applicable to all consumers, the Media Educational Foundation highlights how this is accomplished in their 2008 documentary *Consumer Kids: The Commercialization of Childhood.* The documentary demonstrates how corporations strive to secure "360 degree immersive marketing" in order "to insinuate brands into the fabrics of children's' lives" and to do so from "cradle to grave," the goal being to turn the child into a life-long consumer. The focus in this documentary is on children because it finds this to be particularly problematic as it is children that are developmentally more vulnerable. However, the adults too experience this 360 degree marketing. Further, the children grow up to be adults who are now primed for targeting as an adult audience by the fashion & beauty (cosmetic) industry.
3. Drawing on, as one example, the Kantian ethical tradition, this involves treating these individuals "simply as a means" and not as "ends in themselves," thereby violating the principle of humanity, and is therefore unethical, violating their autonomous existence as rational, self-determining individuals. See especially Kant's second formulation of his categorical imperative, "Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means" (Kant 1785, 36-37).
4. Though the line is gray between the medical use of biotechnologies in dermatology and the cosmetic use of the same, the distinction is generally agreed to rest on one of using the technologies primarily for medical reasons, which may have secondary cosmetic benefits, and primarily for cosmetic reasons, which may yield secondary health benefits (but not enough to warrant the procedure or product alone). In general, and for the purpose of this essay, cosmetic dermatology falls under the umbrella of Enhancement Medicine, which, as Sotonye Imadojemu and Autumn M. Fiester highlight, ". . . intends not to restore appearance or function damaged by disease trauma, or congenital defect to age-appropriate levels, but to improve average appearance or function to some desired level beyond age-appropriate norms" (137). In contrast, plastic surgery, though involving the use of the same biotechnologies, is focused on performing surgery that is medically necessary, even while it may involve some secondary cosmetic benefits. Thus, though many laypersons refer to surgery done for cosmetic purposes as "plastic" surgery, this essay makes a distinction between plastic and cosmetic surgery and finds only the latter ethically problematic as the former, by definition, is medically necessary.
5. Particularly nefarious to the patient are the advertisements that occur in the practice (within the medical office) of a physician. On a recent visit to a dermatologist for a yearly skin check, I was bombarded with advertisements for cosmetic enhancing procedures and products at every turn (in the waiting room in the form of leaflets and posters, in the examining room in the form of a binder of procedures offered and more posters, and at checkout, on my appointment slip and with a coupon given to me as part of my exit materials. Two posters stick out to me most: the first had a picture of a healthy looking woman with arrows pointing at all the potentially problematic parts of her face that could be addressed with various enhancement procedures and the second, located at the checkout counter, had a male and a female cuddling on a couch. The caption above the woman said, "If I ever doubted my decision to have breast augmentation, I don't now." As a captive audience in this practice, and there for purely medical reasons, I find it problematic that I and the other patients are subject to these messages and the not so subtle message that I will be happier (and apparently cuddle more with my partner) if I consider the procedures being offered.

6. As stated by the American Society for Dermatological Surgery (ASDS), "Dermatologists have more influence on a decision to have cosmetic procedures than friends, physicians referral, or 11 other factors, according to respondents" (www.asds.net/about.aspx). Julie Cantor makes a similar point, arguing that while physicians do not carry the same prestige and power that they once had in society, the level of prestige and influence they still have remains significant and means that what he or she says or does carries with it the corresponding added influence (Cantor 2005, 155-160, esp. 156).
7. See Thomas L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 4th ed. Oxford University Press, 1994 and, in reference to the command that we should, ". . . at least do no harm" see the *History of Epidemics* by Hippocrates. In contemporary bioethical terms, the command to ". . . make the habit of two things—to help, or at least to do no harm" is, in part, encompassed and furthered with the four commonly embraced principles of bioethics, which include the principle of respect for autonomy (assure understanding and informed consent, respecting the informed wishes of the patient), the principle of nonmaleficence (do no harm), the principle of beneficence (promote welfare and wellbeing of the patient), and the principle of justice (offer fair distribution of medical knowledge and medical practice).
8. Similarly but not directly addressing the issue of justice are Daniel Callahan's four goals of medicine. These goals include the following: (i) to prevent disease and injury and to promote and maintain health; (ii) to relieve pain and suffering caused by maladies; (iii) to care for and cure those with a malady, and to care for those who cannot be cured; and (iv) to avoid premature death and to pursue a peaceful death (Callahan 1996, 21-27).
9. As Julie Cantor notes, the obligations of a dermatologist practicing cosmetic dermatology include to "act in the patient's best interest, do no harm, serve the interests of justice, ensure informed consent" with an added obligation to "combat the influence of television on patient perceptions, and their informed consent dialogue should be detailed and exhaustive. A truly informed consent process is even more important of cosmetic procedures than it may be in other areas of medicine" (156, 159). In the end, however, she argues that the "ethical obligations posited here are quite simple. Be truthful in advertising, whether selling procedures or products. Be forthright about training credentials . . . . Advocate for patients and maintain the integrity of the profession by demanding that companies deflate claims in their ads . . . . Continue to have medical dermatology practice, and volunteer those services, if not also the cosmetic ones, to those who cannot afford them" (159). With this ending statement she fails to draw the insights she offers earlier about the influence of television on the patient and the possible effects this may have.
10. A distinction between wants and needs is helpful here. "Needs" include those things that are medically necessary and without which the health of the patient would be diminished in the present or future. "Needs" in relation to medical procedures include such things as plastic surgery in order to reconstruct the nose so proper breathing can be established. In contrast, a "want" is something that is not medically necessary for the health of the patient but instead is desired for cosmetic purposes. For example, a patient may want cosmetically motivated plastic surgery to reshape his or her nose because he or she does not like the current size or shape of his or her nose. The nose, in the case of the "want" without an accompanying "need," works perfectly fine but does not look like what the patient would prefer. Of course, there may be needs that are also wants. For example, an individual who needs plastic surgery to reconstruct his or her nose in order to breathe more effectively and also "wants" this surgery for cosmetic purposes. For further discussion on the distinction between plastic and cosmetic surgery, as being used in this essay, see *Vide Supra*, endnote 7.
11. Given the current context of the field of dermatology, where the need for dermatologists that practice medical dermatology is high, this particular option would seem to be especially positive, filling a need in the field while also offering that service to those who otherwise may not be able to afford it. As Roubaix notes, "Restriction of aesthetic surgery to the rich may counteract notions of 'distributive justice', causing envy in the not so affluent . . . . Prohibiting aesthetic surgery is unlikely to divert surgical expertise to more 'deserving' instances, and may cause translocation of medical expertise. Many aesthetic surgeons also perform non-aesthetic surgery (much needed in developing countries). Volandes suggests taxation on aesthetic surgery to subsidize surgery for the poor, which might also improve negative perceptions of the medical profession" (Roubaix 2011, 11-16, esp. 13).
12. This is similar to the argument against viewing the woman as somehow oppressed by the social norms around beauty and youth. Some argue that the availability of these technologies are empowering, allowing the woman to act as an agent in control of her destiny, giving her the ability to meet the criterion of success in her society. This enhances, it is thought, autonomy and rather than being oppressive is empowering. (See reference to this type of argument in Deborah Sullivan's *Cosmetic Surgery: The Cutting Edge of Commercial Medicine in America*.) However, this assumes that we live best without questioning the status quo, but this would be a faulty assumption. If what we are empowering an individual to do or be is oppressive, even if this makes her happy or gives her advantages in society, it is wrong.
13. In Chapter 8 of the *Opinions of the Council on Ethical and Judicial Affairs* for 2016, the AMA augments and

updates the AMA Code of Bioethics with current opinions and guidance on contemporary bioethical issues. Here the AMA insists that "Although physicians' primary ethical obligation is to individual patients, they also have a responsibility to protect and promote public health" (American Medical Association, https://www.ama-assn.org/delivering-care/ama-code-medical-ethics). With this the AMA seems to be laying a foundation that supports an interpretation of the role of physicians in society that is not an atomistic interpretation but rather consistent with the arguments offered in this essay and soon to be developed as part of the social notion of the self and its application to this topic. While, within the opinion offered in this AMA Chapter on "Physicians and the Health of the Community," a specific application to the use of biotechnologies for cosmetic and/or medically necessary purposes is not offered, such an opinion would be consistent with the overarching principle advocated by the AMA and, arguably, given how ubiquitous cosmetic procedures are in our society, seems to be a missing topic in this Chapter.

14. This particular reference to the self as social and co-constitutively always "in-process" is reference to John Dewey's work and, more broadly, the work of many in the American pragmatist tradition, such as George Herbert Mead and, with a more contemporary reference, Shannon Sullivan. As John Dewey explains, "[L]ife goes on in an environment; not merely in it but because of it, through interaction with it. No creature lives merely under its skin; its subcutaneous organs are means of connection with what lies beyond its body frame, and to which, in order to live, it must adjust itself. . . . The career and destiny of a living being are bound up with its interchanges with its environment, not externally but in the most intimate way" (*LW* 10: 13). This is also consistent with many feminist conceptions of the self and is echoed in traditions such as the ethics of care tradition (Noddings, Held, Card, etc.) and in critical theory traditions, with theorists such as Maria Lugones and her conception of the self as being selves who are "mapped" into and within social contexts and social norms.
15. This is similar to what Maria Lugones calls us to consider, which is the nature of our social existence as "mapped." Lugones argues that even those who benefit from the mapping are "spatially mapped by power." Our paths are ". . . marked as places you may, must, or cannot occupy" (Lugones 2003, 8). In these cases, it may be "empowering" to offer individuals tools to better conform to one's expected location and function within the map; however, taking a larger, global view allows one to see that this misses that the map itself may be in need of revision. In this case, empowering the individual to continue to maintain her location within the map is really disempowering that individual and other individuals who are similarly mapped.
16. I borrow this distinction from John Dewey and his distinction between routine and intelligent habits. Dewey, as noted above, embraces a social conception of the self, what he calls a transactional self and integral to this social self are habits and the role habits play in the formation of society and the defining and influence these societal habits (customs) have on individuals. Habits are absolutely necessary for self-formation but they can be more or less conducive to individual and community amelioration. Habits that are intelligent, are, as Dewey says, "sensitively percipient, more informed with foresight, more aware what they are about, more direct, and sincere, more flexibly responsive than those now current" (LW 14: 88-90).
17. This all leads to, Roubaix points out, shame… shame that no matter what one does or doesn't do, one cannot meet the norms. "The underlying dynamic is a culture that shames any divergence from 'an unrealistic aesthetic idea.' The question is whether women really make free choices in favour of aesthetic surgery under these circumstances" (Roubaix 13, quote from Allison A. "Plastic Surgery…When is Too Much not Enough? Celebrating Women, Diversity and Achievement." Online 14, January, 2010. http://ameliaalisoun.worldpres.com.)
18. Surprisingly, there is little direct attention to this question in the relevant academies of medicine or the bioethical societies. For example, *The American Academy of Dermatology (AAD)*, though offering a booklet addressing ethical issues (*Ethics in Medical Practice: With Special Reference to Dermatology*), does not in this booklet speak directly to the nefarious contribution dermatologists makes when promoting cosmetic procedures toward greater physical perfection. The references to ethics are general in nature, arguing that dermatologists should "participate in activities contributing to the improvement of the community and the betterment of public health" but does not specify a position on the most obvious issues related to promoting this culture of perfection. While "unnecessary procedures" are to be avoided, there does not seem to be a willingness to make a connection between cosmetic procedures and "unnecessary procedures." It is curiously silent on this issue. The same is true for the *American Society for Dermatological Surgery* (ASAS). While this society offers an account of the rise in interest in cosmetic procedures, it does not call into question the role that dermatologists are playing in the normalization in these practices or the ethics of doing so. And this while noting that "Dermatologists have more influence on a decision to have cosmetic procedures than friends, physician's referral or 11 other factors."
19. As mentioned above (*Vide supra*, endnote 13), the AMA, in their Code of Medical Ethics, provides not only their principles of medical ethics but also a series of opinions that, though not laws, are "standards of conduct"

or, in other words, guidelines that identify ". . . essentials of ethical behavior for physicians" in relation to particular medical practices (Preface and Preamble to Opinions of the Council on Ethical and Judicial Affairs). Herein the AMA offer guidelines for a large variety of medical topics including, to name just a few, "Assisted Reproductive Technology," "Torture," "Physician Participation in Interrogation," "Genetic Testing and Counseling," and "Cloning for Reproduction." Absent, however, is any guidelines of considerations for the use of biotechnologies for cosmetic purposes.

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The Trinitarian Nature of Biblical Bioethics: A Theological Corrective to Frame's Philosophical Paradigm

DANIEL HEIMBACH

The triperspectival method John Frame (b. 1939) proposed in *Medical Ethics: Principles, Persons, and Problem*s has guided Evangelicals in the field of bioethics for almost three decades.[1] But while the content Frame provides comes from the Bible, the classifications structuring his triperspectival method—his *normative*, *situational*, and *existential* perspectives—come from philosophical thought rather than from what God says. This generates significant problems, not the least of which is deviating from the main stream of Christian ethical thought flowing from Augustine, through Martin Luther, John Calvin, Karl Barth, Van Til, Helmut Thielicke, Jacques Ellul, Francis Schaeffer, Carl F. H. Henry, and Oliver O'Donovan—a stream that disputes mixing philosophy with theology because the Word of God transcends and never submits to humanly conceived theories.

I will follow that tradition by seeking to correct Frame's philosophically arranged triperspectival paradigm by showing there are already in the Word of God Trinitarian categories that give structure to ethical analysis independent of human philosophy and that need not be imposed on revelation, because they already are embedded in what God says. I am not abandoning the triadic complexity in Frame's thought, but wish only to modify it in a manner more consistent with the way God presents moral truth on his own terms, not ours.

Frame's Philosophical Paradigm

Frame believes he is taking "a distinctly *Christian*, indeed distinctly *evangelical*, ethical approach,"[2] and rejects all non-Christian systems because none of them accept the only true source of ethical knowledge, which is "the God of Scripture."[3] Indeed Frame criticizes Gordon Clark for giving "Aristotle's logic the same authority as Scripture"[4] and denies "the idea that Christian morality is a supplement to pagan morality."[5] But Frame himself borrows structural classifications from humanly conceived philosophical systems and uses them to formulate a method of analysis involving three perspectives—the *normative*, *situational*, and *existential*—which he thinks can unite *deontological*, *teleological*, and *existential* (or *aesthetical*) systems of philosophical ethics if they are redefined as elements of divine lordship. So Frame equates *deontological* ethics with divine *authority*, *teleological* ethics with divine *control*, and *existential* or *aesthetical* ethics with divine *presence*.

I must clarify that, in analyzing Frame, I believe certain essentials differentiate theological from philosophical ethics. Both use reason to assess logical consistency and correspondence to known truth. But whereas theological ethics starts with revelation, philosophical ethics starts with human experience.[6] Whereas theological ethics is theocentric, philosophical ethics is anthropocentric.[7] Whereas theological ethics (even making allowance for errors of interpretation) presupposes transcendence,

is dogmatic, and only speculates beyond what God says, philosophical ethics never presupposes transcendence, never is dogmatic, and never goes beyond speculating whether God has spoken or not. As such, rational categories faithful to Scripture may be theologically accurate. But rational categories not arising from Christian worldview assumptions, or that replace the Word of God with words of men, are not.

Trinitarian Ordering Already Present in Biblical Moral Revelation

I do in fact much admire the complexity of Frame's approach, and think Frame gets rather close to saying a Trinitarian model is required to have a full-bodied Christian ethic. But, while Frame heads the right way, I do not think he goes far enough, because moral revelation is already replete with triads reflecting the Trinitarian nature of a Creator who orders ethical reality in a manner aligned to himself. And I believe our Creator's Trinitarian nature not only is reflected in, but also structures ethical reality. God's ordering of ethical reality is Trinitarian because God is Trinitarian, and here are some examples of where that appears in Scripture.

There is Trinitarian ordering in *three aspects presenting ethical reality as a whole*—which are that all we are and do must be *holy* as God is holy (Lev 19:2, 1 Pet 1:16), all we are and do must remain in His *love* (John 15:10), and all we are and do must be for God's *glory* (1 Cor 10:31).

There is Trinitarian ordering in *three elements comprising ethical living*—which are *conduct*, *character*, and *goals*. James says we must "be doers of the word and not hearers only" (Jas 1:22). Romans says we must be conformed to the image of Jesus Christ (Rom 8:29). And Colossians says we must live "for the Lord and not for men" (Col 3:23).

There is Trinitarian ordering in *three categories of biblical law*—which are *moral* law that lasts forever (Heb 13:8; Jas 1:17), *ceremonial* law that changes from the Old Testament to the New (Heb 10:1), and *civil* law that only concerned governing ancient Israel and never was meant for anyone else (Lev 25:3-5).

There is Trinitarian ordering in *three things required to stay in right relation with God*—which are "to *act justly*, to *love faithfulness*, and to *walk humbly with your God*" (Micah 6:8).

There is Trinitarian ordering in *three things Jesus demanded of disciples*—which are to "*love Me*" (John 14:15, 21, 23-24), to "*keep My commands*" (John 14:15, 21, 23-24), and to "*remain in Me*" (John 15:4-6).

There is Trinitarian ordering in *three structural motifs in the ethical teaching of Jesus*—which are the *kingdom* motif, the *family* motif, and the *discipleship* motif.

There is Trinitarian ordering in *three structural images in the ethical teaching of Paul*—which are becoming a *counter-community*, bearing *the cross*, and living as *new creations*.

There is Trinitarian ordering in *three ways of assessing Christian conduct*—which are in *holiness*, *righteousness*, and *blamelessness* (1 Thess 2:10).

There is Trinitarian ordering in *three virtues essential to living the Christian life*—which are *faith*, *hope*, and *love* (Rom 5:2-5; 1 Cor 13:13; Gal 5:5-6; Col 1:4-5; 1 Thess 1:3; 1 Thess 5:8; Heb 6:10-12; Heb 10:22-24; 1 Pet 1:21-22).

There is Trinitarian ordering in *three stages of salvation*—which are *justification* referring to salvation past (Eph 2:8), *sanctification* referring to salvation present (Phil 2:12), and *glorification* referring to salvation future (1 Pet 1:5).

There is Trinitarian ordering in *three functions of moral law*—which are as a *mirror* exposing sin (Rom 3:20; 7:2), as a *bridle* restraining sin (Gal 3:23-24; 1 Tim 1:9-11), and as a lamp revealing the path of righteousness (Ps 119:105; Prov 6:23).

There is Trinitarian ordering in *three classifications of Old Testament Scripture affirmed by Jesus in Luke 24:44*—which are the *Law* (hrfwOt%), the *Prophets* (My) iybin;), and the *Writings* (Mybiw@tk%;).

There is Trinitarian ordering in *three components of the moral self in 1 Thessalonians 5:23*—which are a *spiritual self* (to; pneu`ma), a *mental* self (hJ yuch;), and a *physical* self (to; sw`ma).

There is Trinitarian ordering in *three ways we must love God*—which are to "love the Lord your God with all your *heart*, with all your *soul*, and with all your *mind*" (Matt 22:37).

There is Trinitarian ordering in *three factors sustaining ethical life*—which are that it must come "from a pure heart, a good conscience, and a sincere faith" (1 Tim 1:5).

There is Trinitarian ordering in *three parts to the moral mission of the Holy Spirit*—which is to convict the world of *sin*, *righteousness*, and *judgment* (John 16:8-11).

And there is Trinitarian ordering in *three things that turn men away from loving God*—which are *lust of the flesh*, *lust of the eyes*, and *pride of life* (1 John 2:16).

That we find so many triadic references in moral revelation indicates something deeper, which is the Trinitarian nature of God himself. God's ordering of ethical reality is Trinitarian because God is Trinitarian. The point made here is not that we never find other things added to any of these triads, because we do. For example, Luke adds loving with all our "strength" (Luke 10:27) to the triad of loving God with all our heart, soul, and mind. The point rather is how all these triads present three things as structuring one thing (ethical reality, biblical law, discipleship, Christian conduct, loving God, etc.). They all show something in three parts, or looked at three different ways, which suggests there must be a reason to doing it that way.

The Problem Frame Generates

The problem I have with Frame's method is not with its triadic complexity, nor with how Frame fills his structural classifications with biblical content. I am only concerned with his using philosophical classifications and imposing humanly devised ordering on divine truth ordered by God already. I understand that Frame criticizes the philosophies from which he borrows,[8] and appreciate that he hopes by redefining them to rid them of undesired baggage. But he cannot prevent the many erroneous associations made in the minds of others trying to apply his method to issues like those arising daily in the field of medical ethics. Try as he may, Frame's conception of Christian *deontology* never will be rid of Kantian overtones, his conception of Christian *teleology* never will be rid of Aristotelian overtones, and his conception of Christian *existentialism* never will be rid of Kierkegaardian, Kafkaesque or Sartrean overtones. Frame's adaptation of philosophical classifications in formulating his

triperspectival method is problematic in two ways: first because it uses philosophical classifications in ways philosophers do not recognize, and second because it then imposes these reconceived classifications on revelation ordered by God already in ways other than he supposes.

Frame redefines philosophical classifications so entirely as to sever them from what they mean philosophically. But while that makes theological sense, it leaves me wondering what remaining value Frame sees in using philosophical terms at all. To philosophers *deontology* means thinking moral actions are intrinsically obligatory, regardless of consequences, and not because they come from any ruler.[9] Right actions may be inspired by prudence or benevolence but are obligatory unrelated to anything beyond themselves.[10] In other words, philosophically speaking, *deontology* is not a term for just any sense of duty and does not include commands of God backed by divine punishments and rewards as Frame supposes.[11] To philosophers *teleology* means thinking achieving "good" is more important than doing "right" and supposing everything has a single purpose found in a non-moral inner power or principle directing it to its natural form.[12] To be philosophically precise, *teleology* is not the same as consequentialism and does not refer to serving goals just any way at all,[13] and so is not comparable to Christians seeking the glory of God, as Frame suggests.[14] To philosophers *existentialism* means thinking individuals are ultimate, ethics is a matter of sovereign choosing, life has no intrinsic meaning, or experience is the ultimate reality.[15] Thus, philosophers do not use *existentialism* for dealing with a person's inner life any way at all as Frame presumes.[16] And to philosophers *situationism* means thinking moral principles are unreal and right decisions require following one ultimate social ideal (like do the loving thing) as assessed by individuals each for him or herself,[17] whereas Frame thinks *situationism* can be non-relative,[18] is *teleological*,[19] and is compatible with the unchanging God and all He commands.[20]

This leads me to think Frame's structural categories are neither good philosophy nor good theology. He tries to adapt philosophical classifications, but in doing so leaves them with little integrity either way. This means Frame's triperspectival methodology is confused and may even mislead. It is like running a sandwich shop next to a car dealership and naming menu items for cars. You may claim you are selling "cars" like the dealership next door because you are calling a slice of ham served between slices of bread a "Mercedes." But insisting your ham sandwich really is a "Mercedes" must either confuse customers or give them false expectations. Those looking for a meal will wonder what they are getting and those looking to buy cars will not buy them from you.

Correcting Frame's Philosophical Paradigm

If Frame's paradigmatic categories need correcting, which of the Trinitarian categories already in Scripture should be used to revise his structure of analysis? We might consider how the Bible distinguishes conduct, character, and goals, but these are separate elements comprising a larger reality and do not each characterize that reality as a whole. So, rather than using conduct, character, and goals, I propose using the way moral revelation in Scripture presents the totality of ethical reality as having three aspects, which are that all we are and do must conform to the *holiness* of God, that all we are and do must express the *love* of God, and that all we are and do

must be for the *glory* of God. These are in a way not that different from Frame's three categories. But they are genuinely theological and carry no philosophical baggage. They need no redefining, do not raise false expectations, and questions of right interpretation take us back to the Word of God—not to the words of men.

A Closing Example

I will close by showing how the Trinitarian model I think corrects Frame's approach—the one structured by the *holiness*, *love*, and *glory* of God—might apply to the case of "The Surrogate Pianist" that C. Ben Mitchell and D. Joy Riley present in their book, *Christian Bioethics*.[21] The case involves a single woman paid to play the piano for services at an Evangelical church. Without telling anyone, this woman becomes a surrogate mother for her sister who is married but has a uterine condition making it impossible to carry a baby to term. The pianist did this out of compassion, not for remuneration, and is already six months pregnant before the senior pastor learns of her pregnancy. Has she done something immoral calling for repentance and church discipline? Has she done something pure and beautiful calling for praise? Or does this call for analyzing risks and making decisions that vary with circumstances?

Using only the information Mitchell and Riley provide for this case, I would say the *holiness* of God leads to considering how gestating human life outside the marital union violates something holy to God. Jesus once explained that in the eyes of God, what is unique to marriage is not limited only to genital sex but includes far more, even thoughts (Matt 5:28), and gestating life is more necessary to human generation than mere thoughts. I would say the *love* of God would lead to commending the compassion this pianist had for her sister's plight, but not to the extent of justifying action contrary to the *holiness* of God. And I would say the *glory* of God is best served by trusting His power to control fertility and honoring how He orders human reproduction to affirm and strengthen marital union, parental duty, and the chain of personal identity by which one generation connects with the next.

Thus I would tell the senior pastor to be gentle yet firm, to commend the pianist for having compassion while explaining that what she did violated something holy to God and was for that reason sinful, to have her repent for what she did before the whole church while challenging the church to forgive and support her through the rest of her pregnancy, and then to use this situation to teach everyone in the church about the holiness of marriage, procreation, and gestation and how family decisions have public significance to the Christian community. And lastly, if she does this, I would advise that God's *holiness*, *love*, and *glory* together suggest going on to bless this unmarried woman by keeping her on as church pianist through the rest of her pregnancy and looking for ways to assist her through what for her most likely will be a highly stressful process.

Endnotes

1. See John M. Frame, *Medical Ethics: Principles, Persons, and Problems* (Phillipsburg, NJ: Presbyterian & Reformed, 1988).
2. John M. Frame, *Medical Ethics: Principles, Persons, and Problems* (Phillipsburg, NJ: Presbyterian & Reformed, 1988), 6. My emphasis.
3. John M. Frame, *The Doctrine of the Christian Life* (Phillipsburg, NJ: Presbyterian & Reformed, 2008), 73.

4. John M. Frame, *Cornelius Van Til: An Analysis of His Thought* (Phillipsburg, NJ: Presbyterian & Reformed, 1995, 46.
5. Frame, *Christian Life*, 27.
6. I agree with Pannenberg who says what sets theological ethics apart from philosophy is not the degree to which one or the other does or does not use reason, but rather is the opposed ways each conceives "its ethical foundation." Wolfhart Pannenberg, *Ethics*, trans. Keith Crim (Philadelphia: Westminster, 1981), 57. What I refer to here as "starting point" means the same thing. This means I do not agree with Van Til's claim that, "for Christians the difference between theological and philosophical ethics can be no more than one of emphasis." Cornelius Van Til, *Christian Theistic Ethics* (Kingsburg, CA: Dulk Christian Foundation, 1974), 5. By using "emphasis" for the distinction, Van Til supposes the difference between what God reveals and men conceive is nothing more than a matter of stress or focus. That is, Van Til supposes there is no difference other than variations explained by which part of the same reality is in view. That I think is both wrong and dangerous. What distinguishes revealed ethics from what men conceive is foundational, not focal, and is a matter of supremacy, not stress.
7. Emile Brunner held the main difference between philosophical and Christian ethics is what each presumes about the source of ultimate authority, with one looking to man and the other to God. Emil Brunner, *The Divine Imperative*, trans. Olive Wyon (Philadelphia: Westminster, 1947), 86.
8. Ibid., 124.
9. J. P. Moreland and William Lane Craig, *Philosophical Foundations for a Christian Worldview* (Downers Grove, IL: InterVarsity Press, 2003), 425, 446-447.
10. William Lillie, *An Introduction to Ethics* (London: Methuen, 1957), 100; Robert G. Olson, "Deontological Ethics," in *The Encyclopedia of Philosophy*, v. 2 (New York: Macmillan, 1967), 343.
11. Frame, *Christian Life*, 33-34, 50, 132-143.
12. Robert G. Olson, "Teleological Ethics," in *The Encyclopedia of Philosophy*, v. 8 (New York: Macmillan, 1967), 88.
13. To be fair, Frame is not the only one who conflates teleology with consequentialism. Norman Geisler did years ago (Norman L. Geisler, *Ethics: Alternatives and Issues* [Grand Rapids, MI: Zondervan, 1971], 20), and Geoffrey Thomas did more recently (Geoffrey Thomas, *An Introduction to Ethics* [Indianapolis, IN: Hackett, 1993], 92). For clarification see: Craig V. Mitchell, *Charts of Philosophy and Philosophers* [Grand Rapids, MI: Zondervan, 2007], charts 19, 27, 43; John S. Mackenzie, *A Manuel of Ethics*, 4th ed. [New York: Hinds, Hayden and Eldredge, 1901], 244-248); and Moreland and Craig, 455.
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The Higher-Brain Concept of Death: A Christian Theological Appraisal

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In the practice of Critical Care Medicine, an all-too-frequent scenario involves the care of a patient who is progressing toward a possible state of whole brain death (WBD). Clinical energies which have hitherto been focused on saving life are shifted to confirming what is held to be, by law, a state of actual death, and by law, the regional Organ Procurement Organization (OPO) must be contacted, who will in turn determine the donor-potential of the patient. The OPO is concerned with not just one patient, but hundreds, and many of these will die, should they fail to receive an organ transplant.[1] Much, and for many, hangs on the determination of death.

The significant "supply-demand" imbalance for transplantable organs has generated a number of initiatives designed to make available for transplantation an optimum number of maximally viable organs. One such proposal is to broaden the current criteria that establish brain death to include a determination of death based on the loss of so-called "higher-brain" function, whereby a person, typically a patient in persistent vegetative state (PVS) who has permanent loss of consciousness but continues to breathe unassisted, could be pronounced dead and their organs potentially made available.

The purpose of this essay is to explore the higher-brain death (HBD) criterion, to identify arguments supporting and opposing the proposal, and to locate this proposal, broadly speaking, within the contemporary brain death debate. Finally, the essay will engage the question of how the proposal might be viewed in Christian thought, and whether it may be endorsed from a Christian standpoint.

In this endeavor, it is necessary to acknowledge the inevitable inconsistency of terminology among the concepts of "spirit," "soul," and "mind" across philosophical presuppositions and across history. For the purposes of this appraisal, we will employ a concept of "mind" as articulated by J.P. Moreland: "The mind is that faculty of the soul that contains thoughts and beliefs along with the relevant abilities to have them. . . . The spirit is that faculty of the soul through which the person relates to God."[2]

Less than a year after the first successful human heart transplant, the medical community foresaw the inevitable need for more organs. In 1968, the *Journal of the American Medical Association (JAMA)* published the report of the Harvard Ad-Hoc committee on the definition of irreversible coma;[3] the stated intent of the report was to make hospital beds available, and to increase the number of organs which might be made available for donation. There followed in 1981 the President's Commission Report on Defining Death, which concluded that death could be established by either a cardio-respiratory or a whole-brain death criterion.[4] The Commission's recommendations were codified in the Uniform Definition of Death Act (UDDA); the "dead donor rule" which followed is a philosophical synthesis of the UDDA and homicide law, and establishes that no organ may be procured from anyone who is not dead by one of these criteria.[5]

In 2009, The President's Council on Bioethics (PCB) issued a *White Paper Report on Controversies Surrounding the Determination of Death,* which, acknowledging difficulties associated with the concept of WBD, reaffirmed that the diagnosis of death may be made either by WBD, designated by the Council to be "Total Brain Failure" (TBF), or by cardio-respiratory criteria.[6] The Council affirmed the essential 'unified organism status' of human life, the biological single-event nature of death, and the inevitability of death.[7] This construct is ascendant in philosophy, law, and medical practice, and provides the necessary starting point for this discussion. Current practice is prescribed in the PCB 2009 report.[8] The council acknowledged but rejected alternative brain death criteria proposals, including HBD.

To be sure, the WBD/TBF formula is not without controversy. Critical Care practitioner and ethicist Robert Truog summarizes the obvious "questions about whether patients with massive brain injury, apnea, and loss of brain stem reflexes are really dead. After all . . . these patients [when supported by mechanical ventilation] look very much alive: they are warm and pink; they digest and metabolize food, excrete waste, undergo sexual maturation, and can even reproduce."[9] More substantively, D. Alan Shewmon articulates the confusion inherent in brain death language and terminology, well known to intensive care physicians.[10] Further, he delineates the flawed scientific methodology whereby TBF as a concept was developed, and calls into question the reliability and therefore the ethical acceptability of the apnea test, which is the definitive diagnostic test for WBD/TBF.[11]

Robert Veatch is arguably the premier advocate for a change in practice and policy to a HBD criterion. Agreeing with Shewmon, Veatch's argument hinges on the notion that the "whole" brain criterion cannot possibly be "whole," given that, despite the irreversible loss of consciousness and of brainstem function, neuroendocrine cells within the brain necessarily continue to be active in patients declared to be brain dead; hence the aforementioned physiological homeostasis. This inconsistency of concept and terminology invites Veatch to opine, "If one is to retain a neurologically based concept of death, it is terribly implausible to insist that all functions of the brain must be lost irreversibly. Every reasonable defender of brain-based death pronouncements must exclude some functions, opening up the question of just which functions should be excluded."[12]

Veatch correctly points out that the definition of death, which he considers to be a matter of philosophy, religion, and public policy, must be distinct from the medical criteria that establish death;[13] but in proposing possible answers to his question, Veatch makes a subtle but important shift from a biological to a "personhood" rationale.[14] He lists several options for what might constitute personhood: (1) the capacity for rationality, (2) self-awareness of personal identity, (3) the capacity to experience, and (4) the capacity for social interaction.[15] The first of these he rejects on the observation that "babies are living in a human sense, in spite of the fact that they have never executed reasoning function."[16] On similar grounds he rejects the second option.

But in a synthesis of the third and fourth options (capacity to experience and to have social interaction), Veatch finds his answer. "We opt for the general formulation that a human is dead when there is irreversible loss of embodied capacity for consciousness. This would make those who have lost all functions of the entire brain dead, of course; but it would also include those who lack consciousness, which

includes the permanently comatose, the permanently vegetative, and the anencephalic infant to the extent that these groups can be identified."[17] And, for these patients, 'death behaviors' (grieving, burial, etc) may commence.[18] Veatch has linked his HBD construct to organ procurement, by way of advance directive- or surrogate-mediated consent.[19] Finally, Veatch endorses a 'conscience clause,' that is, the freedom of individuals to select, also by advance directive or surrogate consent, which criteria for death (circulatory, WBD/TBF, or HBD) they wish to have applied to themselves,[20] and more recently has proposed wording for a change in public policy and law to make such an option available.[21]

Others have embraced Veatch's HBD formula, albeit with some variation of rationale. Jeff McMahan endorses HBD on the basis of arguments from 'non-organism' and from 'dicephaly.' In the first instance, McMahan asserts, "Whether we are organisms is . . . not an ethical question. It is a metaphysical one."[22] He denies a human's biologic status as an *organism*, based on the hypothetical transplant of his own cerebrum, leaving his own brainstem and body (i.e., his *organism*) behind. "Since I can thus in principle exist separately from my organism that is now mine, I cannot be identified with it."[23] In the second instance (dicephalic individuals), the question is *to which* of the 'persons' does the organism of the body belong? Because he cannot assign 'organism' status to individuals, he proposes that we are, instead, embodied minds. "What is important to determine is when we die in a nonbiologic sense—that is, when we cease to exist. If we are embodied minds, we die or cease to exist when we irreversibly lose the capacity for consciousness . . . ."[24]

John Lizza moves the argument more definitively into the 'personhood' arena. Indicting the Commission's assertion that there is no philosophical consensus on what constitutes personhood,[25] Lizza, citing Aristotle's contention that "'rationality' is an essential property of man,"[26] invokes a litany of philosophers who actually agree in "the belief that some type of cognitive function is necessary for something to be a person."[27] Lizza also disputes the PCB's rejection of the HBD formula: "[I]t is important to distinguish the question of whether the higher brain formulation can be clearly articulated from the question of whether we have adequate medical criteria for determining whether someone has died under that formulation. The formulation that death has occurred [by HBD criteria] is itself, quite clear."[28] Implicit in Lizza's argument are the notions that the diagnosis of PVS can be made with certainty, that it is certain that these patients lack *any* capacity for conscious awareness, and that his philosophers' 'consensus' of what constitutes personhood is normative.

Lizza subsequently has developed his HBD construct.

> The alternative [i.e., HBD] to this medical or biological paradigm of death is to think that death is a metaphysical, ethical and cultural phenomenon in *as equally a fundamental sense* as it is a biological phenomenon. The definition and criteria of death are therefore as much matters involving metaphysical reflection, moral choice, and cultural acceptance as they are biological facts to be discovered. . . . It [the alternative paradigm] promotes an understanding of our nature as beings that are open ended rather than timelessly fixed, as having an active role in creating and determining the bounds of our being rather than being passive recipients of physical forces.[29]

Against this backdrop, and liberated from a strictly biological definition of death, Lizza may then agree with Veatch and McMahan that death may be metaphysically *assigned* based on the 'locus' of personhood, namely, the capacity for consciousness. Their views are reminiscent of the "consciousness criterion" for personhood of John Locke. "For Locke," says Providence College Professor Joseph Torchia, "personhood presupposes conscious awareness of *self as self* . . . personhood becomes the superogatory attribute that *some individuals* possess and others do not, depending on the quality of their conscious experience."[30]

Lizza continues, "Advocates of this [the HBD] view understand consciousness and other cognitive functions as dependent on or identical to certain higher brain functions, and when those brain functions cease, the human being or person dies. Individuals in a permanent vegetative state…are therefore considered dead."[31] He complains that Veatch, influenced by the "traditional Judeo-Christian concept of a human being as an essential union of mind and body,"[32] has "explicitly avoided"[33] the inevitable conclusion of the higher-brain paradigm, that is, that it must reside either in a "Cartesian dualism" of mind and body,[34] or in a *substantive* concept of personhood.[35] "If there is some sense . . . to the existentialist idea that our nature is not fixed and that we can create, at least in part, who we are, then personhood and personal identity should be approached more as open-ended projects than as realities determined by factors independent of the choices we make."[36] Lizza sums up what might be a 'manifesto': "We need to ask what it is we want to become. We need to be open to the possibility that, just as there are new ways in which we can live, there may be new ways in which we can die."[37]

Both McMahan and Lizza, then, invoke a mind-body hierarchical dualism—the self, as it were, may exist independently of the body and of bodily constraints, which, finally, are irrelevant to who the individual is or can become. For Lizza, the "factors independent of the choices we make" are necessarily biological. McMahan frankly denies that we require or possess "organism status" at all.

HBD proponents, then, despite some variations in rationale, resolutely insist that personhood is contingent upon, and is defined by, the ability to have consciousness. As St. Louis University Ethics Professor Jeffrey Bishop puts it, in the HBD concept, "persons occupy the space of the neocortex, or more abstractly, persons occupy the intangible space of neocortical function."[38] All HBD proponents declare that persons who have permanently lost neocortical function, the ability to interact with their environment, to be dead, regardless of their ability to breathe. They "cease to exist." Death behaviors may be embarked upon, and, with 'proper' consent, organs may be procured. Indeed, advocates of a shift in public policy and law favoring HBD assert that a person is autonomous over the remnant organism that once was theirs—autonomous to the point of choosing to let 'it' die or be killed.

Opponents of the HBD formula have argued on moral, biological, philosophical, and theological grounds. On the one hand, virtue ethicist Edmund Pellegrino opposed any formulation of brain death, including WBD/TBF, on grounds of lack of moral certainty.[39] On the other hand, utilitarian ethicist Robert Truog states, "Veatch argues that the crux of the issue is a moral decision about when patients can be treated 'as if they are dead,' [death behaviors, for example] rather than an ontological decision about whether or not they are dead." And Truog rejects Veatch's 'conscience clause.'[40]

Neurologist James Bernat acknowledges at least one concern raised by Shewmon: "We all agree that by 'death' we do not require the cessation of functioning of every cell in the body."[41] But he states that Veatch's HBD formula "contains a fatal flaw . . . it is not what we mean when we say 'death.'" He points out that no society, culture, or law understands patients with PVS to be dead. "Thus," he says, "the higher-brain formulation fails . . . to make explicit our underlying consensual conception of death and not to contrive a new definition of death."[42] Bernat's biological construct is strengthened by a provocative study in which neurologists, using advanced neurophysiologic imaging, detected awareness in a patient confirmed to have PVS,[43] a finding which, if confirmed, does violence to Lizza's assertion of accuracy and the finality of this diagnosis.

Ethicist David DeGrazia similarly affirms a biologic, or 'organismic,' definition of death; additionally, he offers philosophical arguments against the personhood and moral cases for HBD. "I submit that the patient [for example, with PVS] is alive, because it seems that the organism as a whole—as an integrated unit of interdependent subsystems—continues to function, despite the loss of consciousness."[44] DeGrazia points out, contra Lizza, that the capacity for consciousness is "*necessary but not nearly sufficient* for personhood."[45] Additionally, he notes internal inconsistency in Veatch's claim that death carries moral duty—'death behaviors.' "A more promising view is that death is primarily a biological concept that, at least in the human case, *is morally very salient due to a relatively stable background of social institutions and attitudes.*"[46]

The HBD/WBD/TBF and its interface with formulations of personhood are merging in the public sphere in the literature of organ procurement and transplantation. The public is understandably confused over terms and concepts.[47] Given the gravity of the issue of defining death and the immense need of potential organ recipients, the matter is of urgent practical concern.

Clearly, the issues surrounding the definition of death and its relationship to personhood are of significant theological and pastoral moment. How must the concept of higher-brain death be regarded in Christian thought? Let us look first at currently available ethical guidelines before exploring their metaphysical and theological backdrop.

Roman Catholic and Protestant organizations do not recognize patients in PVS to be dead. On the contrary, the *Ethical and Religious Directives (ERD) for Catholic Healthcare Services* endorse the ongoing care for these patients including the provision of nutrition via feeding tube,[48] and the Christian Medical and Dental Association (CMDA), a predominantly Protestant organization, holds PVS patients to be "neither dead nor less than human."[49]

The higher-brain criterion does, however, find adherents among certain Eastern Orthodox writers. Orthodox Protodeacon Basil Andruchow, in an educational article for Orthodox lay readers, states that "the criterion for life is brain activity within the cerebral cortex. It is activity in that region of the brain that defines the human condition."[50] Orthodox priest Fr. John Breck, in a text covering Orthodox Christian bioethics for a lay public, states that PVS is "often referred to as brain death . . . the death of the cerebrum indicates that the soul, in liturgical language, has 'left the body,' and the person as such is dead."[51] Similarly, Stanley Harakas, Professor

Emeritus of Orthodox Theology at Holy Cross Greek Orthodox Seminary, states in a multi-faith series on healthcare decisions, "Generally, the Orthodox recognize death as the cessation of higher human capacities concurrent with the demise of the cerebral cortex, even though lower brain stem activities may remain."[52]

It would seem, therefore that some Orthodox writers differ from Catholic and Protestant ethicists on this particular issue.

Ethicist Gilbert Meilaender of Valparaiso University articulates what is likely a more widespread Christian understanding as he consolidates philosophical and Christian arguments against a 'personhood' construct that would be typical of HBD. While not mentioning HBD specifically, he does allude to the dualistic thinking that is foundational to McMahan's and Lizza's arguments. He is intrigued that such thinking has a following today. "In an age supposedly dominated by modes of thought more natural and historical than metaphysical, we have allowed ourselves to think of personhood in terms quite divorced from our biological nature or the history of our embodied selves."[53] Biological life, however disabled, is not able to be separated from who we are, and who we are meant to become, that is, from our 'personhood.' "To live the risen life with God is, presumably, to be what we are meant to be. It is the fulfillment and completion of one's personal history."[54] That history is manifest during this fallen biological life ". . . before we are conscious of it and, for many of us, continues after we have lost consciousness of it."[55] Further, Meilaender identifies the connection between a dualistic personhood construct and the 'pretention' and contradictoriness of autonomy,[56] whereby an autonomous 'self' presumes to dictate parameters of life and death onto the 'other' of the organism.

A Christian appraisal of HBD will hinge, in the obvious absence of specific Biblical texts, on that which may be inferred from the tenets of creedal orthodoxy under metaphysical and systematic theological doctrines of anthropology and Christology. Pre-suppositional for Christians are the biological life of Adam—humankind—and the biological life of God the Son in His Incarnation. But Meilaender has correctly located additional grounds on which one must engage the question of HBD. Since Lizza, McMahan, and, by implication, Veatch, have invoked a hierarchical dualistic construct of personhood, a Christian evaluation must address this very construct. We turn to the Church's understanding of personhood, from antiquity.

Torchia states, "The dichotomies between soul and body, spirit and matter, are largely alien to the creation accounts of the Old Testament, where God creates the whole human being. . . . This emphasis on human unity carries over into the New Testament as well." Regardless, he says, there is a considerable 'spiritualistic emphasis' found in both gospel and epistle. "A Christian account of our humanness bears the special burden of navigating between two worlds [that is, the spiritual and the bodily], so to speak, and thereby uphold the unity of every human person."[57]

It is widely appreciated that St. Augustine of Hippo (AD 354-430) was heavily influenced by the Neoplatonism of his day, and struggled in his early thought with the notion that the mind, or soul, was "closest to God among created things."[58] However, even in his early writing, he does articulate a unitary concept of personhood. He states in *De Moribus*, "although they are two things it might happen that one of these would be looked upon and spoken of as man."[59] In his mature writing, Augustine had adapted the composite view of man, which is a "'harmonious union' of the inner man

of the spirit and the outer man of the flesh," and according to which neither soul nor body is ascendant in this composite.[60] Augustine illustrates: ". . . is it neither the soul by itself nor the body by itself that constitutes the man, but the two combined, the soul and the body each being part of him but the whole man consisting of both? This would be analogous to applying the term 'pair' to two horses yoked together . . . we do not call either of them . . . a pair, but only use that term of the two in combination."[61]

St. Thomas Aquinas (d. 1274) also recognized a composite view of soul and body, endorsing Augustine's assessment in *City of God*.[62] "In keeping with the general thrust of Pauline anthropology, Aquinas stresses a unitary conception of our humanity . . . he defines humans as composites of the formal principle of the soul and the material substrate of the body. The soul is thus conjoined with the body in an inextricable union comprising one substantial reality."[63]

Most pertinent to the issue at hand, Torchia observes,

> In contemporary terms, Aquinas's understanding of humans as substantial unities of soul and body implies that the soul cannot be confined to (or localized in) some part of the body (e.g., the brain) or bound up exclusively with physiological processes (e.g., brain wave activity, consciousness, or receptivity to feelings of pleasure or pain). For him, however, rationality . . . defines the parameters of our humanity. In this regard, rationality is not viewed as a behavioral characteristic. . . . Rather, it assumes a definitional significance, as a means of designating those who are spiritual and intellectual beings *by their very nature*, regardless of the quality of their rational output. Aquinas by no means views rationality in the exclusionary sense of contemporary thought, whereby one who lacks the complete use of reason is somehow barred from the moral community and emptied of intrinsic value. One cannot lose what one is by definition as a human being.[64]

Aquinas's thought has informed centuries of Catholic thought. The Second Vatican Council attests to the essential union of body and soul:

> Though made of body and soul, man is one. Through his bodily composition he gathers to himself the elements of the material world; thus they reach their crown through him, and through him raise their voice in free praise of the Creator. For this reason man is not allowed to despise his bodily life, rather he is obliged to regard his body as good and honorable since God has created it and will raise it up on the last day.[65]

More recently, Pope John Paul II affirmed both a "universal human nature" and "that each human person" remains a remarkable psychophysical unity."[66] At no point in the documents of the Second Vatican Council or in John Paul II's thought is there invoked a hierarchical metaphysical relationship of soul (or mind) over body.

The ancient consensus of personhood as a body and soul composite is shared also by the Reformed tradition, was articulated by John Calvin in 1536,[67] and developed, among others, by Herman Bavinck, who contends that the *whole person is* the image of God. Regarding the doctrine of human creation, he states, "[I]t follows . . . that this image extends to the whole person . . . and he is such totally, in soul and body, in all his faculties and powers, in all conditions and relations."[68] "Man has a spirit (*pneuma*)," he says, "but that 'spirit' is psychically organized and must, by virtue of its nature, inhabit a body. It is of the essence of humanity to be corporeal and

sentient."[69] Notably, he points out that of body and soul, the body was formed first, and into it the breath of life was breathed (Gen 2:7).[70] As Thiago Silva observes, "[B]ody and soul are so intimately connected with each other that both are part of and belong to the image of God in human beings."[71] Bavinck articulates this intimacy in a way that has bearing on the issue at hand:

> It is so intimate that one nature, one person, one self is the subject of both and of all their activities. It is always the same soul that peers through the eyes, thinks through the brain, grasps with the hands, and walks with the feet. Although not always present in every part of the body in its full strength . . . it is nevertheless present in all parts in its whole essence . . . . It is one and the same life that flows throughout the body but operates and manifests itself in every organ in a manner peculiar to that organ.[72]

It is necessary to return briefly to the Eastern Orthodox approach to personhood. Despite the endorsement of a HBD construct among some Orthodox ethics writers, other Orthodox theologians are more cautious, arguing that such positions are out of keeping with the moral theological tenets of an Orthodox anthropology. As we begin, physician, ethicist, and Eastern Orthodox believer H. Tristram Engelhardt reminds us of how far the East is from the West on matters of theological approach: "Western Christianity and Western secular moral thought have in great measure sought to articulate morality and bioethics as if they could be adequately understood on the basis of experience and reflection outside a life rightly aimed at God."[73] He traces this philosophical tendency to Augustine and to a "mid-second-millennial confidence in secular discursive reasoning that spanned from Scholasticism to the Enlightenment." An Orthodox morality, he suggests, bypasses much of the influence of the philosophical enquiry of this period, and appeals directly to Holy Scripture and to the Church Fathers, given their historical, cultural, and spiritual proximity to Christ and the apostles themselves.[74]

As to the specific concept of personhood, Orthodox theologian Vladimir Lossky cautions against reading that very 'second millennial' philosophy into the Fathers:

> I would have had to ask myself . . . to what degree this wish to find a doctrine of the human person among the Fathers of the first centuries is legitimate. Would this not be trying to attribute to them certain ideas which may have remained unknown to them and which we would nevertheless attribute to them without realizing how much, in our way of conceiving the human person, we depend upon a complex philosophical tradition . . . very different from the one which could claim to be part of a properly theological tradition?[75]

With this background, Hilarion Alfeyev, Bishop of the Moscow Patriarchate, explains that according to Orthodox thought, human beings, created in the image of God, are in fact *hypostases*, patterned after the eternal *Hypostases* (that is, the three Persons) of the Holy Trinity. John Zizioulas, late Metropolitan of Pergamon states that whereas the term 'hypostasis' originally was never related to the term 'person,' it came over time to embrace what the West now calls personhood, but in continuity with what constitutes the substance (ousias) of human beings generally. "From this endeavor came the identification of hypostasis with person."[76]

Both Zizioulas and Lossky do 'overhear' an anthropology in Patristic thought that is fundamentally tied to humankind's hypostasis being the inevitable creative

work and manifestation of the Trinitarian hypostasis. Since the hypostases of the Triune God are distinguished by their internal relationship one to another, and not by characteristics or qualities, a hypostasis of personhood is to be understood relationally, and not confined to any particular characteristic, quality, or anatomic locus.

Professor Christos Yannaras of Panteon University in Athens agrees:

> What man *is*, then, his hypostasis, cannot be identified either with his body or with his soul. It is only *given effect*, expressed and revealed by its bodily or spiritual functions. Therefore no bodily infirmity, injury or deformity and no mental illness, loss of power of speech or dementia can touch the truth of any man, the inmost *I* which constitutes him as an existential event.[77]

Similarly, Professor Daniel Varghese of St. Vladimirs Seminary states that, according to Eastern Orthodox thought, all human beings are created in God's image "irrespective of the development of organs. Consequently Orthodoxy could reject the arguments for denial of personhood based only on biological or cognitive capabilities . . . . The intellect or reason is not the dominant factor to determine whether a being is a person or not."[78]

The consensus that the human person is the intimate, composite, psychosomatic *hypostasis* of body and soul is thus deeply and widely held throughout Eastern and Western Christian thought and across Christian history, reflecting the clear teaching of Holy Scripture in Old and New Testaments. From the mature thought of Augustine, through Aquinas, and to the present, "personhood" is constituted by what Calvin Seminary professor John Cooper refers to as a *holistic dualism*,[79] to which the idea of a mind-over-body-hierarchical relationship is foreign. Christ's bodily resurrection is the final seal of a fundamental union of body and soul.

The practice of organ transplantation itself is embraced by most Christian traditions,[80] as is the WBD/TBF formula. Pope John Paul II affirmed the concept and practice of WBD in 2000;[81] it is endorsed by Protestant and Reformed,[82] Eastern Orthodox,[83] and Coptic[84] traditions.

Bishop has detailed extensively the political, economical, and philosophical forces which were strategic in establishing the practice of organ transplantation as the practice of WBD/TBF unfolded.[85] Recognizing that "standards of research are relative to their historical circumstance,"[86] he locates the entire evolution of the definition of death in the setting of an organ procurement agenda. Within a greater context, he says, is the paradox that medicine—while serving the preservation of life—is largely unable to accomplish this outside of death itself dictating the terms.[87] One cannot, for example, obtain life from certain transplants unless someone else dies.

But the organ supply-demand gap remains wide, and is very much in the public eye. The question of what constitutes personhood has been brought into the fray.

Lizza and McMahan deploy a concept in which personhood itself is distinct from the physical body, or organism. The organism, McMahan contends, may continue to live, but the person is dead. Although Veatch does not articulate such a dualism in terms quite so extreme, his conclusions, especially regarding 'death behaviors,' necessarily embrace this very notion. Finally, under the HBD theory of these three authors, the 'late' person is able, by advanced or surrogate consent, to execute

biological life-ending authority over the living, breathing body. It is on these points that Christians must pause.

Holy Scripture and Church tradition affirm the absolute sacredness of every human life. The prohibition of taking life is established in Genesis, codified in Mosaic Law, and affirmed and interpreted in its fullest by Christ Himself. This very sacredness is never to be subjected to the assignment, by any temporal authority, of a philosophically derived construct of "personhood," not to mention the assignment of a putative anatomic-physiologic locus of such a construct. This is, of course, precisely what Veatch and others have attempted. Under the HBD agenda, human sacredness becomes, in one group (those in PVS) relatively less sacred than the sacredness of another group (those in need of an organ transplant). Those in PVS, according to Veatch, may be declared dead—which is another way of saying, in the face of majority opinion across Christian traditions, that such patients have *lebensunwertes leben,* life not worth living.

The inevitable implication of the HBD view is the endorsement of a mind-over-body dualism that permits the determination of death, under Veatch's conscience clause, based on a false appropriation of autonomy. By autonomous choice, a patient may request that he be declared dead by advance or surrogate decision, even if he is yet alive. The resulting action may be assisted death, with or without the procuring of organs. Regarding this question of autonomy, Georgetown University ethicist Edmund Pellegrino has stated,

> [I]n ethics generally and medical ethics in particular, autonomy, freedom, and the supremacy of private judgment have become moral absolutes. On this view, human freedom extends to absolute mastery over one's life, a mastery which extends to being killed or assisted in suicide so long as these are voluntary acts . . . . For the Christian, this is a distorted sense of freedom that denies life as a gift of God over which we have been given stewardship as with other good things.[88]

Christians, then, must reject the higher-brain criterion for death as articulated by Veatch and others. The assertion of autonomy presumes to usurp God's sovereignty over life, which is the inevitable outworking of Veatch's, McMahan's and Lizza's dualism in HBD. One may agree with Bishop that the entire history of the concept of brain-death has been driven and tainted by an organ procurement agenda. However, it may be argued that Christians may in good faith affirm organ transplantation as a practice, along with currently practiced WBD/TBF formulations.

The currently accepted practice of declaring death by traditional circulatory criteria or by whole brain criteria holds in balance the deep needs and sacredness of the patient awaiting an organ transplant as well as the sacredness of the patient who may become an organ donor. This practice holds at bay the menace of a man-made personhood dualism of mind over body. For Christians to embrace a higher-brain criterion for death requires the embrace of a lethal anthropological heresy, the inevitable outcome of which is that sacredness of human life becomes relative rather than absolute, and that living persons become subject to exploitation and death.

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Book Reviews

Empathy and Morality

Heidi L. Maibom, Editor: Oxford University Press, 2014.
ISBN 978-0199969470, 320 PAGES, CLOTH, $69.00.

The aim of this edited volume is to explore the role of empathy as it relates to morality. Twelve individual contributors—from the disciplines of philosophy, psychology, psychiatry, anthropology, and neuroscience—address the nuances of this discussion from the perspectives of their disciplines. Virtually all the authors agree on the importance that empathy and empathy-related emotions play in our moral orientation towards others.

An important distinction made in a number of the essays is that of the difference between sympathy (apprehension of another's mental state but not feeling the same feelings as that person) and empathy (the ability to actually feel the other person's pain). Through very careful discussions of empathy and related notions, the book provides various ways of assessing empathy in others, including through the use of imaging of the brain, studying those with autism and psychopaths, psychological test instruments, experiments with subjects, etc. Significant space is devoted in particular to David Hume and Adam Smith, considered by many to be the two major thinkers emphasizing the importance of empathy for morality (a couple mention Aristotle as well).

The book's approach offers a refreshing change to the usual consideration of morality as strongly based in reason. All of the essays contain well-constructed and carefully argued positions. There is deep analysis both for and against the idea of empathy as a source for morality. Having authors from different disciplines adds breadth to the topic, and it is particularly interesting that most come to the same conclusions. As with most edited volumes, though, there is some unevenness—for instance, different authors define key terms differently, and there is some overlap and repetition. Additionally, better titles on some of the essays might help to distinguish perspectives of the various thinkers. However, the book as a whole treats a complicated subject in a very interesting way and forces the reader to think deeply about issues that may not seem, on the surface, to be that complicated. This book is definitely oriented towards a scholarly audience, and would be of interest to scholars in any field who believe that emotions and morality are strongly related. But for those interested in the subject of empathy in general, it is a fascinating read which has the potential to impact how one thinks about morality.

Reviewed by Donna Yarri, PhD (Religious Studies), who is a Professor of Theology at Alvernia University in Reading, Pennsylvania, USA.

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