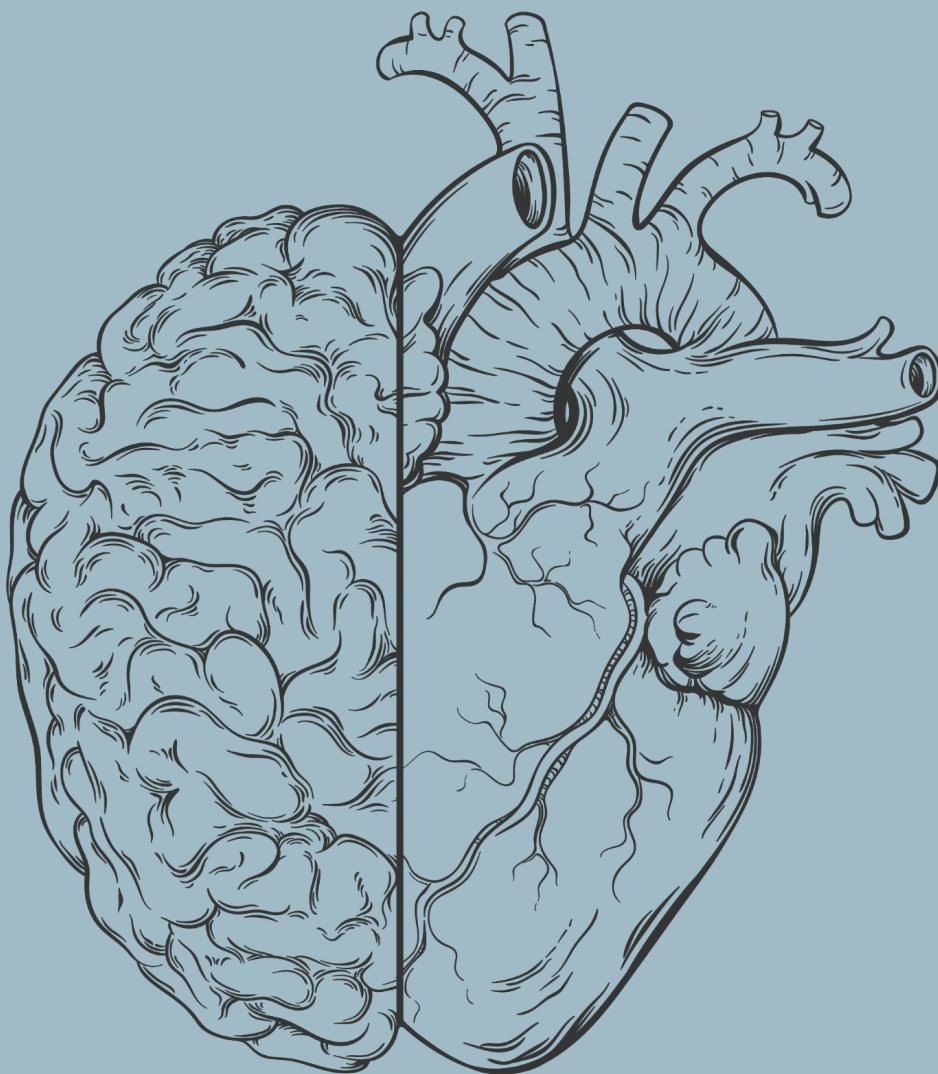


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EDITORIAL

BIOETHICS BY DEFINITION

MICHAEL J. SLEASMAN, PHD

What is bioethics? Or, more specifically, what exactly do you study in bioethics or a bioethics program? Does bioethics include X (whatever the latest news item or hot button topic happens to be)? Whether from prospective students or small talk with new acquaintances, I encounter some variation of these questions on a regular basis. When I first started working in bioethics in the late 2000s, bioethics was not nearly as established in the public consciousness. There were of course individuals, usually in the scientific and medical professions, who were aware of bioethics, but the everyday person usually had no idea what the term meant. Indeed, it was for this reason that several of us regularly worked on “elevator pitches” during my time at The Center for Bioethics & Human Dignity (CBHD). So as to be more accessible, we would often refer to the Center’s work as the ethics of medicine, science, and technology while avoiding as much as possible use of the words “bioethics” and “bioethicist.”

Over the past two decades bioethics has become more familiar, but with that we encountered another challenge: mission creep. Just as awareness of the term grew more common along with interest among prospective students, so too did the scope of things that were covered by bioethics and what was assumed to be covered by the term. Expectations of both internal and external stakeholders pushed for those of us engaged in bioethics to speak to an ever-expanding set of issues and topics. To be sure, bioethics as a field of inquiry itself had grown to encompass more than just clinical/medical ethics, genetic ethics, and research ethics to include the quickly evolving arenas of biotechnology and emerging technology among others—a point that I have reflected on elsewhere under the rubric of Bioethics 2.0 and the technological turn.¹ However, bioethics as a term and interdisciplinary (and for that matter interprofessional) field of study was beginning to feel more like the applied ethics version of the Borg, absorbing every other subspecialty and category of ethics.

It is by now well established that whoever wins the war on terminology has a sizeable rhetorical advantage in the public square. Equally important as the terms themselves is how we define the terms. As I find myself frequently reminding students, one of the fundamental tasks in any good paper is to carefully define your terms and deploy them consistently. Clear definitions assist us in tightening our argumentation, revealing flaws of logic that occur when we conflate divergent concepts and equivocate. Clear definitions also occasionally help to unmask certain assumptions imported into one’s usage of a term.

Part of the broader challenge here is that defining bioethics is itself a contested task. To illustrate this to my first-semester bioethics students, we examine an array of definitions from prominent bioethics scholars, institutions, and publications and then discuss their similarities

Michael J. Sleasman, “Bioethics by Definition,” *Ethics & Medicine* 37, no. 2–3 (2021): 69–72

and differences. There is nothing particularly novel about this as a pedagogical device, but an efficient means to demonstrate the key take away. As the students inevitably identify, such definitions often appear to say more about the source than they do to clarify precisely what is accepted as inside and outside the boundaries of bioethical discourse. Some of the definitions relegate bioethics to a mere evolution of medical ethics, constrained entirely to the domain of biomedicine. Other definitions fixate on specific topical examples, while yet another group focuses on the field as a dialogue between several disciplines and professions around certain applied arenas with no rightful discourse of its own.

Rather than trying to discern if there is contemporary consensus of meaning, another approach to define a term is to try to locate the earliest usage or original meaning. Fortunately, unlike more traditional academic disciplines, the field of bioethical inquiry is relatively young within the academy. Despite first appearing in the work of Fritz Jahr (a German Protestant pastor and philosopher in 1927),² most credit the inaugural use of the term to the work of American biochemist and oncologist Van Rensselaer Potter in 1970.³ Potter advocated for a broad perspective—a “global bioethics”—that explored a more expansive relationship with nature and science. Should this be the preferred understanding? If so, why has environmental bioethics played such a relatively minor role in bioethical inquiry until the most recent decade of discourse?

What becomes clear to the students is that bioethics is a rather flexible, umbrella-like concept covering a wide spectrum of loosely related ethical issues. These issues have emerged alongside an explosion of scientific and technological discoveries relevant primarily to the life and medical sciences, but with ever broadening domains of applications. From traditional explorations of medical ethics as exemplified in the patient-physician relationship and the wealth of the Hippocratic tradition to the contemporary emergence and fragmentation of cutting-edge subdisciplines (such as genethics, neuroethics, nanoethics, roboethics, mashups like reprogenetic ethics, and the list goes on), the expanse of bioethics has grown to include just about everything under the proverbial sun in the life and medical sciences as well as in material sciences and a number of emerging tech sectors.

Thus, several observations emerge from an attempt to define bioethics. The first is the need to determine whether there is properly a field of inquiry designated as bioethics or whether what one refers to as bioethics is itself an interdisciplinary dialogue at the cross-section of philosophy, law, medicine, science, and technology, among a number of other potential disciplinary interlocutors. Within the camp of those who might define bioethics as a field of inquiry unto itself is its status as a subset of applied ethics. Simply stated, applied ethics can be understood as the practical application of philosophical considerations in ethical inquiry to problems in everyday life, with particular emphasis on understanding practices and guiding actions.

A second observation is that there has been an intriguing tension in bioethics in its historic relationship with medical ethics. Clearly, bioethics emerges as a relatively recent concept within the modern history of the technological explosion in medical ethics and controversies in medical research. This much is agreed upon by all. Pointing to this medical context, some

describe a gradual transition from medical ethics—emphasizing the Hippocratic tradition and the covenantal professionalism of the physician—to the broader concerns of bioethics—often interpreted as a devaluation of the profession into a contractualist, provider-of-services model for medicine and healthcare. Others, however, see a much stronger shift given the early concerns of human subject research and forward-looking technologies like genetic engineering, alongside the social upheaval and public policy concerns that moved the physical location of bioethical deliberation from the clinical bedside to legislatures, courts, and governmental agencies. Individuals in this camp distinguish between the professional ethics of medicine (the domain of medical ethics) and the broader ethical engagement of biomedicine and biotechnology (the domain of bioethics).

A final observation that has become abundantly clear is a significant omission in the ever-evolving self-understanding of the field of inquiry referred to as bioethics. Foundational concepts and the fundamental nature of scientific and technological discoveries have by and large gone unexamined. While the public square context of contemporary bioethics demands consensus-based understanding for core terminology, such consensus-based understanding often skims over relatively vacuous placeholder terminology. One thinks, for instance, of justice as one of the four principles universally agreed upon as a central consideration within bioethics, though a precise understanding of what is meant by such a weighty term is widely contested within academic discourse. Clearly the case within mainstream bioethics given its pluralistic context (especially if one accepts the notion of moral strangers), this observation is no less true within Christian bioethics as well. Notable exceptions do exist, but, unfortunately, they are few and far between. Our bioethical reflection holds more than a few philosophically and theologically ambiguous placeholders that inform our “educated” analyses.

Furthermore, in the rush to keep up with the ever-quickenning pace of scientific and technological innovations, we have become decreasingly adept at substantive analysis not just of the implications of such developments and innovations but of the nature of such technologies themselves. In the complex world of technological immersion, we must become better at analyses that move beyond a mere good vs. bad oversimplification, even while recognizing the importance of knowing when to declare something as morally inappropriate or to proscribe against something. In our attempts to define bioethics we need to look not just at the implications of biomedicine and biotechnology for our individual and common humanity but also at the natures of biomedicine and the various biotechnologies themselves, as well as to what it means to be human and remain human in our medtech age. That is why I am grateful for the ongoing existence of this journal as a venue dedicated to the exploration of these weighty, first-order matters even as we explore the bioethical considerations at the forefront of medicine, science, and technology.

In this combined Summer/Fall issue, we begin with a guest commentary from Jacob Robert Morris, MD, that reaffirms the Christian Hippocratic legacy in medicine as a counter to growing acceptance of physician-assisted suicide and medical aid in dying. Next, we feature another entry in the Grey Matters series with an essay by William P. Cheshire, Jr., MD, that explores first principles for medical AI. This essay is jointly published with *Triple Helix*, the magazine

of the Christian Medical Fellowship of the British Isles (UK and Ireland). Due to the combined issue format, we have two installments of the Clinical Ethics Dilemma column edited by Ferdinand D. Yates, Jr., MD, offering revised analysis of cases by the late Robert D. Orr, MD. The first case examines religious refusal of care by a teenager, while the second examines the appropriateness of court involvement in the case of a family request to withdraw a patient from hospital care against medical advice.

Next, we feature four original articles. The first, by Dennis Sansom, PhD, examines empathy fatigue, the pandemic, and ethical motivations. The second article, by Stephen Williams, PhD, explores the concept of human flourishing and the virtue of contentment in the context of biotechnology and human futures. In our third article, Cynthia Nash, MD, examines mitochondrial replacement therapy in light of the embryo and community. Finally, our fourth article, by Everlyne Nyaboke Ombati, MSc, MA, provides a Kenyan perspective on the ethics of the global allocation of COVID-19 vaccinations. We close the issue with several book reviews.

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GUEST COMMENTARY

REVISITING PHYSICIAN-ASSISTED SUICIDE: REAFFIRMING THE CHRISTIAN HIPPOCRATIC LEGACY

JACOB ROBERT MORRIS, MD

Abstract

Support for physician-assisted suicide is growing as a result of ever-expanding cultural pressure. Healthcare professionals should oppose this trend and recognize that physician-assisted suicide is a misguided answer to human suffering. For 25 centuries, the Hippocratic Oath has served as the ultimate credo of the medical professional, and serves as a more trustworthy guide for professional ethics than contemporary culture. In this essay, I reflect on the Hippocratic Oath from a Christian perspective and reaffirm that physician-assisted suicide, despite growing in cultural acceptance, remains a misled answer to human suffering and as such is dangerous for the profession of medicine. Physician-assisted suicide corrupts the medical profession, relies on a distorted view of autonomy, and subverts true compassion. The way forward for the medical professional, in contrast, is an ethic of a “good death” comprised of healing, palliative care, and true compassion.

Keywords: *physician-assisted suicide, euthanasia, Hippocratic Oath, autonomy, compassion, palliative care, medicine, suffering*

Introduction

In the face of expanding cultural pressure to adopt physician-assisted suicide, it is timely to reflect on the opposition to active euthanasia in the oldest versions of the Hippocratic Oath. Drawing on the Oath, this essay does not aim to blaze new trails of argumentation but to reaffirm the well-worn and historic path of physicians protecting the lives of the patients entrusted to them. Before embarking, I will define several terms and provide a brief history. Physician-assisted suicide (PAS), medical aid-in-dying (MAD), and physician aid-in-dying (PAD) are often used interchangeably to describe the same thing: namely, the act of a physician giving a patient life-ending medication that the patient then self-administers.¹ The preferred terminology is controversial. Sometimes, PAD is used as an umbrella term to include both PAS and euthanasia. Euthanasia, in contrast to PAS and MAD, is the act of a physician directly administering a life-ending medication to a patient; this is currently illegal in every state, prohibited under general homicide laws.

The history of PAD is extensive. In brief, the Oregon “Death with Dignity Act” was passed in 1994. In 1998, Dr. Jack Kevorkian, a guest on 60 Minutes, administered a lethal injection on national television to Thomas Youk, a man suffering from ALS. He was convicted of murdering Mr. Youk and sent to prison the following year. In 2008, Washington and Montana followed Oregon by legalizing PAS. Vermont joined in 2013 and California in 2015. At the time of this essay, ten states and the District of Columbia have legalized PAS. Globally, assisted suicide

Jacob Robert Morris, “Revisiting Physician-Assisted Suicide: Reaffirming the Christian Hippocratic Legacy,” *Ethics & Medicine* 37, no. 2–3 (2021): 73–81.

performed by a non-physician was legalized in Switzerland in 1942, which then became infamous for “suicide tourism.”² Subsequently, both euthanasia and PAS were legalized in the Netherlands and Belgium in 2002. Currently, nine countries have legalized PAS in some form.

Notably, the widespread adoption of PAS and euthanasia has been a frequent theme in dystopian novels. In Aldous Huxley’s novel *Brave New World*, the elderly are sent to the Park Lane Hospital for the Dying.³ Once there, they are given increasing doses of soma—a drug that causes rapturous hallucinations—until their respiratory centers shut down. Dr. Shaw comments on how ideal it is that “[the elderly] are most conveniently out of the way.”⁴ He continues, “Of course, you can’t allow people to go popping off into eternity if they’ve got any serious work to do. But as [they] haven’t got any serious work.” In Lois Lowry’s book *The Giver*, the elderly are “released” when they no longer contribute to the society.⁵ Jonas, the protagonist, is aghast when he discovers that being “released” is a euphemism for being given a lethal injection.

Could this dystopian future be ours? A 2015 Gallup Poll revealed that nearly 70% of Americans were supportive of PAS among the terminally ill.⁶ For the first time in American history, over half of all physicians also agreed.⁷ We live in a country where the commonly accepted position increasingly says that, in certain circumstances, it is allowable for a physician to assist in their patients’ self-killing.

Having provided a short history of PAS and an overview of our current state, I now propose to demonstrate the misguided nature of PAS and contrast PAS with a better path forward. Specifically, PAS is misguided because it: (1) over-relies on the moral and clinical competence of practitioners to determine when life is worth living, (2) corrupts the medical profession by undermining trust and turning the physician into a subjectivist, (3) is upheld by a distorted view of radical autonomy, and (4) relies on false instead of true compassion. The way forward for the medical professional, in contrast, is an ethic of a “good death” comprised of preparation, avoiding the over-medicalization of death, and affirming the roles of healing, palliative care, and true compassion.

Despite More Common Acceptance, PAS and Euthanasia Remain Misguided

PAS over-relies on the moral and clinical competence of practitioners to determine when life is worth living. I once heard a physician lecturing about PAS pose the following question to a group of medical students: “How many of you have classmates to whom you would not trust the care of a dog of yours?”⁸ Most of the hands in the room went up. Though anecdotal, this reflection represents something we all know: medical professionals are human; many are moral and virtuous, but many are not. This fallibility of medical professionals should make us think twice before bestowing them with the power to actively assist in the death of another. Physicians are not able to determine when life is worth living and when life is worth ending. To believe that they are is to over-rely on their moral and clinical competence.

Reckoning honestly with the imperfect nature of medical professionals, the Hippocratic Oath served as the ultimate credo of the medical profession for 25 centuries. In one section of the oath the physician swears:

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury or wrong doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.⁹

Anthropologist Margaret Mead commented on the revolutionary nature of this oath:

For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world, the doctor and the sorcerer tended to be the same person. He with power to kill had power to cure, including specially the undoing of his own killing activities. . . . With the Greeks, the distinction was made clear. One profession, the followers of Asclepius, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect—the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child. . . . [T]his is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer—to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. . . . [I]t is the duty of society to protect the physician from such requests.¹⁰

Humans are fallible and occasionally untrustworthy, including physicians. However, by adopting a professional pledge to not poison—intentionally kill—another human being, and by banishing those who violate this stipulation, the medical profession has engendered patient trust for centuries. This trust undergirds the doctor-patient relationship. As a patient, I trust that my doctor is committed to my healing and will not take my life or maliciously harm me.

PAS undermines this trust and thereby corrupts the medical profession. When a physician embraces PAS, the fundamental nature of the doctor-patient relationship changes. Suddenly, the physician is placed in the position of providing, or not providing, a life-ending “medication.”¹¹ The patient may be a voluntary moral agent requesting the medication, but the physician ascends to a seat of power in determining whether or not to provide the medication and, therefore, whether or not to participate in ending the patient’s life. Rather than esteeming life as a near-absolute value, life becomes valuable only under certain circumstances, and the physician is the ultimate judge. Trust is compromised. Instead of being wholeheartedly committed to the life, healing, and palliation of their patient, the physician instead becomes an arbiter of life and death.

This also turns the physician into a subjectivist. For the physician consenting to PAS, the value of the patient’s life is not sacrosanct. PAS acknowledges that there are certain conditions whereby it is right for the physician to assist in killing their patient. These conditions are necessarily subjective and influenced by the country, culture, and worldview that surrounds the physician. To illustrate this point, one only needs to consider the varying acceptable criteria and safeguards for PAS around the world, including in Belgium, where assisted suicide is available even for those who are not terminally-ill.¹² The Hippocratic physician, in contrast, upholds an objective oath. She will not administer a poison to intentionally harm or kill her patient. She is unashamedly committed to the life and healing of her patient, and to palliation in the face of natural death. This is an objective ideal that has upheld the medical profession for centuries and protected the doctor-patient relationship.

It is dangerous and corrupting to turn fallible physicians into subjectivists concerning the value of their patient’s life. Consider the logic of bioethicist Jonathan Glover, who in his essay, “The Sanctity of Life,” argued that to destroy life or conscious life is not inherently wrong—it is only

wrong to destroy life worth living. He notes:

For these reasons, someone's own desire to live or die is not a conclusive indication of whether or not he has a life worth living If we are to make these judgements, we cannot escape appealing to our own independent beliefs about what sorts of things enrich or impoverish people's lives.¹³

While recognizing the incredible danger of one person determining whether or not another's life is worth living, Glover nonetheless justified some subjective determinations about the value of another's life. I hope that the peril of such subjective determinations is obvious. We should oppose PAS because it moves the value of a patient's life, and the physician's duty toward that life, from the realm of the objective to the subjective and relies on morally flawed physicians to make these subjective determinations.

PAS is also deeply misguided because it presupposes a distorted view of autonomy. In medicine, one of the primary strategies for resolving ethical disputes is that of principlism, which analyzes an issue within the framework of four principles: respect for patient autonomy, beneficence, non-maleficence, and justice.¹⁴ Beauchamp and Childress, in their seminal work on principlism, define autonomy this way:

Personal autonomy is, at minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan.¹⁵

The idea of respect for patient autonomy has to do with self-governance. Patients should be free from external controlling influences that limit their agency, they should be informed, and they should be able to make choices in-line with their values. This notion of respect for patient autonomy should be supported.

However, PAS relies on a distorted view of patient autonomy. Rather than relying on respect for patient autonomy, arguments for PAS rely on "radical" autonomy. By radical autonomy, I mean a notion of autonomy that does not recognize *limits* on patient autonomy. It is completely consistent to say that the Hippocratic physician respects patient autonomy by ensuring their patients are free from undue controlling interference and values their individual choices while simultaneously recognizing *limits* to patient autonomy. Just because a patient desires something as an autonomous agent—such as medications to end their lives—that does not mean that they *should* have their desire satisfied out of respect for autonomy. That assertion misconstrues radical autonomy with respect for autonomy, is dangerous, and should be rejected.

The emergency room patient with chronic back pain and a substance abuse history should not be given a prescription for opioids just because they request it. A football game would not function if the first rule was "Do whatever you think best," with only secondary suggestions to not go out of bounds. In life, autonomy flourishes only when properly constrained. But in the debate over PAS, autonomy is given a preeminent moral seat; the physician *should* give the cancer patient a lethal prescription if that is what the patient has determined is best for them. The age-old boundaries of medicine are secondary considerations. In the words of Leon Kass, this turns the physician into "a highly competent hired syringe."¹⁶ The professional, committed to an ethic of life and healing, is replaced by the provider beholden to radical patient autonomy.

PAS is also misguided because it relies on false compassion instead of true compassion. If autonomy functions as the moral club to squash other ethical considerations, then a false sense of compassion is the underlying driving force or proverbial arm behind the club. What do I mean by false compassion? Philosopher J. Budziszewski discusses the difference between true and false compassion: “In compassion we *feel with* the sufferer, but there is a right and a wrong way to act upon this. The right way relieves *his* suffering, the other relieves what I suffer for him; one gives him what he needs, the other merely gives him what he wants—or just puts him out of sight.”¹⁷

It is incredibly painful to watch the suffering of another. Not that long ago, I lost my mother to a two-year battle with pancreatic cancer. As the cancer invaded her body, her suffering was incredible. First, intense pain racked every step as bony metastases overwhelmed her spine and pelvis. Then, she became too frail to walk or even hold up her own head. Horrible chemotherapy ulcers cracked her lips and filled every corner of her mouth. Her hair fell out and her legs swelled with fluid as the rest of her body withered. Her mouth became so dry she could only speak after we helped her suck on a moistened sponge. Night-black cancerous tumors covered her skin, eventually breaking through the skin and bleeding like angry ulcerated craters.

It is one of the most horrendous experiences imaginable to watch someone you love so dearly suffer so gravely. True compassion sits at the bedside as a comforting human presence, as a hand to moisten the lips and administer medications, as a voice to speak and read stories, as a source of encouragement that reflects on the value of the beloved’s life. False compassion can bear it no longer and slips the terminal sedative onto the bedside table. The 1980 Vatican Declaration on Euthanasia states:

The pleas of the gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact it is almost always a case of an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses.¹⁸

Mother Teresa is lauded as a paragon of humanity because she gave true compassion—tears, food, and a human presence—to the destitute and ill of the slums of Kolkata. Her legacy would be very different if she had merely provided terminal sedatives to those who did not want to live anymore. It has been said, “Suffering is not a question which demands an answer, it is mystery which demands a presence.” PAS provides a misguided answer to human suffering.

I have asserted that PAS should be rejected because it over relies on the moral and clinical competence of fallible physicians to determine when life is worth living. Further, it corrupts the medical profession by turning the physician into a subjectivist and fracturing the sacred trust that undergirds the doctor-patient relationship. Lastly, PAS relies on unsound notions of radical autonomy and false compassion, instead of the superior guides of respect for autonomy and true compassion.

After rejecting PAS, how should the medical profession address the depths of human suffering? The charge of 17th century physician Thomas Sydenham rings clear: “The physician should be diligent and tender in relieving his suffering patient, knowing that he must one day be a like sufferer.”¹⁹ What is the Hippocratic physician to do in the face of natural death? How can we

address the suffering that so many of our patients (and ourselves) are sure to face? Bioethicists Scott Rae and Paul Cox write:

Caring well for the dying is a moral obligation for professional caregivers and loved ones who take care of dying family members. . . . Good care for the dying does what is possible to create the possibility of a “good death” for the patient and his or her family.²⁰

Throughout history, much attention has been devoted to this question of what comprises a “good death.” After the bubonic plague devastated 14th century Europe, the Catholic Church offered a guide on how to die well. This guide, first published in the early 15th century, was known as the *Ars moriendi* or “The Art of Dying”²¹ and consisted of texts and woodcut reliefs that contrasted good and bad deaths. Those dying were encouraged to avoid the temptations of unbelief, despair, impatience, pride, and avarice. Instruction was offered for those who attended the bedside of their dying loved ones. Two centuries later, Jeremy Taylor, a cleric in the Church of England, wrote “The Rule and Exercises of Holy Dying,” a similar manual that exhorted its readers to strive for a pious and God-honoring death.

Lydia Dugdale comments on the valuable examples of these works:

The *Ars moriendi* of the late Middle Ages was successful precisely because it addressed a universal need in a manner that fit a particular culture and was easy to understand and apply. Such a tool today would need to accommodate a vast array of belief systems while remaining easy to use. The deathbed must again become a place of community, a place for the dying to forgive and receive forgiveness, to bless and to receive blessing, and a place for the attendants to anticipate and prepare for their own deaths.²²

Her point is apropos—we should re-imagine the deathbed. From the outset, it should be acknowledged that medicine does not bestow the answers for what comprises a good death; the deathbed is in such a sorry state because for too long we have assumed that it does. As a Christian Hippocratic physician, however, I would espouse an ethic of a good death as one that is: prepared for, not overly medicalized, and comprised of healing, palliative care, and true compassion.

In my work as an emergency physician, I recently cared for a woman in her forties who had recurrent stage IV breast cancer. Her skin was yellowed. Her bilirubin, a marker of liver function, had climbed every visit for the past two months. The metastatic breast cancer was overwhelming her bile ducts, despite chemotherapy, and her abdomen was protuberant with a sickly, yellow fluid that was requiring drainage twice per week. She was listed as full-code and had future aggressive therapies scheduled. As I sat in the room with the patient and her husband, I was convicted to ask a difficult question: “Do you want to know, from a medical outlook, how much time you may have left?” I assured her that only God knows the day and the hour of the end, but my experience as a physician has prepared me to anticipate the final stages of life. Also, as a son who watched his mother die of cancer, I knew how difficult it was to reckon with the end—we always want more time. But, I wanted to give her the gift of preparation. The patient and her husband both assented, and I told her, “Days, possibly weeks.” There were tears, and I grieved with them. I encouraged them to leave nothing unsaid.

Two days later her liver shut down to the point of coma, and the following day she died. After

our conversation, she had opted to avoid ventilators and CPR. I pray that her final days were meaningful, that she reminisced of her love for her husband and said goodbye to family while she was still cogent. I hope that this was a better death than the alternative, of dying in the ICU, sedated, having let one's final moments of cognition and communication slip away, with no chance to bless or be blessed, still holding onto the delusion of more time. Death often comes sooner than expected—this is especially true for those fighting long battles with chronic illnesses and cancer. We know death lurks in the future; we refuse to believe that it is coming tomorrow. Medical professionals often feel like they are failing when they bring up the possibility of impending death. Surely our armamentarium of technology can buy a little more time? Like those bailing a deluged boat with cup, refusing to look up at the swelling waves, too often we clinicians reach for ventilators and vasopressors and rob our patients of the gift of preparation. We must do better. We must humbly and sensitively give our patients the gift of preparation, and not overly medicalize death.

From a Christian perspective, it is helpful to recognize that the avoidance of pain and the avoidance of death are *relative* goods, but not *absolute* goods. This means that it is good for the medical profession to seek to alleviate the pain of a suffering patient and leverage their expertise and resources to forestall death. If healing is possible at a tolerable cost, it should be pursued. It is also important to not confuse healing and curing. A patient may not be able to be cured of their terminal cancer or their kidney failure, but the role of physician as healer is still valuable. Skin maladies of the suffering and bed-bound colon cancer patient can be alleviated even if the underlying disease cannot be cured. Respiratory ailments can be mitigated through diuresis or antibiotics even if the cardiomyopathy is irreversible. The physician can still be a healer and comforter, even in the face of death. The aphorism is true: "To cure sometimes, to relieve often, to comfort always."²³

To seek comfort and relief, but not cure, is the definition of palliative care. Palliative care is a medical discipline that takes a multi-faceted approach to challenging medical illnesses with the goal of improving quality of life and not seeking a cure. Palliative care recognizes the limits of human health and longevity and focuses on improving quality of life for those who are suffering. When death appears imminent, palliative care transitions to hospice care. Medical professionals can help their patients achieve a good death by focusing on palliative and hospice care, especially when a cure is no longer possible or likely. In this setting, the responsibility of the medical professional transitions from cure to care. Ira Byock notes the following about the effectiveness of palliative care:

In more than 35 years of practice I have never once had to kill a patient to alleviate the person's suffering. When other measures fail, palliative sedation for alleviation of physical suffering is reliably effective. Alleviating suffering is different than eliminating the sufferer.²⁴

Finally, perhaps most importantly, a good death looks like true compassion. It looks like the family sitting at the bedside of the dying cancer patient. It looks like teamwork between medical professionals, family, friends, and community supports such as the church to keep the suffering patient comfortable and surrounded by human love and care. This often requires an incredible amount of work. It can be unfathomably difficult and distressing to help the dying patient with simple tasks such as having a bowel movement, eating, or bathing. The same amount of

effort and care expected in welcoming a newborn home is necessary in helping a loved one die well—often more. However, true compassion looks like engaging in this work out of love for the dying father, mother, or friend. This opportunity celebrates the dignity of the dying patient, and is often meaningful to family and friends.

In summary, PAS is misguided and should be rejected, as it corrupts the medical profession by threatening patient trust and turning physicians into subjectivists, disregarding the wisdom of the Hippocratic Oath that has guided the medical profession for centuries. PAS stands on the shaky foundations of radical autonomy, as opposed to respect for autonomy, and false compassion, as opposed to true compassion. The better way forward for the medical profession, and society writ large, is to embrace an ethic of a good death: we should help our patients prepare for death, avoid the over-medicalization of death, and focus on healing, palliative care, and true compassion. We would do well to heed the words of the late bioethicist Daniel Callahan, who said, “Consenting adult killing . . . is a strange route to human dignity.”²⁵ Let us reject that misguided route, and follow the well-worn path of the Hippocratic Oath.

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GREY MATTERS

FIRST PRINCIPLES FOR MEDICAL
ARTIFICIAL INTELLIGENCE¹

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Abstract

Medical artificial intelligence (AI) technologies, by their capacity to decipher enormous data sets, identify meaningful patterns beyond what human intelligence can recognize, and in some cases render decisions without human assistance, are poised to transform healthcare. As with any powerful technology, careful ethical analysis is needed if we are to realize the benefits of AI while avoiding its perils. Four available perspectives are recognized. One perspective is technological sentimentalism, which resists novel technologies that seem to displace a more natural way of inhabiting the world. A second perspective is technological messianism, which uncritically welcomes novel technology as intrinsically good and the answer to all human problems. A third perspective, common today, is technological pragmatism, which weighs benefits and risks in a utilitarian framework that emphasizes empirical facts but disregards moral values, considering them to be opinions without consequence or validity. A fourth and preferred perspective is technological responsibilism, which considers not only outcomes but also the moral values laden in the design and implementation of technology. Technological responsibilism respects the deeply human attributes of voluntary responsibility, moral agency, and character. Morally responsible use of AI is needed if healthcare professionals are to sustain their focus, not on technology, but on patients.

Keywords: *Artificial Intelligence, Christian Bioethics, Ethics of Technology, Medical Technology, Moral Responsibility, Pragmatism, Virtue*

Introduction

The history of medicine is punctuated by novel innovations. Consider the impact of anesthesia, antibiotics, the hypodermic syringe, the stethoscope, x-ray imaging, MRI, artificial ventilators, pagers, pacemakers, organ transplants, gene sequencing—the list goes on. The first use of each of these inventions revolutionised diagnosis and treatment of the sick. Technology turns the pages of the book of medical progress.

Prophets of the technosphere predict that the next wave of extraordinary progress lies with artificial intelligence, or “AI” for short. AI refers to the simulation of human intelligence by machines that are programmed to mimic human thought patterns such as learning, adapting to new data, problem-solving, executing complex tasks, even social interaction—without being assisted by humans. Enthusiasm for its transformative potential has led to predictions that AI will usher in a fourth technological revolution comparable to the neolithic transition to agriculture, the industrial revolution utilising mechanised production, and the digital revolution based on computer processing of digital information.

William P. Cheshire, Jr., “First Principles for Medical Artificial Intelligence,” *Ethics & Medicine* 37, no. 2–3 (2021): 82–86.

Medical AI

What AI might mean for medicine is a subject of exciting speculation. Inspired by accelerating change, the CEO of Google has predicted that, within the next five years, “we will shift to a world that is AI-first.”² The challenge for physicians will be to calibrate medical AI in such a way as to place the interests of patients first. With that in mind, a responsible approach to making decisions about medical AI must not be limited to technique but should explore thoughtfully the ethics of human interaction with technology.

Ways to Think About Technology

The bioethicist Michael Slesman offers a helpful ethical framework for thinking through decisions about the use of technology.³ He proposes four categories, which he labels as sentimentalism, messianism, pragmatism, and responsibilism. How one navigates these categories and balances their concerns draws from prior assumptions about what it means to be human and to be a thinking, morally responsible being.

Technological Sentimentalism

In one corner are those who instinctively question or resist technological innovation. They may feel threatened by technological trends that erode kindness in communication or that seem to treat people as things to be manipulated. Finding it increasingly difficult to unplug from electronic connectivity, they feel that technology deprives them of a more natural way of inhabiting the world. They see technology as the source of a host of social problems and, thus, novel technologies such as AI a Pandora’s box of potential new problems. Recognising that AI has the potential to magnify biases in data, they worry that AI could worsen unjust disparities and social inequalities, placing the poor and vulnerable at greater disadvantage. Sentimentalists value being satisfied with what one has and lament the loss of what is nostalgically imagined as a simpler, less technological age. Sentimental rejection of medical AI, however, would deny us its benefits.

Technological Messianism

At another corner are those who regard technology as intrinsically good and desirable. The potential useful benefits of AI stagger the imagination, especially as medical progress relies increasingly on digital technologies. The enormous amount of data in every person’s genome and the accumulating scientific content in medical journals exceed the capacity of the human brain to recall, interpret, or synthesise all there is to know relevant to health and disease. AI promises to augment our ability to assess megadata and bridge the information gap. An already familiar application of AI is natural language processing to generate clinical notes efficiently from speech. In medical research, machine-learning algorithms are mining vast clinical data sets to detect previously unrecognised disease patterns. Artificial neural networks utilising deep learning are beginning to analyse radiographic, histologic, and morphologic images with stunning diagnostic accuracy. Such advances may lead to earlier detection of disease when it is more easily treatable.

Optimism in technological progress traces to the European Enlightenment, which sought to improve the human condition by applying rational knowledge and invention to fulfill material needs. Optimism in technology can overlook unintended bad consequences, and it flies off the rails if taken to the extreme by those who would place ultimate hope in machinery as the saviour of society.

The uncritical adoption of technology sometimes appeals to the technological imperative, which is the philosophical claim that technology in all its achievable forms is inevitable. Bowing to supposed inevitability, the technological imperative reduces to the belief that, if it can be done, it should be done. Such fatalism is seriously mistaken because it abandons ethics by denying the role of human decision and responsibility.

Technological Pragmatism

The prevailing attitude toward technology today is pragmatism, which regards usefulness as the ultimate measure of truth and meaning. From a pragmatic perspective, AI is a transactional tool for solving human problems by plugging predicted benefits and risks into a mathematical equation, digesting more and more data to calculate potential consequences far into the future. Would such hyperpragmatism ultimately deliver human flourishing?

Thinking about thinking technology brings this question to the forefront. Projects to construct a machine intelligence superior to human intelligence presuppose that thought is reducible to matter and its physical causes and random collisions. If intelligence were nothing more than neurons firing and neurochemicals churning in a particular pattern, then, in principle, intelligence equivalent to or surpassing the human mind could be replicated in electronic circuits. Some philosophers go so far as to suggest that, if machines can mimic human intelligence, then more powerful machines will eventually exceed it and potentially replace it. The Oxford bioethicist Julian Savulescu speculates that, “Humans may become extinct. . . . We might have reason to save or create such vastly superior lives, rather than continue the human line.”⁴ One rightly shudders to consider the implications of such a view for medicine.

Whereas pragmatism seems objective, its blind spot is the assumption that empirically verifiable facts are the only valid knowledge. If that were true, then ethical problems could be resolved by acquiring a sufficient amount of measurable factual data and subjecting that data to intense machine analysis. In reality, facts are necessary but insufficient for ethical analysis. As the volume of clinical data increases, the variables that can interact increase, and the number of potential outcomes enlarges exponentially. Having more facts is not enough. Ethical decisions depend on considering what is meant by “useful,” which requires assigning to facts not just numerical value, but moral value. Lacking or ignoring knowledge of moral right and wrong, pragmatism and computer programs that emulate it descend into moral relativism.⁵ C. S. Lewis understood this when he warned that recognising facts while denying the realm of value undermines the authority of the ethical principles needed to justify limits on human manipulation.⁶ Unconstrained pragmatism makes it possible to justify committing any evil, provided a greater benefit is predicted for society at large.

Powerful computational technology, even if supplied with unimaginable quantities of data and

outfitted with the superfast computer processing speed of AI, operates within the realm of fact. Technology, while useful, is not alone the final answer to human problems. Also needed is virtue, an aspect of human intelligence that surpasses the realm of factual knowledge where AI operates, not by degree but in kind.

Technological Responsibilism

Technological responsibilism realistically accepts both the promise and peril of technology while engaging with it critically and with an awareness of what it means to be human. This perspective recognises both fact and value and distinguishes between the real and the artificial.

Technology itself is morally ambiguous and laden with the values of its designers and implementers. AI is a tool and not an agent, a machine made of matter and not a living being. Although AI might be programmed to imitate human emotion and in some ways to deliver care, it cannot truly care about the patient. An AI might be programmed to render responsible decisions that conform with humanly decided values, but it cannot be programmed to be responsible. Applying the attribute of trust to AI, according to physicians Matthew DeCamp and Jon Tilburt, “is a category error, mistakenly assuming that AI belongs to a category of things that can be trusted.”⁷⁷ AI cannot be said to have the human attributes of voluntary responsibility, moral agency, motives, or character.

Some uses of AI blur the line of moral responsibility. A signature feature of deep learning AI is what is known as its “black box” problem, in which hidden layers within artificial neural networks are inaccessible to human users, who see only input and output and cannot know how the AI is analysing data. One might accept an AI diagnosis of cancer based on a proven track record for accurate analysis of images, but if an unsupervised AI supplied with clinical data were to advise an elderly patient to forego life-prolonging treatment, without giving reasons, one would be justified in querying whether the machine decision was ethically valid.

Technological responsibilism entails a more comprehensive perspective on human nature than is available within the paradigm of pragmatism. Christian healthcare professionals affirm that humans are much more than the sum of their cells. Every patient is a precious unity of body and spirit who is loved by God (John 3:16–17). All people are endowed with unique dignity as image-bearers of the Creator (Genesis 1:27). Responsible use of technology respects this innate dignity in others, a dignity affirmed by Jesus Christ, who, though being in the form of God, took on humanity (Philippians 2:5–7). Unlike AI, which is incapable of compassion, Jesus loves us (John 15:9, Romans 5:8) and came that we might have life abundantly (John 10:10).

Moral responsibility for medical AI lies with those who design and implement its programming, for which reason it matters what moral vision is embedded in the technology. For medicine to retain its moral integrity, AI must remain our tool and not become our master. We must ensure the prerogative to override an AI-generated healthcare decision we believe to be morally wrong and harmful to patients. In harnessing the power of AI, we must be careful not to become so enchanted by its technical charm that we lose sight of the special dignity of our patients, who are bearers of God’s image.

Responsible use of AI extends to awareness of how its use may influence implicit attitudes

toward others. Once we habitually converse with AI, a mere machine imitating human emotion, we must guard against thinking of other persons as objects. The philosopher Jay Richards observes, “The greatest delusion of our age is the paradoxical penchant to deny our own agency while attributing agency to the machines we create.”⁸

Conclusion

The potential medical benefits of AI are promising. If used wisely, AI promises to be a powerful tool to assist Christian healthcare professionals in their calling to heal the sick and to love and serve those in need (Mark 12:31, Luke 10:24–37, Galatians 5:13). Caution also is needed to fulfill the Hippocratic imperative to first do no harm.⁹

The eventual entry of superintelligent AI into medicine will challenge healthcare professionals in new ways to choose whom we will serve. When we reach the limit of what we as finite humans can accomplish, will we place our ultimate trust in supercomputers or in Christ? Will we look to and empower technology, potentially allowing it to master us, or will we strive to align our use of technology with God’s good purposes? Christians understand that God’s thoughts are infinitely higher than anything possible by machine intelligence (Isaiah 55:8). Christians believe that Christ, not technology, is the true saviour, and His teachings our first principles for providing medical care. Christians know that Christ, not machine intelligence, is the way, the truth, and the life (John 14:6), our only reliable source of wisdom, our rescue from disease and death, and our everlasting hope.

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CLINICAL ETHICS DILEMMA

RELIGIOUS DECISION-MAKING IN A TEENAGER

ROBERT D. ORR, MD, CM; FERDINAND D. YATES, JR. MD, MA
(BIOETHICS): COLUMN EDITOR

Editor's Note:

This column presents a problematic medical-surgical case that may pose a medical-ethical dilemma for patients, families, and healthcare professionals. As these cases are based on real medical situations, identifying features and facts have been altered to preserve anonymity and to conform to professional medical standards. In this case, the physician needs to ascertain whether or not a teenager's statement of religious faith should be allowed to direct her life-sustaining medical treatment.

Question: May we accept this adolescent Jehovah's Witness refusal of blood transfusion?

Story:

Debbi is a 13½-year-old girl who was well until two weeks ago when she developed knee pain without obvious trauma. She subsequently developed a fever and was admitted to the hospital with a septic knee found to be caused by *Staphylococcus Aureus*. She was started on appropriate antibiotics, but developed toxic shock and has subsequently been found to have staphylococcal sepsis,¹ osteomyelitis² of the femur and bilateral staphylococcal pneumonia with large pleural effusions.³ Her osteomyelitis has been surgically drained. Her sepsis has come under control with the use of two antibiotics (Vancomycin & Cefotaxime). She is on supplemental oxygen and Total Parenteral Nutrition. The pneumonia is improving, but it has not been possible to relieve the pleural effusions with either needle aspiration or placement of chest tubes, and surgery was proposed for this afternoon.⁴ Her Red Blood Cell count has dropped from normal level on admission (hemoglobin = 11.5) to a very low level (6.1). She was begun on erythropoietin (an enzyme to stimulate her bone marrow) several days ago.

Debbi is the oldest of six children in an intact family. The family has a long and strong Jehovah's Witness tradition. Her parents were baptized as adolescents, her maternal grandfather and uncle are Jehovah's Witness pastors. The patient is an excellent student in the 8th grade. She was accepted as a full member of the church five months ago after examination by the elders found her to be of sufficient understanding.

I spoke with the patient (parents, uncle and grandfather present) and she clearly articulated the Jehovah's Witness position on receiving blood or blood products. She quoted scripture and explained her understanding of Jehovah's prohibition and did not "want it on [her] conscience" to accept

Robert D. Orr and Ferdinand D. Yates, Jr. "Religious Decision-Making in a Teenager," *Ethics & Medicine* 37, no. 2-3 (2021): 87-90

blood. She asked that blood not be used, “if possible.” When challenged on this last point, she clearly stated that she did not want blood even if it meant that she might die as a result. She repeated this sentiment on re-discussion without her family present and after being told that I would accept her statement as her true desire rather than assume she wanted us to override her refusal.

Her physicians believe they must proceed with more aggressive intervention because of the lack of response of her pulmonary condition. I spoke with the pediatric thoracic surgeon, and he reports that decortication is likely to involve significant blood loss. Because her anemia makes surgery risky, repeat chest tube placement under fluoroscopy will be attempted today while waiting a few more days for a response to erythropoietin.

Discussion:

The Jehovah’s Witness belief about blood transfusion is a deeply held rational belief based on their interpretation of scripture. There is strong ethical precedent for honoring such a request from an adequately informed patient with decision-making capacity, even if non-use of blood will lead to their death. Some suggest that many Jehovah’s Witnesses will state the church’s position but secretly hope that medical or legal professionals will override their refusal in order to save their lives. It is my belief that we should not engage in this charade, but should honestly accept their statement as their desire.

There is legal precedent to obtain a court order to transfuse children of Jehovah’s Witnesses over the objection of their parents if the non-use of blood is likely to lead to death or disability. There is growing sentiment, however, that it is not the legal age of majority which is morally relevant, but the child’s level of understanding, so that the refusal of a mature minor should be honored as if she were an adult.

In this case, I believe this adolescent is making an informed, non-coerced, choice against potentially life-saving blood transfusion.

Recommendations:

It is my recommendation that this patient’s physicians and the hospital should respect her refusal of blood products and should continue to do everything possible short of using blood products to improve her condition. Should she deteriorate to the point where she will surely die without blood, I believe we should reluctantly accept that tragic outcome.

If her physicians wish to honor her refusal, they should make it clear to her that her words of refusal will be accepted as her true desire; it will not be assumed that she wants to be rescued by seeking a court order over her objection.

Because of the legal precedent of over-riding the refusal of Jehovah’s Witness parents, her physicians should initiate a report of this situation to Child Protective Services. If her physicians agree with my stance, the purpose of the report would be to seek judicial relief from the precedent. If her physicians disagree with my stance, the purpose of the report would be to seek the court order authorizing transfusion.

Follow-Up:

Child Protective Services and subsequently the Juvenile Court were notified of the situation. A hearing was held three days later, with testimony from pediatrician, surgeon, and ethicist. By this time the patient was slightly better (no fever, some drainage from the new chest tubes). The judge said she would issue an order for transfusion over parental objection if the patient's condition deteriorated. When the tube drainage slowed and her fever returned several days later, her parents chose to transfer her to a hospital where surgeons said they would be willing to operate without giving additional blood. This was done with the judge's approval. It is not known whether surgery was, in fact, done, but it is known that the patient survived the illness.

Comment:

Four of the most difficult ethics consultations I have done have been on adolescents in Jehovah's Witness families. Each was handled a bit differently, varying with the circumstances.

In this case, I felt the patient was very mature and was making a truly informed decision based on the views she had adopted when she became a Jehovah's Witness several months earlier. Her answers to my questions seemed a bit rote, but this probably reflected her recent teaching. At the same time, they seemed sincere and informed.

It has been my observation that physicians coming from a strong faith perspective usually take one of two positions in relation to transfusion of patients from the Jehovah's Witness tradition. The majority, relying on the importance they place on the tenets of their own faith, reluctantly accept the refusal of blood products. A minority, believing their own faith is correct on this issue and that the Jehovah's Witness teaching is in error, are often more willing to ignore the patient and transfuse over their objection, believing their professional mandate is to save lives when possible.

Editor's Comment:

In situations such as this, physicians speak of decision-making capacity (DMC)—and not competence—as the latter is a legal term. The granting of DMC is based on the physician's assessment of the patient's comprehension of the medical situation associated with the patient's articulation of the issues and assurance that the patient is not being coerced. The evaluation of these aspects can be quite complicated and typically take some time to ascertain. Furthermore, in this situation, the physician needs to make an assessment of the appropriateness of granting DMC to a minor child regarding the refusal of a specific treatment that may have a direct impact on her life.

The medical ethicist will often make recommendations or speak of something as being ethically permissible. However, as these medical options are appropriated, and decisions are being made, it is imperative for the attending physician—early in the course of the healthcare relationship—to put forth guidelines as to how (s)he will approach the issue of Child Protective Services and/or Juvenile Court. A minor child and parents need to be aware of how these external services

will be employed in the care of the child so that they can take advantage of available alternate healthcare resources.

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1. A life-threatening spread of the infection throughout the body, usually through the blood stream.
2. Localized infection of a bone, often caused by spread of the bacteria through the blood stream.
3. Collection of fluid in the pleural space, between the lungs and the chest wall; it may compress the lungs and cause difficulty breathing; it often needs to be removed by needle aspiration or continuous drainage through a chest tube.
4. When the fluid is collected into multiple small cavities, it is necessary to do a procedure called “decortication”, a peeling away of this thick infected layer. This is a large and bloody operation since innumerable small blood vessels have grown between the lung and the abnormal tissue.

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CLINICAL ETHICS DILEMMA

A CLASH OF MEDICAL CULTURES

ROBERT D. ORR, MD, CM; FERDINAND D. YATES, JR, MD, MA
(BIOETHICS): COLUMN EDITOR

*Editor's Note:*¹

This column presents a problematic medical-surgical case that may pose a medical-ethical dilemma for patients, families, and healthcare professionals. As this case is based on a real medical situation, identifying features and facts have been altered in this scenario to preserve anonymity and to conform to professional medical standards. In this case, a family wishes to offer cultural treatment rather than continue traditional American treatments.

Question: Should we go to court to prevent this Samoan man's family from taking him home against medical advice?

Story:

Tuiasosopo is a 39-year-old Samoan agricultural worker who was admitted 7 weeks ago after two weeks of headaches and intermittent nausea and vomiting and blindness for 24 hours. He was found to have cryptococcal meningitis² and has been treated with 2 standard antibiotics for this uncommon infection (amphotericin intravenously and flucytosine by mouth). He initially had gradual improvement, demonstrated by repeatedly testing of his spinal fluid and considerable improvement in his mental status. He was nearing the end of his 6-week course of treatment when 1 week ago he suffered a stroke. This precipitated vomiting which precluded retention of his flucytosine for several days. He has subsequently had a worsening of the spinal fluid test, and his mental status is again severely depressed. Immunosuppression³ is suspected, but no source has been found.

The patient has lived in this country for 2 years, is married, and has one child, a 6-month-old son. He has been employed as a farmer worker, but has no health insurance. He has qualified for emergency Medicaid coverage for this hospitalization only. He has a supportive large extended family. A brother (with whom the patient and wife live) is the family spokesperson.

The patient started asking to go home early in his course of therapy. He consented to stay because Medicaid declined to cover home I.V. therapy. He was receptive to conventional therapy, but did refuse his fifth weekly spinal tap. When told that the test was necessary to monitor improvement, he agreed to a final one at the end of his 6 weeks of therapy.

Since his recent setbacks, his family have asked to take him home to pursue ethnic treatments (application of leaves and lotions to his skin; taking of homemade herbal mixture by mouth) believing that hospital treatment has failed to cure him. They have not been antagonistic. Their

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cultural beliefs include spirits of deceased relatives as the cause of illness and/or failure to respond to conventional therapy. They also put faith in dreams, and the family reports that some dreams about this patient and his course of illness have come true.

Psychiatric consultation has confirmed that the patient does not now have decision-making capacity. The infectious disease consultant states that he will surely die if he leaves the hospital, and may even with continued treatment. The most recent neurology note states that his prognosis is guarded, even with treatment, since he is not responding to treatment, presumably on the basis of immunosuppression. His vision will not improve, and his cognitive recovery is questionable. On exam, he is somnolent and appears to be in no distress.

Discussion:

We traditionally allow competent patients to refuse treatment, even life-saving treatment, as long as they understand the consequences of their decision. We are more reluctant to honor such requests from surrogates. When working with surrogate decision-makers, the primary questions are: (1) is the proxy making the decision which the patient would make, and (2) is the proxy acting in the patient's best interests? It is often helpful to articulate the goals of therapy before judging a particular decision about a particular modality.

These matters become even more complex when dealing with patients from another culture. Requests for unorthodox therapies can sometimes be accommodated without compromising conventional therapy; other times this is not possible.

This patient (and his family) apparently chose a goal of cure and accepted conventional medical therapy. Now that he has worsened and has lost decision-making capacity, his caring family still want to pursue that goal of cure through other means. At the same time, the care team believes that the possibility of cure (restoration of previous level of impaired function) with continued therapy is fading.

Recommendations:

If the proposed ethnic interventions are not recognized as toxic and can be administered in hospital in conjunction with continuation of conventional therapy, this option should be offered to the family. If this is acceptable to them even for a few days, his prognosis may become even more clear.

In light of his poor prognosis for recovery (and for survival) even with continued therapy, if the proxy making the decision which the patient would make is not possible, or if they insist on his discharge, a non-adversarial meeting with them should be held in an effort to determine whether the patient would choose this move. They must clearly realize that it is our understanding that he will die if they take him home. If the care team is convinced that the family is making a truly informed substituted judgment, it would be ethically permissible to allow them to take him home "Against Medical Advice"⁴ since they appear to be acting in his best interests.

If this cannot be determined, or if the responsible physicians are not willing to do this, the only alternative would be an adversarial court proceeding.

Follow-Up:

The patient's neurologist permitted the family to apply the topical therapies, but could not be convinced by the family or the nurses to allow the internal herbal mixture. He initially seemed to show some improvement and was a bit more alert. However, his fever continued and his kidney function deteriorated, probably from the prolonged use of Amphotericin. The spinal fluid tests monitoring his progress initially improved, then bounced up and down. His mental capacity also fluctuated considerably. Phone consultation with a nationally known expert in cryptococcal infections offered no other options. His family considered flying him back to Samoa, but the cost was prohibitive. Nearly 4 months after the consultation (over 5 months after admission), he was found unresponsive in bed. No resuscitation was attempted.

Comment:

Would it have been better to either allow his family to take him home, or at least to allow the administration of the herbal mixture in hospital? It is difficult to know. The administration of unknown chemicals might have adversely affected the antibiotics, worsened his failing renal function, or caused other unexpected side effects. They might have had no effect at all. Could they possibly have helped? While this latter possibility seems unlikely, in a patient with a very poor prognosis it might have been helpful to the family as they looked back on the sequence of events if they were able to think they had fulfilled their duty to the patient.

Editor's Comment:

Occasionally, at end-of-life situations, the medical team seems to appropriately focus on the wishes of the patient (or the health care proxy), sometimes not giving gracious thought to the intentions of the family in attendance at the bedside. Whereas this may occur for a variety of reasons, one may well be because the goal-oriented team does not recognize the importance of cultural preferences and—perhaps—makes the assumption that these carry no recognized medical contribution. A less directive-oriented team may be more open to cultural options of unproven but (likely) nonharmful effects. “First, do no harm” has broad latitude in such a situation.

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2. A life-threatening infection around the brain, in this case caused by a fungus rather than by the more typical bacteria or virus.
3. A decrease in the body's ability to resist or fight infection; can be caused by many things including illness (e.g., diabetes), infection (e.g., AIDS), or drugs (e.g., steroids).
4. Documentation in a patient's hospital chart that a discharge is Against Medical Advice (often called an AMA discharge) is a standard procedure when a patient insists on leaving the hospital but his physician believes this is medically unwise.

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ORIGINAL ARTICLE

THE PANDEMIC, EMPATHY FATIGUE, AND ETHICAL MOTIVATIONS: KANT ON CONSCIENCE AND SCOTUS ON LOVE

DENNIS SANSOM, PHD

Abstract

The social effects of the pandemic have exacerbated the ability and desire to overcome empathy fatigue and, consequently, have engendered more indifference towards others and isolationism among the population. These effects challenge society's moral resolve to care for others. In this paper I present two ethical explanations of the basis of morality and moral action—Immanuel Kant's ethic of pure will (conscience) and John Duns Scotus' ethic of an ontology of love, and endeavor to show that a morality based solely on our rationally justifiable conscience does not adequately compel us to overcome empathy fatigue, whereas a morality based on an acknowledgement and affirmation of the loveliness of others can propel us to overcome empathy fatigue.

Keywords: *Pandemic, Empathy Fatigue, Love, Conscience, Scotus, Kant, Augustine, Enjoyment*

Introduction

In September of 2020, Olga Khazan published an article in the *Atlantic* in which she argues, just six to seven months after the COVID-19 virus was declared a pandemic, our society was suffering from “empathy fatigue.”¹ This empathy fatigue is a person's or collection of people's hesitancy to care for others, especially strangers. It is the negative consequence of repeated exposure to stressful or traumatic events. Of course, empathy fatigue existed before the pandemic, for many people during war or who work around large amounts of suffering and grief immunize themselves with empathy fatigue just so they can continue their task and maybe even daily living. However, our nearly three-year struggle with the Covid virus has definitely exacerbated empathy fatigue.²

During the full and partial lockdowns, people would read of large numbers of others dying from the effects of the virus and begin what Martha Lincoln calls “necrosecurity” reasoning. She notes this “neologism . . . describes the cultural idea that mass death among less grievable subjects plays an essential role in maintaining social welfare and public order.”³ That is, for many, to keep our resources plentiful enough for the largest number of people and to assure the most viable of our population thrive, we should not grieve as much the death of the old or those with co-morbidities than we should the young and productive. Like the old classroom dilemma of the dangerous runaway trolley in which we must throw off some individuals to save the greatest number of people, we have to make ethical trade-offs. Even though we may be glad we personally are not required by the social forces of the situation to make the concrete decisions

Dennis Sansom, “The Pandemic, Empathy Fatigue, and Ethical Motivations: Kant on Conscience and Scotus on Love,” *Ethics & Medicine* 37, no. 2–3 (2021): 95–109.

of who gets needed healthcare and who does not, we know it is for the good of society to let some die to keep our resources and society secure.

This form of reasoning creates tremendous anxiety in our conscience. To become so callous about the death of people whom we cover with a statistic, we choose to diminish our empathy capacity and, consequently, become fatigued in trying to be sympathetic for those whom we do not know and whom we now think probably should be sacrificed for the greater good of society. Consequently, we become even more fatigued due to our empathy fatigue. For most people, there is something unsettling in our consciences about “necrosecurity” reasoning. Consequently, we keep our physical and emotional distance, and, according to the World Happiness Report of March 2021, this withdrawing definitely erodes the moral fabric holding society together. Authors Okabe and Lyubomirsky state, “One noteworthy and particularly relevant potential harm discussed by these researchers is the possible increase in social isolation and strife in intimate relationships, which can be exacerbated by the many sources of stress (social, financial, health, etc.) associated with the pandemic.”⁴ Of course, not everyone has withdrawn from the sick and needy during this pandemic, but the social indicators of a society under great ethical and emotional stress (such as the growing number of emotionally and physically isolated people, the displays of fatigue and frustration among portions of society who face debilitating problems such as poverty and the harms resulting from the social breakdown of families, and the increasing fear of potential virus carriers) have increased. Consequently, many are more averse to taking risks to care for strangers, to sacrifice time and money to support others suffering from the virus and other maladies, or to be emotionally affected by the general plight of the present world. We are becoming more of a society of functional loners.⁵

How shall we respond to empathy fatigue? Do we have emotional and intellectual resources to bridge the space that exists among us? Will we as a society let empathy fatigue harden into a permanent emotional and maybe even a permanent ethical outlook towards others? I want to argue that we do have such resources, that a strong commitment to an ethical way of living can motivate us to resist empathy fatigue and to care for people—especially those whose well-being and sense of life’s purpose are under assault—and, thereby, hopefully, to overcome the isolation, fear, and empathy fatigue that exist among us.

Preview to Conclusion

Before I start the details of my argument for why we should be motivated to overcome empathy fatigue and to cultivate deep moral obligations towards others, I give a preview of where I plan to conclude. It is a fact of existence that each of us is an individual and a separated self from others. We alone experience our own thoughts and feelings. We are unique within the world. We can call this an epistemological gap—that is, although I know my thoughts and emotions directly, I cannot know yours directly. There are various ways to respond to this gap, but I want to examine two. First, there is the viewpoint that says since we cannot really know in any convincingly rational way other people’s selfhood, the world, and God, the best we can ethically do is always to act with a good, rationally defensible conscience. This is the position of the influential 18th–19th century German philosopher Immanuel Kant. Second, there is the viewpoint that says that if we properly understand the nature of existence and why the

world exists, we will be motivated to love others. This is the position of the 12th–13th century Franciscan philosopher John Duns Scotus, who derives his ethics of love from the nature of the world and God as the world’s creator. Even though we can learn much from Kant about the importance of reason to our ethics, I hope to show that Scotus’ ontology of love is a better ethic for us to adopt in this time of the pandemic.

The Epistemological Condition

I think the Oxford philosopher and economist E. F. Schumacher offers for us a straightforward way to understand the epistemological gap.⁶ All of us experience a fundamental division between ourselves and the world, between our inner experiences and the appearances of the world. We can sort out this division into four different categories: (1) there is the I; (2) there is how we appear to others; (3) there is the inner you; and (4) there is the outer world. We can elucidate further these four categories by asking four different kinds of questions. First, it is meaningful to us to ask, “what is really going on in my own inner world?” Second, we can ask, “what is going on in the inner world of other beings?” Third, we wonder “what do I look like in the eyes of other people?” And four, we ponder “what do I actually observe in the world around me?”

Schumacher concludes that we personally have direct access only to numbers one and four—that is, we know what we feel and think and that we observe the world. However, we have to accept that we do not have direct access to the inner world of others, and we cannot directly know what others know about ourselves. The epistemological gap means that although I can explore, clarify, and change the thoughts, emotions, and memories of my inner world, I cannot do the same directly to your inner world. Of course, we indirectly learn about other people’s inner worlds through language and common experiences, but, in a sense, the singular uniqueness of other people remains separate from us.

Kant versus Scotus

Many philosophers and theologians have tackled the issue of how ethics can deal with the epistemological gap (e.g., Aristotle, Thomas Aquinas, Jean Paul Sartre, John Rawls, and Alasdair MacIntyre), but I believe we can learn valuable lessons about how to overcome empathy fatigue in our culture from the different ethical theories of Kant and Scotus.

Kant

The following quote from one of Kant’s more accessible books, *The Fundamental Principles of the Metaphysics of Morals*, is representative and exemplary of most of his thinking:

All rational knowledge is either material or formal; the former considers some object, the latter is concerned only with the form of the understanding and of the reason itself, and with the universal laws of thought in general without distinction of its objects. Formal philosophy is called logic. Material philosophy, however, which has to do with determinate objects and the laws to which they are subject, is again twofold; for these laws are either laws of nature or of freedom. The science of the former is physics, that of the latter, ethics; they are also called natural philosophy and moral philosophy respectively.⁷

Kant makes several claims in the quote that underlie most of his vast philosophical output. First, when he mentions “material philosophy,” he refers to things that we can actually know, and he divides that between nature and freedom. We can make knowledge claims about the world, but physics (in the sense of the theoretical knowledge of physical reality) is the only form of knowledge that produces objective, measurable, and predictable knowledge. Kant is famous for saying that “thoughts without content are empty and intuitions without concepts are blind.”⁸ That is, our reasoning about the world must be based on actual empirical experiences, and since physics deals with physical reality, it alone can tell us about the basic laws of physical reality, and, hence, we must be skeptical about any metaphysical or theological explanations of being itself, the soul, and God. We have no empirical experiences of them.

However, physics cannot tell us anything about our inner experiences of freedom. Only ethics can describe what it means to be free, but ethics cannot tell us anything about the world known by physics. Thus, we live in two cognitive realms—a realm of natural science that explains the physical world we all live in, and a realm of ethics that attempts to explain what we ought to do as rational agents cognizant of our duty to follow the moral law.

Second, when he mentions “formal philosophy,” he refers to logical analyses, to conceptual clarifications, and to deductive reasoning. Just as physics must rely on mathematics and logic to explain the laws of nature, ethics must rely on logic to explain what it means freely to make dutiful, moral decisions. However, for Kant, if we are coerced, commanded, or influenced by biases or transitory experiences to act morally, then we are not acting freely. Only free choices are truly moral choices. We must know with rational certainty our moral duties, and only then can we truthfully know we are following a moral law.

Our duty requires us to act out of a pure will, not derived from external sources but solely from our own rational capacities to say that we must act a certain way indicative of a universally valid moral law. Kant calls this the categorical imperative, “Act as if the maxim [that is, the articulated principle] of your action were to become by your will a universal law of nature.”⁹ That is, I can only be certain that I am acting morally if I autonomously and rationally decide with a pure conscience, not influenced by external pressures, that I wish what I would do would be universalizable, morally a duty without exceptions, and that I reach this conclusion strictly by my autonomous, rational decision. Kant, furthermore, derives from this categorical imperative of universalizability that I should always treat other people as persons who are also moral agents—as moral ends in themselves, not a mere means to another end. Thus, a pure conscience is the necessary and sufficient condition for dutiful, moral action.

Before I leave this brief explanation of Kant, I offer a summary:

- First, only natural science can explain the world, but only I can explain myself, thus the epistemological gap is real and prevents us from knowing another person’s inner world.
- Second, however, I can act as though I know what is universally right for all people (without actually knowing the inner world of those people) by acting with a pure, responsible, and rationally defensible conscience: that is, dutifully.

- Third, because of the categorical imperative, I must act morally towards others, respecting their own dignity as people with moral consciences.

Kant and Moral Action

My main contention is this—Kant’s ethic based upon the rational conscience cannot satisfactorily motivate us to rectify the empathy fatigue in our present moral malaise. However, I do not intend outright to dismiss Kant’s account. What Kant does (especially in emphasizing the importance of conscience or the pure will), he does well. For instance, Kant rightly emphasizes the role of autonomy in moral actions—that is, we must be the sole cause of our moral actions; we must conscientiously grasp and apply our moral duties, choosing them because they are universalizable. If something coerces our presumed moral acts—for example, if we are compelled by personal fears, societal prejudices, or an overwhelming authority outside our consciences—then our moral agency would not be the sole cause of our action.

Also, Kant correctly stresses the need to deliberate on our moral actions. For Kant, we must rationally evaluate our motives and test them, distinguishing hypothetical from categorical imperatives. Because an ethical theory needs to show how we can reason about morality, his explanation of how to apply the categorical imperative is appealing. Even though for Kant our moral duties are necessarily true and binding on our moral conscience in all cases without qualifications, we still must recognize them and select the corresponding correct actions, not relying on guesses or sentimental intuitions about our dutiful requirements. We must be serious, consistent, and conscientious in our morality, and Kant rightly highlights this aspect of moral action. Kant emphasizes all of this.

However, even though Kant acknowledges there is the “thing-in-itself,” the noumenal world, he maintains we are cognitively unable to understand and explain it rationally. Hence, he is a metaphysical skeptic, and this skepticism undermines the comprehensiveness of his ethical approach. Because all knowledge that can be rationally explained starts with our sense experiences, we conceptually know only the phenomena of experience and not the noumena (that is, the thing-itself) of the realities of the world—in particular others, being-itself, and God.¹⁰ Since we cannot base ethics upon a knowledge of the world, others, or God, we should not attempt to base ethics on ontology. For Kant, the gap between the noumena and phenomena, between the realities of God, being itself, and the soul and our psychological-rational capacities to make our empirical experiences of the world intelligible is permanent and unbridgeable. Although our moral actions presume a goal, we cannot give a purely rational explanation of the goal of the moral life. The most we can do is give practical rational guidance. We can assume that if there is a real moral law, then we would need a pure will guided by the rational confines of the categorical imperative to act consistently with it, but we do not base nor derive our moral actions upon a knowledge of the moral law, God, or being itself. Thus, the question of the truth of our moral accounts is not raised, nor can it be raised. The truth of the metaphysical grounding of morality is impossible to determine rationally. Our primary concern is whether our actions are derived from our good conscience, from our sense of the universalizable duty.¹¹

Moreover, Kant gives no room in our deliberations on our duties for desires and deeply felt preferences about what reality must be and why we should know it and live in harmony with it.¹² Because the duty is universally binding and can be known only through the criterion of the rationality of articulating a categorical imperative, we should resist either cultivating and nurturing preferences for moral ends or feeling the need to explain our moral actions according to what the proper desires and preferences of a morally defensible action would be. In fact, he is suspicious of desires, fearing they reflect too much our personal and social biases and epistemological limitations, and hence he dismisses their necessity in moral reasoning. For him, our moral deliberations must consciously set aside any emotional investment in the truth of our end, goals, and purposes.

Because of the absence of right beliefs and proper desires in Kant's account, his ethic cannot provide us with an account or motive to overcome the "epistemological gap" and the influence of "empathy fatigue." In his explanation, we know ourselves but cannot know the selves of others, cannot know their own moral requirements or responsibilities. It is true that Kant sought to create an ethic that would lead to the enlightenment of 19th century Europe and, hopefully, to end wars and to establish peace and justice in society. But his ethic tends towards an individualistic account of autonomy and moral duty. Our moral consciences are based on our autonomous convictions, not on a knowable and explainable reality we share with others. Of course, the categorical imperative demands that we treat the humanity of people as moral ends in themselves, never as mere means, but the categorical imperative does not compel or propel us to form moral relationships with others. It primarily demands that if we have the occasion to respond to the humanity of others, we must do so with a pure conscience. There is no emphasis on the rational or emotional necessity to seek out others, to form relationships, or to engage the life-situations of others.

During this time of the pandemic in which we suffer the socially harmful consequences of becoming more isolated from others and callous to the suffering of strangers, Kant's ethic cannot convincingly motivate us to find more personal and moral ways to engage people and to care and be compassionate about our neighbors. We need more to overcome the effects of the pandemic than personal conscience and rational postulates. Of course, formulating a strong, rational conscience is laudable as a display of thoughtfulness and sincerity, but to cultivate a motivation to try to bridge the "epistemological gap" and overcome "empathy fatigue," we need, first, a metaphysical account of the ontological dimension of morality and, second, a more compelling conviction to connect morally with others.

Scotus

Scotus is a complex thinker (in fact, his nickname is the "Subtle Doctor"). The following quote is representative and exemplary of Scotus' ethical writings.

Therefore, God, infusing the love by which all beings tend towards him in a perfect and appropriate way, gives this disposition by which he is held dear as a good that is to be loved by others as well. Thus this disposition which regards God in himself, makes a person inclined to will that he is had and loved by someone else, at least by anyone whose friendship he is pleased to have, or whose friendship is not displeasing to him for

that time when it is pleasing to him. Just as the disposition, then, inclines to a perfect and appropriate love of God, so does it also incline one to want him to be loved by oneself and by anyone whose friendship is pleasing to him.¹³

Scotus makes several claims in this quote that underlie his philosophy and theology. First, when he says that God “gives this disposition,” Scotus refers to a fundamental feature of creation itself. Creation reflects a design ordered by the love of God. God is infinite (the description of God Scotus uses the most) and thus lacks nothing (otherwise God would be finite). Consequently, because God is infinite, all of God’s characteristics are also infinite, lacking nothing as a characteristic of God. That is, God is infinite in being, goodness, and wisdom. Furthermore, since creatures are finite—that is, it is possible for them not to exist and also to cease from existing—they owe their existence to God, who wills the world to exist. Because God is infinitely good and cannot do evil, whatever God does is thus good. God makes the world to be good, not in the sense that God long ago was the first cause of all things, but in the sense that God is the continual power of existence of all finite creaturely things. God’s creative power is not like a chain of causes in which the last effect is remote from the first cause. Rather, God’s power is like the movement involved in swinging an axe—the shoulders move the arms, which move the axe, which hits the tree.¹⁴ All are moving simultaneously but the shoulder gives movement to all the other parts. So does God. God’s infinite reality causes the existence of every finite reality by affirming that their existence is better to be than not to be. Hence, because God is the essential cause of all of creation (and not an accidental cause as in a chain of causes), all things created by God are good according to their existence.

For Scotus, creatures’ goodness resides in the basic fact that they exist.¹⁵ Our existence *per se* is good, and it is better to exist than not to exist. All creatures are therefore disposed to their goodness, to the sheer fact their existence fulfills the goodness of God’s creative actions. Because finite things cannot bring into existence their own beings, the fact that the world and people exist indicate that God created their existence. Hence, the existence of others shows it is better and is a good that they exist than if they had never existed at all.

The second important claim Scotus makes is when he says, “so does it also incline one to want him to be loved by oneself and by anyone whose friendship is pleasing to him.” Each creature is inclined towards love. Since it is reasonable to love the greatest and infinite goodness, we should love God and should acknowledge and praise the being of God. Also, because God creates the goodness of creatures, of people, we should also love the goodness of others—that is, the goodness of their existence. We perform this love by affirming and promoting the value of their existence, enabling them to experience their goodness. Furthermore, by affirming their existence, we share in God’s love for them, enabling them to experience fulfillment as persons in the love of God and in experiencing their goodness within creation.

The major arresting feature of Scotus’ ethic is that he connects ethics to ontology, connects what we must do towards creation and other persons with the basic existence of the world and others.¹⁶ His ethic shows the interdependencies of existence, goodness, and love, and offers a compelling reason for seeking out and promoting the value and worth of other people. It is an ontology of love reflective of the namesake of his religious order, Saint Francis of Assisi, who,

in his famous *Canticle of Brother Sun and Sister Moon*, extols the good existence of all aspects of creation as witnesses of the goodness and love of God.

Scotus provides a metaphysical account to explain this Franciscan love of all creatures based on his understanding of God as an infinite being.¹⁷ God is the only being who is not without what it takes to be an existing reality.¹⁸ We cannot imagine God containing a lack of what is required for something to exist, which means that God is the perfect being without deficiencies and limitations. Because God is the perfect being, God ought to exist rather than not exist, and hence it follows that God is perfectly good. As the perfectly good being, God's being infinitely preserves itself, because it is more perfect to persevere in existence than not to exist. As the infinitely perfect, good being, God moreover desires and wills goodness, and this divine will creates objects to love by affirming that it is better that these objects exist than not to exist. So, whatever exists, exists because God seeks to preserve its existence. The goodness of each creature is its existence and its perseverance in existence. When we realize that our existence is better to be than not to be, we naturally seek to sustain our existence. In loving our existence in this way, we also realize that our existence comes from God and thus we should love God for creating us. Love in this sense means gratitude for existence, for the fact that it is better for us to exist than not. Finally, in knowing that love is the proper response to our existence, we also acknowledge that other people exist for the same reason that we exist, and as manifestations of the love and goodness of God we should love their existence as well. This is his ontology of love, describing a grand vision of the valuable existence of all creatures and provoking an active affirmation and gratitude for the existence of God and our neighbors. Therefore, just as it is fitting to love God for our existence, we should love our neighbor for their existence as objects of God's love.¹⁹

Before I leave this brief explanation of Scotus, I offer a summary:

- First, because God is infinite, all of God's characteristics are also infinite—that is, God is infinitely powerful and infinitely good and loving.
- Second, all of God's actions reflect the infinite characteristics of God—that is, God loves infinitely whatever God does powerfully.
- Third, God creates the world by God's infinite power, goodness, and love, and whatever exists is loved infinitely by God.
- Fourth, the proper way to respond to creation is with love for it as a product of the infinite God.

Scotus and Moral Action

I believe Scotus' account can give us the insight and conviction to address our concerns about the present worry of empathy fatigue in our society, and that is primarily because he offers an ontology of love, a way to derive ethics from an account of the nature of existence.

Recalling what was explained above, the “epistemological gap” exists because for us properly to understand our place in the world, we naturally ask two questions—“what is going on in the inner world of other persons,” and “what do I look like in the eyes of other persons?” It is an

ontological fact that we can never be other people; we are our own selves, and they are theirs. Thus, it would be logically and conceptually futile to attempt to bridge the gap by seeking an ontological monism in which all people are actually one “Self” embodied in different bodies. However, I ask, is it possible to identify and create a familiar and reciprocal relationship between ourselves and others, so that we could share a knowledge and experience that enable us to see how others experience the world and us in it? Scotus’ ontology of love attempts not only to explain such a possibility but also to compel people to act in ways indicative of a familiar and personal ontological connection.

Scotus bases his ethic on the metaphysical claim that God creates the world out of love for the world, out of the creative power to affirm into existence the world.²⁰ This affirmation means that it is better for creation to exist than not to exist, and that each creature receives its existence from the loving affirmation of God. We as creatures, therefore, rightly understand ourselves by realizing we are the creative work and objects of God’s love, and we accurately understand and affirm our own existence by loving God, by affirming the unique reality of God as the loving creator of the world.

Furthermore, in loving God, we also recognize that God loves the unique existence of all creatures, and consequently in loving God, we naturally love others as loved by God, as creatures whom we should love, acknowledge, and affirm the value of their existence. In loving others, we identify with their place in the world, not in the sense that we become them, but we become part of their necessary nexus of divine and creaturely love. Love as the affirmation of the essential uniqueness of what it loves thus creates a reality in which all things support and fortify the value of creation.

Both Kant and Scotus make intellectually attractive cases for morality in that they articulate a goal for the moral life and the ways we can reach the goal. However, in light of my above argument, Scotus’ ontology of love better explains how we can ontologically connect with others and, consequently, how to overcome “empathy fatigue.”

Building the Habit of Love

Because, according to Scotus’ ethic, it is natural and rewarding to our existence as contingent creatures dependent upon the necessary existence of God to love others, to approach all of creation as recipients of God’s love, and to value the essential realities of others, we are compelled by our very being to resist and overcome the “empathy fatigue” of the present age. Even though the pandemic has forced many to retreat from others and perhaps has caused society as a whole to become more psychologically callous towards the suffering of others, in Scotus’ ontology of love it has not changed our role within God’s creation. It has not erased the value of people’s existence and has not removed the ontological imperative to love God and our neighbor.

To strengthen our resolve to believe and apply the ontology of love, we need to articulate and adhere to reasons that compel society’s members to resist what morally and sociologically divides people, whether it is partisan political ideologies, class, race, religious doctrines, or geographical regions. Rather than advancing or tolerating divisive ideologies, we should

promote and participate in the kinds of relationships and groups dependent upon love for their identity and survival. Of course, not all relationships and organizations depend on people loving each other (for instance, business is based on production, government agencies upon governing the people, sports upon playing games, etc.). However, relationships and organizations such as families, places of divine worship, and intimate neighborhoods require and rely upon love.

To help identify the relationships and organizations that are based on love, I appeal to a point made by St. Augustine of Hippo. In various places he distinguishes between what we should “use” (*uti*) versus what we should “enjoy” (*frui*). He says in *The Trinity*, “We enjoy things we know when the will reposes in them because it is delighted by them for their own sakes; we use things when we refer them to something else we would like to enjoy.”²¹ The word *frui* for Augustine means more than a simple pleasure. Our English words fruitful and to fructify have the same root as does *frui*. That is, proper enjoyment produces a profound satisfaction to our desire for fulfillment. It indicates the appropriate response to relating to objects that have inherent value. We should in fact experience fulfillment when we appropriate into our self-understanding relationships based on limitless respect and devotion.

However, not all relationships produce fulfillment. Some relationships and groups are strictly utilitarian and serve relative and transitory goals, such as businesses and political parties. We deem people’s value in these cases as to whether they serve these goals. However, in such relationships and groups people are not primarily considered as moral ends in themselves but as means toward other ends. The more society’s economy, government, rule of law, etc. require these kinds of “useful” relationships, the more these transactional types of organizations define our social experiences and self-evaluations and the less committed and less cognizant we are of the essential identity of our neighbors and strangers.

It is thus important to know what to enjoy and what to use and not confuse them, a problem St. Augustine addresses in *Teaching Christianity*:

So if we wish to enjoy things that are meant to be used, we are impeding our own progress, and sometimes are also deflected from our course, because we are thereby delayed in obtaining what we should be enjoying, or turned back from it altogether, blocked by our love for inferior things. Enjoyment, after all, consists in clinging to something lovingly for its own sake, while use consists in referring what has come your way to what your love aims at obtaining, provided, that is, it deserves to be loved.²²

The point is that since the inherent quality of all relationships and activities is not the same, that some relationships we are meant to affirm and promote because of their special nature, we must properly order the loves in our lives. What makes the relationships and activities special ones and, consequently, objects of our enjoyment are the intimation of eternity in them. Of course, Augustine never contends we should treat temporal objects as though they were eternal, as though they were God, but he does recognize that some relationships convey the impression of eternity in their fittingness for perseverance and future orientation. That is, their unique constitution and construction aim for permanence and continuation, and by engaging in them we better understand and appropriate into our own self-identity the significance of eternity.²³ By them, we better grasp the fulfillment of our temporal existence and dependence upon God and, thus, as Hannah Arendt says of the concept, we “‘enjoy’ (*frui*) future eternity.”²⁴

We are most fulfilled as beings designed to love when we enjoy the relationships that brings the greatest delight to our lives. Because love is a craving for more fulfillment, we are most fulfilled by enjoying what always has a future, what cannot cease to gratify our need and desire for more love. However, we misuse these relationships and consequently ourselves if we use what we should enjoy, if we treat them as though they were commodities with relative value to the particular social need and situation and, hence, dispensable when we no longer can use them. If we treat what ought to be enjoyed as though it were a commodity, we distort its nature by changing it from an intimation of eternity into an object with an expiration date, as though we can use up its value.

Yet, we have relationships and groups that require more of us than acknowledging and using their utility. They require love—the recognition of others’ inherent worth as human beings and that we should enjoy them for their own sake—acknowledging that it is better that they are alive and in relationship with us than not.²⁵ For instance, in a family, even though parents and children serve roles and actions relative to their generations and responsibilities, these functions are the proper practices for parents and children to be recognized and appreciated as moral ends in themselves, as possessors of inherent value, and as worthy objects of love. Families lose their unique contribution to people’s wellbeing when they are no longer relationships of love, no longer based on the commitment and action to acknowledge and foster the unique existence of all members.

By committing ourselves to relationships and groups based and dependent on enjoying others for their existence in our lives, we not only convince ourselves that we are relating to them as they should be related to as human beings, but that we persuade ourselves to seek ways to acknowledge the essential value as human beings of others, even strangers. By learning how to love in families, we are better able to love others. By encouraging and fortifying the love endemic to family structures, close neighborhood associations, and communities of faith toward God, we equip ourselves to be more loving, even to strangers, to the large number of people in our society who suffer the suffocating effects of the pandemic.

The “Ontology of Love” and Clinical Ethics

To love someone is to enjoy them. We should not try to enjoy what should be only used about other persons. For instance, just because we rightly use the talents of another person does not mean we enjoy them, but we enjoy them when we affirm their unique existences. To enjoy someone is like “loving them as we love ourselves.” That is, in realizing in what way we love ourselves we can learn how to enjoy others. Of course, we do not love everything about our lives—that is, for example, our transient-practical skills (the skills of work and play) or our moral mistakes. But we do love that we exist, that we are the unique selves we are in the world. We praise the fact that we exist rather than never have existed. To love others means we enjoy the fact that they are the unique existing persons they are, that the reality and value of their existence as humans is the same as our existence. When we enjoy others, we thus make an ontological statement about the goodness of human existence.

In clinical ethics we do not deal just with injuries, illness, and failing bodies. We deal with persons who suffer injuries, illnesses, and failing bodies. The way we treat the injuries etc. are situational and varies with the needs of the context, but the way we estimate the goodness of patients is always the same—that is, it is good that they exist. We should enjoy them, recognize that we share an ontological fact with them: that is, it is better to exist than not exist as the unique selves we are in the world. Hence, the good of healthcare is what Edmund Pellegrino calls the acknowledgement and promotion of the goodness of the patients as persons.²⁶

In clinical settings this disposition towards patients does not necessitate that we are either sentimental or intimate with patients.²⁷ Because to enjoy others means we praise the shared human existence we have with others, we logically need not think it is always synonymous with specific behavior. Rather, it is a matter of being committed to acknowledge and promote the goodness of the patients' existence, to treat people not as organic machines that follow mechanistic laws but as individuals who understand themselves as a continuous self with a history shaped by their unique personalities and events. Thus, the common moral trait exhibited in clinical ethics is to enjoy the patients, to "love them as we love ourselves," to treat them in ways that reflect that it is good they exist rather than not exist.

This commitment can be displayed in special ways: for instance, calling patients by their names, looking them in their eyes, listening to their concerns and worries, recognizing their life-situation (for example, as member of a family), cultivating a hospitable social and physical environment, acknowledging that their pain is inseparable from their selfhood, and respecting their spiritual desire for divine presence and healing.

Conclusion

Therefore, for us to react successfully with our ethical commitments to the epistemological gap and to the disastrous effects of the growing empathy fatigue in our society, we should commit ourselves to our loving relationships, and through them to cultivate habits of love that equip us to approach strangers as neighbors who also participate in a world formed by the love of God. By acknowledging that the basis of creation is the love of God affirming into existence the world and that we share with others the same value of existence, we can possibly cultivate a desire to love others, to recognize and promote the value of their existence, and to celebrate our common humanity as creatures who are recipients of divine love.

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2. Perhaps the *World Happiness Report 2021* is the most thorough statistical analysis of the physical, social, and psychological impact of the Covid-virus. John Helliwell, Richard Layard, Jeffrey Sachs, and Jan-Emmanuel De Neve, eds. *World Happiness Report 2021* (New York: Sustainable Development Solutions Network, 2021), <https://worldhappiness.report/ed/2021/>.
3. Martha Lincoln, "Necrosecurity, Immunosupremacy, and Survivorship in the Political Imagination of COVID-19," *Open Anthropological Research* 1, no. 1 (2021): 49, <https://doi.org/10.1515/opan-2020-0104>.
4. Karynna Okabe and Sonja Lyubomirsky, "Social Connection and Well-Being during Covid-19," in *World Happiness Report 2021*, ed. Helliwell, Layard, Sachs, and De Neve, <https://worldhappiness.report/ed/2021/social-connection-and-well-being-during-covid-19/>.
5. Peggy Noonan wrote an editorial in the *Wall Street Journal* about how the pandemic has exacerbated anti-social behaviors, in particular a fear and aversion to forming intimate and lasting relationships that fosters functional loners and engenders a social and moral passivity. She quotes Yuval Levin of the American Enterprise Institute detailing some of the socially deleterious consequences of the pandemic. We are seeing "a rising generation acutely averse to risk, and so to every form of dynamism," and this trend is not confined to the young. "Excessive risk aversion" is deforming other areas of American life, from child rearing to work and public leadership. And it seems intertwined with a more general tendency toward inhibition and constriction—we see this in speech and conduct codes, which leave Americans "walking on eggshells around each other in many of our major institutions." This new ethos "stifles the public arena while denying us recourse to private arenas and tells us how not to behave without showing us how to thrive." (Peggy Noonan, "Social Distancing Was a Problem before Covid," *Wall Street Journal*, November 25, 2021, <https://www.wsj.com/articles/social-distancing-was-a-problem-before-covid-family-marriage-pandemic-religion-11637795685>).
6. E. F. Schumacher, *A Guide for the Perplexed* (New York: Harper, 1977), 62–63.
7. Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals*, trans. Thomas K. Abbott (Indianapolis: Bobbs-Merrill, 1949), 3.
8. Immanuel Kant, *Critique of Pure Reason*, trans. J. M. D. Meiklejohn (New York: Barnes and Noble, 2004), 22. This quote represents the profound tension that runs throughout Kant's philosophy, even his ethics, between the accomplishments and severe limitations of what we can know. Norman Melchert's summary of Kant's explanation of the work of this tension is illuminating: "As you can see, the quest for reasons will not be satisfied until it finds some condition that doesn't need to be explained by a further condition." Norman Melchert, *The Great Conversation: A Historical Introduction to Philosophy*, 6th ed. (New York: Oxford University Press, 2011), 445. He further notes, "We have seen that in no case can we have knowledge of the things-in-themselves these Ideas [the soul, world, and God] point to. Taken as sources of knowledge, the Ideas are illusory" (452).
9. Kant, *Fundamental Principles of the Metaphysics of Morals*, 38.
10. Kant calls this approach a "Copernican Revolution" in which instead of the mind conforming to the ontological features of the world, our experience of the world conforms to our cognitive a priori categories. Although the Copernican Revolution permeates Kant's philosophy, perhaps the clearest place to find his explanation of it is in the *Critique of Pure Reason*, "Transcendental Logic: Analytic of Conceptions"; see Kant, *Critique of Pure Reason*, 30–68.
11. Because Kant refuses to specify any metaphysical content to morality, his categorical imperative actually becomes malleable to hidden influences. Alasdair MacIntyre makes this criticism: "Because the Kantian notion of duty is so formal that it can be given almost any content, it becomes available to provide a sanction and a motive for the specific duties which any particular social and moral tradition may propose." Alasdair MacIntyre, *A Short History of Ethics: A History of Moral Philosophy from the Homeric Age to the Twentieth Century* (New York: Touchstone, 1966), 198.
12. When scholars talk about the role of emotions in Kant's philosophy, they mainly look at the psychological assumptions involved in Kant's *Critique of Pure Reason*. Patricia Kitcher is representative of this; Patricia Kitcher, *Kant's Transcendental Psychology* (New York: Oxford University Press, 1990). Recently, Maria Borges has offered an account of emotions in Kant's moral philosophy: Maria Borges, *Emotion, Reason, and Action in Kant* (New York: Bloomsbury Academic Press, 2019).
13. John Duns Scotus, *Ordinatio* III 28, 8; in *Duns Scotus on Divine Love: Texts and Commentary on Goodness and Freedom, God and Humans*, ed. A. Vos et al. (Hants, England: Ashgate, 2003), 45.
14. It is debatable whether Scotus argues that God can do anything (even contradict God's self) or that God must work within ontological boundaries. Because Scotus' arguments are often very intricate and subtle, we can find quotes that would suggest God's will is arbitrary. However, according to Allan Wolter, the dominate concept guiding Scotus' overall thoughts about God's relationship to creation is *ordinatissime volens* ("a most methodical lover").

- Hence, [God] first loves himself ordinately and consequently not inordinately in an envious or jealous manner. Secondly, he wills to have co-lovers, and this is nothing else than willing that others have his love in themselves Thirdly, however, he wills those things which are necessary to attain his end, namely, the gift of grace. God is always ‘ordinatissime volens’—a most methodical lover. Grace builds on nature, after all, and the supernatural on the natural.” (Allan Wolter, *Duns Scotus: On the Will and Morality* (Washington, D. C.: The Catholic University of America Press, 1997), 20.
15. For a good account of the metaphysical basis of Scotus’ ethics see Caleb J. Clanton, “Aquinas and Scotus on the Metaphysical Foundations of Morality,” *Religions* 10, no. 2 (2019): 1–14, <https://doi.org/10.3390/rel10020107>.
 16. Perhaps the most informative book on Scotus’ efforts to connect God’s being, creation, and divine love is Vos et al., *Duns Scotus on Divine Love*. For instance, they say, “As God is the source of all good, I must love him above anything else. When I love him in this way I have a ‘right act’ or ‘an act of righteousness (‘*actus iustitiae*’)—that is, an act which does justice to the most fundamental nature of things. . . . If, however, loving God is good in itself, I cannot love him *and* not wish that he be loved by all other human beings. . . . So if I want others being to have that love (‘*caritas*’), I love them, I want *their* good.” (Vos et al., *Duns Scotus on Divine Love*, 68).
 17. Scotus’ argument for God’s existence and God’s creation of the world is complicated and found in various places. The following is a summary from the following sources: *Lectura* 1, d. 2, q. 1, nn. 38–135; *Ordinatio* 1, d. 2, q. 1, nn. 39–190; *Reportatio* 1, d. 2, q. 1; and *De primo principio*. (1) Causal relationships exist; (2) effects cannot cause themselves; (3) there cannot be an infinite regress of causes, because if there were, there would only be an infinite number of dependencies and not a source for the object that are dependent by their nature; (4) hence, there must be a first cause; (5) since a first cause is a causal agency, then a non-dependent being causes creation; (6) this being’s existence cannot be limited or conditioned by another being, because if it were, it would be conditioned by something else; hence there must be something unlimited or infinite; (7) as an infinite being, God is infinite in all ways—goodness, power, wisdom, etc.; (8) God causes the world as an infinite being; (9) since all dependent, finite beings are dependent upon something for their existence, then what is non-dependent and infinite must cause their existence; (10) this cause is not an accidental chain of causes, like falling dominoes; (11) rather, this cause is an essential causality—that is, God causes the existence of everything, like the moving shoulders move the arms which move the hands which moves the axe; (12) the essential causality occurs by causing the existence of everything—that is, the existence of finite beings is a finite form of the infinite existence of God; (13) since God’s existence is infinitely good, creature’s existence is finitely good; (14) creatures exist because God wills goodness to exist finitely; (15) creation is thus not arbitrary—as the first cause, God by nature is a causing agent, and because God is infinitely good without any imperfections, God causes the existence of creatures by causing the existence of finite beings as finite good beings; (16) to cause something to be good implies to love its goodness; (17) since God is infinitely loving in the same way as God is infinitely good and in causing creatures to exist by infinite power and infinite goodness, God causes creatures to exist by God’s infinite love; (18) God wills creatures to exist because it is better (that is, a manifestation of goodness) that they exist than that they do not exist; (19) therefore, since it is better that they exist than not exist and God causes them to exist, and since God loves the goodness of existence, God loves into existence all creatures.
 18. For an accurate and logical summary of Scotus’ argument for God’s existence, see Thomas Williams, “John Duns Scotus,” in *The Stanford Encyclopedia of Philosophy*, Winter 2019 ed., ed. Edward N. Zalta (Metaphysics Research Lab, Stanford University, 2019), <https://plato.stanford.edu/archives/win2019/entries/duns-scotus/>.
 19. For an account of how Scotus explains the connection between God’s commandments and the ontological goodness of creation, see Oleg Bychkov, “In Harmony with Reason: John Duns Scotus’ Theo-aesth/ethics,” *Open Theology* 1, no. 1 (2014), 45–55, <https://doi.org/10.2478/opth-2014-0005>.
 20. This statement highlights a central issue in Scotus’ philosophy—the relationship between the necessary being of God and the contingent reality of all creatures. Because humans are contingent, they have free will—that is, they must both affirm and reject the possibilities before them. However, this freedom is not divorced from God. Creatures are ontologically contingent and thus dependent on the creative force of God for their preservation of existence. Because creatures are dependent upon God for their existence, it is consistent with their ontological reality for humans to love and be grateful to God for this preservation. Instead of our contingency suggesting a tenuous and fragile place within the universe, in Scotus’ view our contingency indicates an ontological connection with the necessity of God’s existence. For a thorough explanation of the importance of contingency in Scotus’ philosophy, see Michael Sylwanowicz, *Contingent Causality and the Foundations of Duns Scotus’ Metaphysics* (New York: Brill, 1996), especially chapter seven: “The Human and Divine Will: Freedom, Contingent Causality and Determinism.”
 21. St. Augustine, *The Trinity*, introduction, translation, and notes by Edmund Hill (Brooklyn, NY: New City Press, 1991), 296.
 22. St. Augustine, *Teaching Christianity: De Doctrina Christiana*, introduction, translation, and notes by Edmund Hill (Hyde Park, NY: New City Press, 1996), 107. Augustinian scholars debate whether Augustine

- argues (as he appears to do in *Contra Faustum Manicheum*, 22, 78) that we should love our neighbors only as a way to love God or should we love our neighbors as a good in themselves, not merely as a means to loving God. After a fairly thorough examination of the relevant passages in Augustine's works, Robert Dodaro concludes (as do I) that the upshot of Augustine's thinking is
- Thus, we enjoy the goodness in the other as we enjoy it in ourselves. For Augustine it frequently happens that our perception of the other's goodness awakens in us the enjoyment of our own. . . . We enjoy the neighbor to the extent we honor his good. (Robert Dodaro, "Augustine on Enjoying One's Neighbor: *Uti-Frui* Once Again," *Lateranum* 80, no. 3 (1976): 525).
- By loving the goodness in the neighbor, we love their existence and how that existence reflects the creative, loving power of God. Or, in another way to say it, we love the image of God in the neighbor.
23. Augustine connects the love of God with the love neighbor, and thereby we should enjoy our neighbor in a finite way as an intimation of eternity. "But this [when the emphasis seems to be only on the love of the neighbor] is because if a [person] loves his neighbor, it follows that above all he loves love itself. But *God is love and whoever abides in love abides in God* (1 Jn 4:16). So it follows that above all he loves God." (Augustine, *The Trinity*, 252).
 24. Hannah Arendt, *Love and Saint Augustine*, edited and with an interpretative essay by Joanna Vecchiarelli Scott and Judith Chelius Stark (Chicago: The University of Chicago Press, 1995), 28. Arendt gives a probing analysis of Augustine's teachings on love. In terms of the concept of "enjoy," she connects it to Augustine's teachings on love as a craving that seeks permanence (Arendt, *Love and Saint Augustine*, 31–35). Because we fear and dread death, we crave what continually has a future, and we find moments of eternity in the relationships built upon the revelation and image of God. Hence, the intimations of eternity is the special quality that belongs in the objects that should be enjoyed.
 25. Sharon M. Kaye and Paul Thomson explain how for Augustine enjoying someone is an act of love/charity, There is the charity called "enjoyment." This is the good, well-ordered love that one has for things that are valuable in and of themselves. Augustine likes to use the metaphor of home to capture the feeling of enjoyment. Home is the place that you want to go for its own sake. You go to the bank or to the market for the sake of doing or getting something; you go home, in contrast, just to be. You can rest there. You experience a sense of comfort and peace. Your love for your home is the love for enjoyment. (Sharon M. Kaye and Paul Thomson, *On Augustine* (Belmont, CA: Wadsworth, 2001), 66).
 26. "Medical good and the patient's perception of the good life must be related to the good for humans as humans. . . . At this level, we are concerned with the good peculiar to humans, . . . The patient is a fellow human with the physician to whom he is bound by solidarity and mutual respect." Edmund Pellegrino, "The 'Telos' of Medicine and the Good of the Patient," in *Clinical Bioethics: A Search for the Foundations*, ed. Carrado Viafora (Dordrecht, The Netherlands: Springer, 2005), 26.
 27. Christy A. Rentmeester makes a good case that healthcare workers must protect themselves from becoming too emotionally exhausted as a result of becoming overly sentimental or intimate with patients. They have a professional responsibility to sustain their responsibility to treat patients. This requires providers to become inured, not callous, to their patients. Callousness is indifference and hinders the provider's ability to discern rightly the patient's situation. "Inurement is the cultivation of strength, of endurance of emotionally distressing conditions, and it is a process of *learning how* to preserve a mindset of caring and *learning how* to maintain capacious perception, despite such conditions." Christy A. Rentmeester, "Should a Good Healthcare Professional Be (at Least a Little) Callous?" *Journal of Medicine and Philosophy* 32, no. 1 (2007): 47, <https://doi.org/10.1080/03605310601152982>.

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ORIGINAL ARTICLE

HUMAN FLOURISHING AND CONTENTMENT IN A BIOTECHNOLOGICAL CONTEXT

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Abstract

Flourishing and contentment are connected but distinct. In Christian perspective, the goal of human enhancement is not conducive to human flourishing, whereas a therapeutic approach to the body is. However, the virtue of contentment means willingness to forgo even therapeutic treatment under certain circumstances. This article attempts to argue for these conclusions with reference to the contrast between the natural and the transhuman and by considering the significance of disability and the church as the body of Christ.

Keywords: contentment, enhancement, flourishing, nature, therapy, transhumanism

Introduction

How should we think of human flourishing and contentment in a biotechnological context? “Flourishing” and “contentment” are obviously different things. “Flourishing” connotes growth, activity, maximisation of potential. “Contentment” connotes stasis, passivity, equilibrium. However, if we adopt a Christian perspective on their relationship in a biotechnological context, the superficially contrasting connotations or meanings of these words conceal important positive connections between them. Contemporary perceptions of human flourishing often spring from the soil of a seething discontent that animates modern life. Our instinct will surely be to appeal to the virtue of contentment as a salutary brake on restless aspirations and to affirm that true human flourishing occurs only when contentment grounds human life. Nor do we need to appeal to a Christian perspective in order to make that kind of conceptual connection; a significant recent contribution to the topic of contentment naturally slides into talk of “human flourishing” on the first page of its first chapter.¹ I am not aiming to tackle my subject by a conceptual analysis that systematically inter-relates flourishing and contentment. Rather, in the context of biotechnology, I am keeping both notions on the table in their ordinary-language sense. Firstly, I shall take a look at the surface, where flourishing has pride of place; then, a look at what lies beneath it, where contentment comes into its own.²

On the Surface: Flourishing and Limitation

The most radical proposal for human enhancement in a biotechnological context is the transhumanist proposal. Enhancement is viewed here as a mode of flourishing to the point where

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humans graduate to a new form of existence, sometimes called “Humanity +” or “posthuman” being.³ Who can object to this aspiration—all-round enhancement to the point of felicitous immortality, the curses of disease and ageing nullified? It may be objected that this cannot be achieved. It may be objected that, even if it can be achieved, the risks involved in trying to achieve it should put a spoke in the wheel of the whole enterprise. But why should anyone fault the aspiration itself, considered simply as the expression of human desire? The maximisation of human flourishing is surely self-evidently a worthy goal, and if there are biotechnological means to that end, anyone who stands in its way on principle demeans human possibility and humankind. What can Christians (or anyone else) plausibly find objectionable about this line of reasoning?

Within the terms of our discussion, the obvious response is to challenge the claim that human enhancement, as understood here, is an authentic form of flourishing. A distinction between therapy and enhancement has long been familiar and handily steers our description of the moral limits of biotechnology. Where there is nothing amiss with the former, the latter runs into theological trouble. The distinction is valid. True, we are equally familiar with the difficulty that confronts it. Even where we enjoy tolerable success in drawing the line theoretically, it is sometimes hard to apply the distinction in practice when we tackle the appropriateness or moral implications of specific, given biomedical practices. However, we must not fall into the trap of abandoning or marginalising the distinction in question just because of problems in application. The distinction is neither constitutionally unstable nor irredeemably unwieldy. However hard it may be to apply it consistently in practice, the distinction signifies and is grounded in an important substantive insight. The core of the insight is an intellectual conviction about, or an intuitive sense of, what is natural for human beings as God’s creatures, as opposed to what transcends or contravenes the natural. Therapy re-constitutes its object in accordance with the proper functioning of the human body. Enhancement re-constitutes the idea of proper functioning. Of course, this has to be fleshed out, lest it be suspected that the distinction is conceptually fuzzy. But the underlying theological idea is that humans belong to a natural order so designed by their creator, and flourishing occurs when we tap into and discover the potential of the natural, not when we deny or ignore it for the sake of putative enhancement.

Biotechnological advance has put pressure on the whole notion of the “natural,” an advance possible only because the “natural” was already under pressure from scientific, philosophical, and cultural quarters. Advance has taken place against the intellectual and cultural background of the standard scientific picture of humankind as an evolved species, and the standard picture generates the question of what we mean by the notion the “natural” and what room there is for it. It is not that the vocabulary of “natural” has no place within the framework of evolutionary history. It may be applied to describe what biologically constitutes a given entity that has evolved without the shaping hand of humans. It may even be applied to humans themselves with reference to the acquired biological characteristics of *homo sapiens sapiens*. But when Christians or any others claim that certain proposed enhancements contravene what is “natural,” they are judged guilty of imposing on what has emerged in the course of evolution some sort of historicist, contingent norm drawn from evolutionary history, or an ideological norm external to that history. If such norms are brought to bear critically on proposals to enhance

the human species, they function to constrain without warrant the further development of the evolved entity. When Christians aver that human flourishing and contentment are rooted in what is natural, a normative standpoint gets in the way of an account properly constrained by dispassionate scientific description. So it looks to critics.

Conflict over the natural lies close to the heart of disputes over what makes for human flourishing in a biotechnological context. “Human beings appear to the biotechnological industry as a *state of possibles* at a given moment of evolution,” including with respect to their genetic material.⁴ The notion of the natural is systematically ambiguous within Christianity, because the traditional affirmation that humankind is fallen entails that it has thus acquired a kind of second nature.⁵ It is a controversial, as well as ambiguous, notion. When more broadly or more narrowly traditional theology takes on board mainstream scientific anthropology, the question of whether disease and death are “natural” provokes theological disagreement. I mention this issue not in order to discuss it, but just to indicate that I am not assuming that the “natural” is a theologically straightforward matter. What we can and must say is that humankind, as created by God, has a determinate earthly structure; that the vocabulary of the “natural” indicates that structure; and all this implies limits to human rights of biological self-determination. How that structure should be described, and what constitutes those limits, are legitimate subjects of debate, but the existence of both a structure and a limit entail that whenever the scope of human enhancement is determined by what is technologically possible, rather than by what accords ontically or morally with God’s created order, the operative notion of human flourishing is skewed. However tricky the notion of the natural, our take on it underlies our view of human flourishing. True flourishing occurs when we rightly apprehend the created order. Biotechnologically induced enhancements that ignore that order do not promote human flourishing.

It is not implied that creation should be theologically viewed simply and straightforwardly as a once-for-all, completed event. The tragedy of the fall, however we understand it in a scientific context, is not only that humankind becomes spiritually alienated from God. It is also that it fails to exercise the dominion over the non-human created order for which it was itself created. It is thus alienated from creation as well as from God. It is hard, if not impossible, to know fully just how that alienation works, because we cannot envisage what the result would have been had humankind fulfilled its mandate obediently and discovered its capacities and potentialities under the acknowledged lordship of God. While creation may have been complete prior to the arrival of humankind in terms of the basic structures within which human and cosmic life were divinely established, it was incomplete in that humankind had a job to do in and with it. “The Lord God took the man and put him in the garden of Eden to work it and keep it” (Gen 2:15, ESV).⁶ On account of the fall, creation awaits its redemption, and not just its completion.

Included in the eschatological prospect is the redemption of the human body, and the way in which Scripture speaks of its eschatological form invites comparison with transhumanist ideals of human enhancement and flourishing, which may differ amongst themselves in their detail with respect to embodiment but make common cause in their aspiration to overcome disease and ageing technologically. Unparalleled biblical attention is given to the question of the future of the body in Paul’s first letter to the Corinthians (15:35–58). While Paul maintains that there

is some principle of material continuity between the present fleshly and the future spiritual existence of humans, the whole force of his argument depends on establishing discontinuity; his disputants mount their challenge on the false presumption that our future bodies are in fleshly continuation with the present one. Whatever the principle of continuity is, the body that is sown is emphatically not the body that is raised. In making the point, Paul strongly implies that an empirical type of account of the constitution of our future spiritual bodies is not available to us. Sufficient for us to know that God has the power to bestow on us an appropriate form of eschatological existence. Perhaps there is an echo of our ignorance on this score in John's observation that "what we will be has not yet appeared" (1 John 3:2).

On its surface, the Pauline prospect of a humanity immortally freed from fleshly encumbrance may look rather like a description of the posthuman condition. Yet, the prospect he holds out is one of human fulfilment. Can we credibly say: "fulfilment, not enhancement?" Can we not say that human eschatological enhancement is clearly a fulfilment? So, should we state the problem that Christians have like this: the attempt to remove creaturely limitations is an illicit enhancement when we undertake it technologically here and now, but their removal under eschatological conditions is a welcome divine gift, properly reckoned as human fulfilment, whether or not we allow the vocabulary of enhancement as well? One and the same thing counts as mistaken human enhancement under earthly conditions and as blessed human fulfilment under eschatological conditions?

If that is the right way of putting it, the problem with radical biotechnological advance is that it tries to anticipate under earthly conditions what is rightly reserved for eschatological life. But why should different timings and different methods—earthly/technological as opposed to eschatological/gift—make one and the same thing a case of illicit enhancement in the first and welcome fulfilment in the second instance? The answer is that we are doing more than just saying that radical biotechnological advance aspires to anticipate under earthly conditions what is properly reserved for eschatological life. The pivot on which the movement from the earthly present to the eschatological future turns in Scripture is redemption. Humans flourish when their temporal lives are ordered to eschatological redemption. Biotechnological enhancement is not redeeming. In theory, the technologically enhanced state and the eschatologically fulfilled state may have some external bodily features in common. But a humanity constituted without redemption and a redeemed humanity are different humanities. Only the latter is a fulfilled humanity.

Our question about human flourishing in a biotechnological context is a question about human flourishing in a fallen context. Obviously, no technology is evil just for that reason, because a good creation underlies fallen human existence. "Fallen context" means the context of a fallen *creation*, not the entire substitution of fallen for created order. But the first eleven chapters of Genesis issue a biotechnologically relevant warning in their account of dominion gone awry. The dominion for which humans were created is corrupted in embryonic form when Eve wrongly judges the fruit of the tree of the knowledge of good and evil to be desirable for the attainment of wisdom (Gen 3:6). It is not; hers is a mistaken judgement, not a true perception, and sustained human error consequent on her wilful misperception culminates in the building

of the tower of Babel (11:1–9), following a series of judgments that include increased pain in childbirth, work being transmuted into toil, years of human life truncated, and a flood. The building of the tower was motivated by the will to “make a name for ourselves, lest we be dispersed over the face of the whole earth” (11:4). A commentator aptly observes that this reflects the pride and anxiety that are the joint drivers of culture.⁷ There is hubris and there is pathos, and transhumanism evidences both a desire to rise high and a worry about the global scene.

Is my discussion of biotechnology skewed by treating it with reference to transhumanism, which is only one of its applications? I think not. Transhumanism is wheeled into my discussion in order to get a grip on the question of flourishing and contentment in a biotechnological context. It is being treated neither as a subject in its own right nor as representative of all biotechnology. What is on biotechnological offer will (in theological perspective) potentially be a mixed bag of what makes for true flourishing and for unwarranted enhancement in the earthly lives of humans. But where biotechnological advance takes place without reference to either divine creation or the limits of human dominion, Babel issues a canonical warning about what is all too possible or even all too likely. Transhumanism is a standard-bearer of a cultural movement to enhance humans, as far as is technologically possible, without prior commitment to the kind of definition of humanity found in Scripture, which sets human flourishing within assigned limits. According to the opening chapter of Genesis, human dominion does not extend beyond the non-human realm. It does not extend to unlimited authority over our own bodies. It is certainly important to explore the relationship between the limits of the dominion given to humans and the limits of legitimate biotechnological cultivation of the human body, if it ever is legitimate. Constraints of space do not allow this. My article is a rudimentary attempt to get discussion of flourishing and contentment off the ground, so it is not directly focussed on ethical issues in biotechnology. As a matter of fact, “flourishing” has reared its head hitherto far more than has “contentment.” Time, then, to move on to the second, and deeper, level.

At Greater Depth: Contentment and Culture

Human flourishing has certainly received theological attention, both generally and specifically in the context of bioethics.⁸ In connection with it, I have adopted a broadly intellectual perspective on biotechnology. However, there is a biblical text about contentment that conducts us to deeper level: a broadly spiritual and emotional, more than narrowly intellectual, orientation to biotechnology. It is Paul’s injunction to Timothy: “if we have food and clothing, with these we will be content” (1 Tim 6:8). Paul has referred to “contentment” just before that (6:6). On the lips of a first-century Stoic around the time the New Testament was written, the Greek word for “contentment” (*autarkēs*) would have connoted or denoted “self-sufficiency,” a fact that would have been lively in Paul’s mind, a mind familiar with Stoicism in Tarsus from an early age. Potentially, there is mileage in studying the contrast between Stoicism and Christianity in our current technological context. There is plenty on the web about contemporary Silicon Valley Stoicism, Ryan Holiday having led the way in its promotion. Perhaps the potential mileage is not very great, because we cannot assume that first-century Stoicism is the same animal as prowls around the Valley sporting that label. Viewed from ground-level, Silicon Stoicism,

though united in self-mastery, apparently harbours some diversity of attitudes and practical philosophies that, at their best, seek to foster an attitude of acceptance where technological (and, consequently, biotechnological) limits are encountered, a humility to accept what lies outside our control.⁹ As a counter-balance to unbridled hubris and impatience with limits, this slice of contemporary Stoicism is doubtless palatable. However, in a secular context, it is a recipe for self-sufficiency rather than for finding our sufficiency in God. It is certainly very different from that state of contentment with food and clothing which Paul commended.

Contrast between Christianity and Stoicism is one thing; contrast between the church and Silicon Valley is another. All too frequently, the Christian in the Western church can ill afford to impress effectively on the Stoic in Silicon Valley the Christian-Stoic contrast. Silicon Man and Woman who subscribes to his or her style of Stoicism may be far more consistent than the Christian who professes subscription to Pauline contentment. Not that Paul came by it easily: he had to learn it.¹⁰ What does proper Christian contentment realistically entail in a biotechnological context? I have alluded to the position that human *flourishing* countenances therapy, but not enhancement, on the grounds that therapy accords with God's design and with what is natural, where enhancement is not limited by it and knows no constraints from the allegedly "natural." But can we simply substitute *contentment* for flourishing here, and say that contentment entails settling for therapy and eschewing enhancement? We surely cannot. That therapy is in accord with God's created design for human flourishing, where enhancement is not, is an intellectual conviction. We may correspondingly be intellectually convinced of the importance of contentment, but contentment itself is a spiritual disposition. On examination, the introduction of spiritual disposition into matters blocks an automatic move from the premise that human flourishing is consistent with availing ourselves of therapy to the conclusion that the pursuit of contentment is consistent with availing ourselves of it. Why so?

There is a widespread, though inadvertent, tendency to approach ethical issues in biotechnology from what is customarily described as "a Western perspective." As an example of how distorted this perspective can be, take a remark made by a man devoted to the expanding practice of biohacking, the implantation of devices that function as convenience technologies in our bodies. He asked why on earth we should carry around in our pockets cumbersome things such as wallets, mobile phones, and sets of keys, when implantation enables us to transfer, communicate, scan, or access what we need without carrying around numerous physical items.¹¹ His question well illustrates the blindness that biotechnology can induce or, more accurately, further. Although the incidence of mobile phones amongst many people otherwise deprived is quite extraordinary, it remains the case that a vast number of people in the majority world would give anything—if they had anything to give—for the luxury of a functional phone, a building into which they could insert a key and that gave them shelter, and a wallet that actually contained money—paper, let alone plastic. In fact, we do not have to travel to the majority world to witness that; the condition pertains to an alarming and increasing number of people in Western societies. When we probe the question of human flourishing in a biotechnological context, we are often at risk of presupposing a standard of living, luxury, and access that exposes the fact that we do not in practice settle for the Pauline terms of contentment. Indeed, many questions or dilemmas in bioethics more widely apply only in our highly privileged and, from a global point of view,

rarefied Western or Northern Hemispheric context.

We know that biotechnological availability, like all availability, generates and is not simply the end-product of desire. There are sophisticated analyses abroad of the connection between technology and desire.¹² We enter deep waters here that eventually plunge us into the waves of discussion of Western capitalism.¹³ And even here we appear to be in theological shallows when faced with Brian Brock's averment that "it is not going too far to say that the technological age is the crucible in which the dross of certain forms of Christian theology must burn away."¹⁴ In this article, I am cravenly sticking to the shallows! When desire is not satisfied and discontent ensues, we are prone to moralise our spiritual state to our advantage—what starts life as personal desire is transmuted into a claim that we have a social and political right to its satisfaction. Where unsatisfied desire breeds discontent, rights language gets us off the hook of dealing with our spiritual state, for it is much easier to summon others to attend to my social rights than to summon myself to attend to my spiritual disposition.

Biohacking alerts us to the fact that bodily enhancement is liable to occur at the expense of the shrivelling of the human soul, a soul that is a light world removed from Pauline contentment, as demonstrated in its forgetfulness of the underprivileged. Our distinction between therapy and enhancement is valid, important, and practically, if not always easily, applicable. However, it does not follow that therapy is our right, nor will the quest for it—however conscientiously distinguished from the quest for enhancement—protect us from an attitude towards therapy that is also challenged by the Pauline injunction to contentment.

In a more extended discussion, we should need to explore the uncomfortable proposition that, in a world of need, those of us whose basic needs are met should choose to forfeit the maximal flourishing of our bodies by setting aside what is, in itself, a morally legitimate therapeutic provision for the body in order to promote the flourishing of the human soul.¹⁵ Concretely, this means that we should be open to the possibility that there are occasions when availing ourselves of what, considered in their own right, are morally unimpeachable forms of therapy imperils the proper contentment of the human soul. For we cannot in practice consider them simply in their own right, as socially detached moral practices, but only in their social and existential context, including our relationship to the global population. To relieve the needs of others, I must consider forgoing what is morally permitted in principle and on paper so that resources can be re-allocated. Quizzed specifically on the question of contentment, Malawian friends have told me that if they have one square meal a day, one change of clothes, and healthy relationships, they are content. It is a sobering and salutary word to those of us who, distinguishing between therapy and enhancement in moral favour of the former, directly and carelessly infer from the moral permissibility of therapy our corresponding right to it. Must we not be prepared to forfeit the maximal flourishing of the body in order to achieve maximal contentment of the soul?

In this discussion, I am making an assumption that must be brought to light. All too often, when considering human flourishing and contentment, we envisage the able body and the able mind. Why? It is not only instructive, but important, to consider disability, whether physical or intellectual, at the ground level of our thinking about human flourishing, and not as though the subject were a casual appendage to our treatment of it.¹⁶ On the contrary, it would be not only

possible, but justifiable, to do what I have not done here, which is to orient to the phenomenon of disability our whole treatment of the question of contentment and flourishing. Attending to accounts of the experiences both of the disabled, when they can articulate it, and of those who work with them, enables us to grasp the need to examine critically the theological or philosophical anthropologies that explicitly or implicitly underlie our moral assessment of biotechnologies. Take the celebration of the value of autonomy, which intrudes forcefully into debate on biotechnology—indeed, we may say, less intrudes than informs. The companionship of the disabled reveals how dependence far more than autonomy expresses the relational depths of what it is to be human. If, accordingly chastened, we reform our thinking about the relative positioning of autonomy and dependence, the questions of human contentment and flourishing begin to look quite different, and their connection with biotechnology is accordingly affected.¹⁷ All I can do here is to signal these questions; confines of space prohibit engaging with them.

Conclusion

Within the confines of this article, I have been general, viewing biotechnology through the lens of a spiritual disposition whose extreme form is Promethean aspiration, and within a contemporary cultural framework imbued with a neo-Darwinian anthropological outlook.¹⁸ It is in this context that I have drawn attention, in Christian perspective, to flourishing as conformity to our created being and contentment as a disposition of the heart. As intimated at the beginning of this piece, I have undertaken no conceptual analysis of the relationship of contentment to flourishing—or, indeed, of either notion considered independently. Moreover, I have omitted discussion both of specific moral rights and wrongs in relation to biotechnology, and of human rights to accessing that technology.

Without doubting the importance of specifically discussing rights in their place, we also need to identify what that place is. Luke narrates an incident when someone in a listening crowd hails Jesus with the words: “Teacher, tell my brother to divide the inheritance with me.” Jesus responded: “who made me a judge or arbitrator over you?” He continued: “Take care, and be on your guard against all covetousness in the abundance of one’s possessions,” and proceeded to tell the parable known as the parable of the rich fool (Luke 12:13–21). In its place, resolution of an inheritance dispute is important and certainly necessary, but Jesus bids us set out on the path of moral reflection by scrutinising basic attitudes before tackling legal niceties. I have had those attitudes in mind more than moral or political detail in my overall discussion of flourishing and contentment in a biotechnological context.

The church is the place where our attitudes are meant to be on parade. When we face death with calm, age without desperation, or endure sickness without complaint, then we reveal what it is to flourish. We reveal that we flourish when we grasp the fact that contentment underlies flourishing. When we could spend money on a therapy that promotes flourishing in accordance with what we understand to be God’s design for the human body, but pause to ask how our expenditure is related to the needs of those in the majority world who do not possess even basic goods, then we disclose what it is to be contented. When such attitudes characterise us at heart, intuitions begin to crystallise about rights and wrongs, appropriate and inappropriate uses of medicine and technology, and thus of biotechnology, where we were previously unsure. Sure,

intuitions need to be formalised into arguments, as far as they can be, and controversy will often be the order of the day. But let arguments and controversy take their rise from lived ecclesial obedience. The formulation: “The church does not have a social ethic; the church is a social ethic” is patient of misunderstanding and, even when not misunderstood, controversial.¹⁹ Yet, it harbours more than a grain of truth, and this applies in a biotechnological environment.

Some time ago, Leon Kass referred to biotechnologies as a “ripple” on “the great wave” of the modern project of “the conquest of nature for the relief of man’s estate.”²⁰ This apt remark gives my article the appearance of myopia, where Kass opens out before us a whole Baconian vista.²¹ It seems myopic when, instead of expanding our vision to take in the panoramic historical scene, we narrow it to conclude with the church. Yet, it is “through the church the manifold wisdom of God” is to be “made known to the rulers and authorities in the heavenly places” (Ephesians 3:10)—the inconspicuous church of the foolish and weak, the low and despised, who embody the wisdom of God given in Christ, author, perfecter, and exemplar of human flourishing and contentment in a biotechnological, as in any other, context.²² The battle for ideas is important, but action must issue from an ecclesial base.

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1. Benjamin Storey and Jenna Silber Storey, *Why We Are Restless: On the Modern Quest for Contentment* (Princeton, NJ: Princeton University Press, 2021), 1. This volume provides us with a deep background against which contemporary discussion of contentment may fruitfully take place.
2. This article started life as a paper delivered in 2018 at the twenty-fifth anniversary conference of The Center for Bioethics & Human Dignity, Trinity International University, Deerfield, Illinois. While only the word “flourishing” appeared in the actual title of the paper, a request had been made for some reflection on contentment to be incorporated as well. Although I have substantially revised the paper here, I have retained this dual focus.
3. Although “transhuman” and “posthuman” are often used interchangeably in the literature, they are strictly distinguishable. The transhuman represents the broadly transitional stage from humanity to posthumanity.
4. Bernard Stiegler, *Technics and Time, 3: Cinematic Time and the Question of Malaise*, tr., Stephen Barker (Stanford, CA: Stanford University Press, 2011), 202.
5. A deliberate orientation to Christianity in this paper should not obscure the fact that there are plenty of analyses compatible with Christianity in salient respects that approach cognate matters from a different point of view. Amongst other contributions, see Jürgen Habermas, *The Future of Human Nature* (Cambridge: Polity Press, 2003), with its sobering plea for us to consider how freedom becomes straitened, not enhanced, when we tinker biotechnologically with what I am discussing under the rubric of the “natural.”
6. In appealing to Genesis in this article, I am not dependent on any particular way of approaching Genesis but reading it theologically in a way which should be compatible with differing approaches.

7. Gerhard von Rad, *Genesis: A Commentary* (London: SCM, 1961), 145. Commenting on this passage, Claus Westermann observes that “the building of a massive structure that presumes definite technical discoveries and mathematical skills . . . in essence anticipates the possibility of a development that would be realized only in the technical age in a way that would affect the whole of humanity,” in Claus Westermann, *Genesis 1-11: A Commentary* (Minneapolis, MN: Augsburg, 1984), 554. I quote Westermann to show that this sort of application of the Babel account to the contemporary world is not the sole preserve of those who approach the Bible conservatively.
8. For a characteristically solid contribution, see Neil Messer, *Flourishing: Health, Disease and Bioethics in Theological Perspective* (Grand Rapids, MI: Eerdmans, 2013). When a version of this paper was originally delivered, the Center for Faith and Culture at Yale was sponsoring a project on “God and Human Flourishing.”
9. I am basing this judgement on informed conversation rather than on explicit publication.
10. Not that contentment came automatically to Paul; see his reference to the need to learn it (Phil 4:11). He uses here a different form of the same word as he uses in 1 Timothy 6:6.
11. I encountered this in a newspaper report. I take the attitude to be fairly representative.
12. Bernard Stiegler mounts an argument for the way the industrial and information revolutions have produced a situation “in which all the horizons of anticipation from which desire is constructed are effaced,” in Stiegler, *Technics and Time*, 75. See also 200–02: “What Do We Want?” Stiegler’s remarks on desire must be set against the background of his thesis that contemporary “technoscience,” i.e., science in the service of technology, privileges the possible over the real in its implied ontology. The importance of desire in his thinking is signaled early in Bernard Stiegler, “How I Became a Philosopher,” in *Acting Out*, trans. David Barison, Daniel Ross, and Patrick Crogan (Stanford, CA: Stanford University Press, 2009), 7–8. Desire is also cemented into Jacques Ellul’s conviction that “in 1900 truth was central. After 1920 happiness is central.” Jacques Ellul, *The Technological Bluff* (Grand Rapids, MI: Eerdmans, 1990), 174. But his remarks on the relationship between comfort and power indicate that Ellul looks at the connection between technology and desire from more than one angle; see, e.g., Jacques Ellul, *The Technological System* (London: Continuum, 1980), 69.
13. Ellul makes a pointed remark on this too: “It was not the public which demanded air travel or television,” *The Technological Society* (New York: Vintage, 1964), 212. It is a weakness of Shoshana Zuboff’s instructive and thorough account of *The Age of Surveillance Capitalism: The Fight for a Human Future at the New Frontier of Power* (London: Profile, 2019) that she leaves capitalism in general out of account in her critique of surveillance capitalism. See Nathan Mladin and Stephen N. Williams, “The Question of Surveillance Capitalism,” in John Wyatt & Stephen N. Williams, *The Robot Will See You Now: Artificial Intelligence and the Christian Faith* (London: SPCK, 2021), 214–27, especially 225–26.
14. Brian Brock, *Christian Ethics in a Technological Age* (Grand Rapids, MI/Cambridge, UK: Eerdmans, 2010), 168. In his volume, Brock makes helpful reference to another important thinker on technology, George Grant.
15. This formulation does not imply a dualistic understanding of the human person. It is simply an acknowledgement that there are such things as dispositional states of the soul (the word itself is not important), like pride or envy, that are distinct from physical states of the body.
16. Different conventions sometimes obtain between different countries and languages with respect to the proper vocabulary to use in speaking of “the disabled” or using associated terms.
17. In light of my allusion to the Baconian project in the final paragraph of this article, see the connection Jason Reimer Greig makes between our approach to disability and “the inordinate desire for the eradication of human contingency and the quest for autonomy” which he identifies as lying “at the heart” of that project. Jason Reimer Greig, *Reconsidering Intellectual Disability: L’Arche, Medical Ethics, and Christian Friendship* (Washington, DC: Georgetown University Press, 2015), 65.
18. Neo-Darwinism refers here to a broad, secular worldview, not to specific biological science. It is often intertwined with a mechanistic view of human persons whose modern roots go historically deeper than Darwin and neo-Darwinism.

19. Stanley Hauerwas, *The Peaceable Kingdom: A Primer in Christian Ethics* (Notre Dame, IN: University of Notre Dame Press, 1983), 99. For the interpretation of that formulation, see 99–102.
20. Leon R. Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: The Free Press, 1985), 69.
21. There is also a Cartesian, not just a Baconian, trail to be followed when tracking the modern context of biotechnology, as Kass indicates from the outset. Kass, *Towards a More Natural Science*, 2.
22. I draw here on Paul's words in 1 Corinthians 1:26–28.

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ORIGINAL ARTICLE

MITOCHONDRIAL REPLACEMENT THERAPY, THE EMBRYO, AND COMMUNITY

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Abstract

Mitochondrial replacement therapy (MRT), also known as mitochondrial donation (MD), is promoted as an option to prevent transmission of mitochondrial disorders to offspring. Since its first reported use in humans, MRT has raised numerous ethical and medical concerns. This article will explore the technology behind MRT and arguments in favor of and opposing it, concluding that a response through the lens of Scripture promotes flourishing of individuals and families affected by mitochondrial disorders without sacrificing others in the process.

Keywords: mitochondrial disorders, mitochondrial replacement therapy, DNA, embryo, germ line, disability, parenthood

Introduction

Leigh syndrome is one of a number of genetic disorders whose inheritance is through the mitochondrial DNA (mtDNA) passed on by the child's mother. In its most severe form, it leads to muscle weakness in infancy, loss of peripheral sensation, and ultimately respiratory failure.¹ Mitochondrial replacement therapy (MRT), also known as mitochondrial donation (MD), is promoted as an option to prevent transmission of mitochondrial disorders like Leigh syndrome to offspring.² Since its first reported use in humans, MRT has raised numerous ethical and medical concerns.³ This article will explore the technology behind MRT and arguments supporting and opposing it, concluding that a response through the lens of Christian Scripture promotes flourishing of individuals and families affected by mitochondrial disorders without sacrificing others in the process.⁴

The Disorders

Mitochondrial disease exists in approximately one in 5000 adults.⁵ Presentation is variable, however, due to genetic influence from both nuclear and mitochondrial DNA, which in turn affect the biochemical process of mitochondrial oxidative phosphorylation involved in energy production within the cell.⁶ In all, over two hundred genes within the nucleus and mitochondria are involved.⁷ Variability makes diagnosis and treatment difficult, with defects in oxidative phosphorylation leading to alterations in organs requiring high energy loads.⁸ In mild cases, ocular manifestations cause blindness or deafness; whereas severe forms lead to organ failure, seizures, and death.⁹

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The Technology

MRT claims to cure disorders inherited through mtDNA of affected embryos and prevent inheritance in future generations.¹⁰ Four technologies to relocate genetic material have been identified—pronuclear, maternal spindle, blastomere, and cytoplasmic transfer. Pronuclear transfer (PNT) involves the creation of two fertilized eggs, one from the intending mother who carries the defective mitochondria and her partner or sperm donor, and another from a fertilized egg created by a “donor” with healthy mitochondria which also contains sperm from the intending mother’s partner or a sperm donor.¹¹ This second fertilized egg is then enucleated and the pronucleus from the intending mother’s fertilized egg is transferred to this “donor” embryo.¹² Maternal spindle transfer (MST), on the other hand, involves the transfer of the intending mother’s nuclear DNA (nDNA) via her spindle from her affected egg to a “donor” egg that has had its own maternal spindle removed.¹³ The modified egg is then fertilized and allowed to develop in vitro before transfer to the intending mother or her surrogate.¹⁴ Although presented as mitochondrial donation by a third party, in essence both these procedures actually result in the intending mother donating *her* nuclear material to what is referred to as a “donor” egg.¹⁵ In fact, Newman argues that the woman providing her enucleated egg with its mitochondria provides the majority of the genetic material needed for early development.¹⁶ Therefore, she is closer to being the “biological mother” than is the intending mother.¹⁷

In blastomere nuclear transfer (NT), a fertilized egg is created using the intending mother’s egg and partner or donor sperm, but the egg is allowed to develop to the blastocyst stage, approximately five days after fertilization.¹⁸ Cells are then harvested and the nuclei removed and injected into multiple enucleated “donor” eggs, in essence creating cloned embryos.¹⁹ Here again, the “donor” egg is actually the recipient of the intending mother’s fertilized nuclear material. One or more of these new embryos is then transferred into the intending mother or her surrogate.²⁰ Finally, mitochondrial or cytoplasmic transfer (CT) involves the transfer of healthy mitochondria from a donor egg into the cytoplasm of an affected egg before fertilization to “dilute” the effect of abnormal mitochondria in the intending mother’s gene line.²¹ Although this technique most closely represents true donation of mitochondrial material to the intended mother’s egg, it, along with the other techniques, results in the addition of close to 20,000 mitochondrial genes from the “donor” in the process.²² Of the four procedures, PNT and MST will be the focus of this discussion, as NT has fallen out of favor due to its creation of multiple embryos with identical genes—in essence “cloning” an individual—whereas research involving CT has been largely discredited because of questionable benefits.²³

Support for MRT

The United Kingdom’s Human Fertilisation and Embryology Authority (HFEA) was the first governmental entity to recommend approval of MRT following its legalization by Parliament.²⁴ This followed the Nuffield Council on Bioethics’ review that recommended in favor of cautiously proceeding with the technology, citing “health and social benefits to individuals and families of living free from mitochondrial disorders.”²⁵ Providing genetically related but disease-free offspring to mothers affected by mitochondrial disorders is the primary factor in calling for the

approval of PNT and MST techniques.²⁶ Craven et al. point out that, outside of MRT, no options exist for a woman carrying defective mitochondrial DNA to have a healthy genetically related child.²⁷ Therefore, refusing a woman the option of MRT denies her autonomy to make her own reproductive choices.²⁸

Pompei and Pompei go further, stating, a “ban on MRT is in direct violation of a woman’s constitutionally protected rights to privacy and reproductive autonomy, encompassing both positive [freedom to decide whether or not to have children] and negative [freedom to prevent the conception or birth of afflicted children] rights.”²⁹ They note women can abort *unwanted* children, but, by not allowing MRT technology to be offered more universally, these same women “are prohibited by the government’s mandate from assuring the health and wellbeing of their unborn and *wanted* children.”³⁰ Therefore, as a means to allow women to have genetically related children free from mitochondrial disorders, MRT should be embraced.

Beneficence toward future children and their descendants also prompts support for MRT.³¹ Afflicted families testify to the devastating effects on their offspring. Often these children appear healthy at birth only to quickly deteriorate, suffering seizures, organ failure, and subsequent death.³² For others, the disorder does not appear until well into adulthood, leading to infertility or early pregnancy loss, blindness, multi-organ failure, and early death.³³ In both cases, families acknowledge the physical and emotional suffering they and their loved ones experience.³⁴ Techniques that offer future generations a chance to avoid such deleterious effects, the Nuffield Council concluded, should be pursued.³⁵

Briscoe approaches MRT more from the ethical perspective of reducing maleficence, in essence claiming MRT is the lesser of two evils. She argues that, in any case, many children who are conceived with a disability are later aborted; therefore “it is likely that most people would prefer to intervene during the conception of the child rather than merely prevent it from being born.”³⁶ For her, MRT “is arguably a more ethically justifiable method” of procreation and is therefore acceptable.³⁷ Briscoe’s belief that early manipulation of a human gamete or embryo is ethically more permissible than abortion is echoed by others as well. Shannon and Wolter, for example, speaking from a Catholic perspective, believe the embryo does not have the moral status of personhood until approximately the third week after fertilization.³⁸ Although arguing from the standpoint of justified early abortion, their logic would extend to those embracing MRT. They point to the lack of differentiation within early cells, including their totipotency and ability to twin.³⁹ Because of this lack of differentiation, the authors claim “neither the zygote nor the blastocyst is an ontological individual, even though it is genetically unique and distinct from the parents. . . . One can reasonably conclude, then, that if there is no single human entity, there is no person.”⁴⁰ Recognizing there is a unique *life* created after fertilization, the authors claim this life is not an individual *person*.⁴¹ Arguing from this standpoint, then, early manipulation of an embryo to correct a mitochondrial deficiency would be permissible because that which is being manipulated does not have personhood.

Peterson argues also from a Christian viewpoint that permitting germ line modification, as long as it is done appropriately, is morally ethical because it avoids “errors of omission” that Christ cautions against in Matthew 25.⁴² He believes we can “best serve our neighbors” by intervening

early enough in a disease process to prevent transmission of severe mitochondrial disorders to future generations.⁴³ Peterson recognizes genetic intervention of any type as a possibility, providing it is “safe and reliable.”⁴⁴ As long as the risks are proportionate to the benefits, a technology should be considered. For Peterson, faithful stewardship as Christians compels us to do what is possible, including germ line therapy, to improve the lives of those suffering from genetic disorders, as long as the technology subscribes to his five standards.⁴⁵

Still others see a much broader benefit of MRT. Shortly after his announcement of a successful birth of a baby boy via MST to a carrier of Leigh syndrome, Zhang formed a company, Darwin Life, to offer germ line therapy to women to treat age-related infertility.⁴⁶ A further step he planned was to “combine the technique with editing genes, so that parents can select hair or eye color, or maybe improve their children’s IQ.”⁴⁷ Human enhancement was clearly Zhang’s goal. For others, MRT is a way to expand biological parenthood for non-traditional families, including lesbian couples who each desire to share their genetic make-up with a child.⁴⁸ This technique is also of benefit for three individuals who want to share parentage of a genetically related child.⁴⁹ Reconsidering parenthood, it is argued, is what really is at stake in the MRT debate.⁵⁰

Thus, it is argued by supporters that MRT is ethically moral because it considers the autonomy of a mother who desires children who are biologically related to her, while also practicing beneficence by making it less likely the child will suffer from a debilitating mitochondrial disorder. Manipulation of the embryo is appropriate because it lacks personhood. Since the resulting child’s mitochondria have been changed, further generations will be protected from mitochondrial disease, extending beneficence to them as well. In addition, with society’s changing views of parenthood, MRT levels the playing field for non-traditional parents to participate in the genetic make-up of a child, providing justice to certain members of the population.

Concerns with MRT

Whereas supporters of MRT express their arguments mainly as duties to intervene to aid a mother and her child, those opposed more likely cite concerns over the value and dignity of the egg “donor,” mother, embryo, and future child. First, there is concern for the woman who serves as the mitochondrial “donor.” In preparation for harvesting her eggs, she undergoes artificial hormonal manipulation of her reproductive cycle.⁵¹ Eggs are then harvested surgically.⁵² To date, there has been no long term follow-up of egg donors to determine the effects of this type of intervention on these women.⁵³ This practice, whether or not the woman is paid for her participation, commodifies “donors.”⁵⁴ As MRT technology gains traction, and especially if its use expands to treat infertility or produce “designer” babies as Zhang envisions, the demand for egg donors is expected to increase.⁵⁵

The intending mother is commodified as well. She, too, is subjected to medical manipulation, including hormonal interventions and egg harvesting, but will also face painful decisions on which and how many fertilized eggs to implant. During the pregnancy, she will be offered prenatal diagnosis (PND) testing, since MRT procedures still carry the risk of transmitting low

levels of diseased mitochondria.⁵⁶ If the developing fetus is found to have a defect, she will be counseled to abort a child with which she has bonded. Likewise, rather than providing an option for all women carrying a mitochondrial defect, MRT is likely to suffer from inequitable distribution by limiting its services to those with the financial resources to afford it.⁵⁷ Since only a few women will be considered eligible each year for MRT, it is likely to be offered at just a few specialized care centers, further raising costs for women who would be required to travel for treatment.⁵⁸

It is the embryos and children themselves, however, who are most exploited in MRT. In PNT, for every one embryo created, two will be destroyed.⁵⁹ In both PNT and MST, only about half will survive to the blastocyst stage.⁶⁰ More will be discarded during preimplantation genetic testing.⁶¹ Only the “healthiest” embryos will be transferred to the womb. Once transplanted, PND will identify others to abort.⁶² Assisted reproduction technology (ART) alone, even for those not affected by a chromosomal defect, carries two times the risk of birth defects, increasing the chances that the developing child will be disabled or discarded.⁶³

George and Tollefson, although writing prior to the inauguration of MRT, hold it is “morally impermissible to engage in any research, for any purpose, that involves the destruction of human beings at any stage of their lives,” regardless of their inabilities.⁶⁴ Due to the unique changes that occur at fertilization that differentiate humans from other developing animals, the authors advocate that even those in the earliest stages of development “are the subjects of rights and the objects of moral duties and responsibilities.”⁶⁵ Applying natural law, they point out that “basic human goods”—such as health and the preservation of life—must be “pursued for their own sake.”⁶⁶ Therefore, anything that takes away from these goods, like embryonic manipulation, violates the human rights of individual persons.⁶⁷

MacKellar points to still another problem with MRT. He cites two types of identities individuals have: numerical and qualitative.⁶⁸ For numerical identity, the biological sense of being remains the same from conception to death and is situated “in the three dimensions of space and over time.”⁶⁹ Qualitatively, the “psychological or biographical perspective” of being one and the same also remains consistent throughout time even if qualitative changes, like a joint replacement, occur.⁷⁰ Alterations of a somatic genome maintain this numerical and qualitative identity of an individual, as the intervention affects only the existing individual.⁷¹ The distinction between numerical and qualitative identities becomes important, however, when a germ line is edited because, as MacKellar and others point out, editing a germ line does not provide a therapy for an existing individual, but instead *prevents* that specific individual from existing.⁷² A separate person, MacKellar explains, “is being brought into existence and the manner in which this happens is inherently part of who he or she is. . . . A new individual with his or her particular beginning and subsequent life trajectory would be created who would be different from the one who would otherwise have existed had the biological change not occurred.”⁷³ The individual brought into life is an entirely different person, with different numerical and qualitative identities and a different future than that which would have been born without intervention.⁷⁴

MacKellar then goes further, pointing out that germ line modification is essentially eugenics, selecting which individuals should be born.⁷⁵ This is not therapy for an existing disability, but

instead prioritizes the creation of an individual over that of one lacking the genetic makeup preferred by the intending parent(s).⁷⁶ Going further, UNESCO acknowledges the risk of moving from interventions to prevent a disease process toward ones designed to select for desired features in order to fulfill a “wish for a better, *improved* life,” however that may be defined.⁷⁷

Once born, exploitation continues.⁷⁸ Research shows an inter-connection between the pronucleus and mitochondria that accounts for “subtle selective pressure” from nuclear genetic material on the mitochondria.⁷⁹ This raises a concern the child would develop unanticipated and unknown health issues later in life.⁸⁰ Any adverse effects could be passed down to future generations and may not be discovered until much later.⁸¹ The President’s Council on Bioethics summed this up in 2004, stating, “There are today no safe and effective means of genetic modification of early embryos.”⁸² Eleven years later, UNESCO echoed these same concerns.⁸³

Adding to the ethical dilemma, these children are denied autonomy because they cannot give informed consent or refuse modification even though experimentation on them will affect themselves and their offspring.⁸⁴ To resolve part of this problem, it has been proposed that sex selection of embryos be prioritized, with only males allowed to mature, as they would be unable to pass their mitochondria on to future generations.⁸⁵ This proposal, however, raises concerns about distributive justice. First, it favors the treatment of males for mitochondrial disorders over females, even denying females life. Secondly, it discriminates against males by permitting unique experimentation only on their sex.⁸⁶ Minimizing the impact that these decisions have on the rights and autonomy of affected existing embryos and those created through MRT equates them to property rather than unique developing human beings worthy of dignity.

Sutton agrees, stating the embryo and eventual child are treated as a “mere commodity of only instrumental value to us,” but are no less a “participant in human nature and thus in the image of God” than the rest of us.⁸⁷ Embryos re-designed by MRT are, in fact, “assembled according to design as manufactured items.”⁸⁸ These embryos become artifacts, “things produced or crafted by human endeavor,” whose worth is decided by those who have designed their purpose.⁸⁹ She goes on to say:

The end product of the technique is a “collage” assembled from pieces of previously complete embryos. And in both cases the child-to-be is fabricated with a view to meeting a certain standard. These techniques pursue established parameters of health at the expense of nascent human life. This is not to accept the child-to-be as an intrinsically valuable gift and as it is, with inherent integrity. . . . Rather, both pursue health at the expense [of] depersonalizing the child. Nor does the use of maternal spindle transfer satisfy the principle. . . . Once again, the child-to-be is not treated as a neighbor and gift, and it is not given an unconditional welcome as such.⁹⁰

The modification, selection, and implantation of an embryo by MRT defines the worth of a child undergoing the procedure, signifying conditional acceptance within her family and society. With the harvesting of selected embryos and the discarding of others, some lives are judged more valuable than others.⁹¹

Germ line therapy redefines what is considered an “acceptable birth.”⁹² Parents who permit the conception and birth of a child who suffers from a mitochondrial disorder fear being

stigmatized.⁹³ Others have gone so far as to claim it is immoral to bring a child into the world who is disabled, ignoring the intrinsic worth of the disabled person as deserving equal status alongside others.⁹⁴ For Sutton, “At issue are human attitudes and aspirations that undermine the welcome of the child as a gift and deny it the respect it deserves as another person whose life comes to us as a gift from God.”⁹⁵ The sense of belonging by a child, by virtue of being born unconditionally into a family, becomes qualified for those whose genome takes precedence over their humanity.

Equally concerning is proponents’ advocacy for using MRT to address issues beyond mitochondrial disorders. Zhang’s ambitions included creating enhanced children with traits picked by parents.⁹⁶ Other countries have claimed successful births using MRT to treat infertility, although their studies are questionable.⁹⁷ Likewise, none of this takes into account the changing understanding of biological parenthood when three adult germ lines are used to treat a disorder or further creative procreation.⁹⁸

A Christian Response

An appropriate Christian response to MRT takes into account these complex issues in light of Scripture. First, we learn through the Creation story that God is the designer of all human life and calls all he makes “good” (Gen 1:31, ESV). Proclamations in the Bible confirm God’s active involvement in the creation of each person (Ps 139; Luke 1:13–25). Ramsey notes that, until a child is created, disability concerns or the need for germ line manipulation do not exist.⁹⁹ Should a child’s germ line be modified to prevent a disease, a “hypothetical” child is brought into existence from the original.¹⁰⁰ Instead of providing medical treatment to an already existing person, a new child is formed. From a Christian viewpoint, Ramsey recognizes that technologies like MRT shift the focus from God as Creator to humankind as creators, now able to manipulate cells to their design to fulfill their own desires. O’Donovan agrees, lamenting the anonymity of ART that changes the status of children from “begotten” to “made.”¹⁰¹ This is not to negate the value of the “made” child, who shares the same intrinsic dignity as the “begotten” one, but points to how God’s providence fades into insignificance when humankind determines it knows better about a child and his ability to flourish than God does.

Additionally, although it is claimed these technologies are gifts from God to be used to overcome effects of the Fall, any technology that glorifies God cannot destroy embryos or reshape parenthood in the process. Science confirms the fertilized human egg is a unique human individual, and therefore a person.¹⁰² In accepting this confirmation of humanity from science, the embryo bears a distinct individuality and commands “inherent human dignity.”¹⁰³ Because dignity is derived from our status as image-bearers of God, humanity should take seriously the commands to honor and respect others (Exod 20:10–17; Matt 22:39). The destruction of embryos to create new ones is morally unjust because it places greater value on the new embryo due to its genome than it does on those that preceded it. Ramsey points out we are more than our parts, or, in the case of MRT, our genes. We are “embodied soul[s],” sacred, and worthy of “the awesome respect required of men in their dealings with men.”¹⁰⁴ Whether begotten or made, the human embryo is of intrinsic worth to God and should be treated reverentially.

Living post-Fall, though, subjects us to disease and disability that cannot be ignored. Nonetheless, eugenic policies cannot be supported as part of a Christian response. MRT as it exists today is not the lesser of two evils, as Briscoe would claim, but is in and of itself evil due to its destruction of preexisting embryos in order to avoid disability.¹⁰⁵ Christians must acknowledge that the sanctity of the individual extends even into disability. Individuals with disabilities have much to teach families and the Church. Within disability, we learn the virtue of compassion without expecting anything in return. Other virtues, like patience, gentleness, and long-suffering, are also molded (Gal 5:22–23; Jas 1:2–15; Rom 1:2–4). The Church should be counter-cultural as it embraces those with broken bodies and minds as well as their families.¹⁰⁶ Rather than attempting to solve a genetic problem by denying life to those with disabilities, greater efforts should be placed on caring for those affected by mitochondrial disorders and advocating for safer techniques to treat them. The Church should be a place where the disabled and those who care for them experience hospitality and glimpse the New Creation promised to all who place faith in Christ. Community must be created, encouraging these families in their faith as they experience difficult trials (Rom 1:11–12).

However, we cannot deny the right or responsibility for humankind to steward Creation in such a way that disease and disability, both consequences of the Fall, are mitigated. Techniques that overcome the disabling effects of an inherited mitochondrial disorder should be sought out and developed as long as doing so does not endanger the life of another embryo or future generations.¹⁰⁷ Regardless, if mitochondrial disability cannot be surmounted without harming others, the positive impact of these affected children through all stages of development must be affirmed by the Church and society. O'Donovan notes that a reverential awe of God's creation of "new human beings, including those whose humanity is ambiguous and uncertain to us" is mandatory in helping us learn how to love others.¹⁰⁸ God values all human life equally from conception to death. We are better able to understand Christ's love for us and to love others when we embrace the creative design of God in humanity.

Finally, we must be reminded that Scripture teaches us that we are not individually autonomous creatures. A mother's decisions argued upon autonomy affect that of those around her, including the child, the father, extended family, and future generations, even as she is situated under her vertical relationship with God. Christ has made us to be in community, positioned with and dependent upon each other. Decisions are not made in a void, but their consequences reflect the inter-relatedness God designed us for (Gen 2:18, 3). God's Word roots us within our situated beings. Our true autonomy comes from recognizing God's authority over Creation and our dependence on Christ's sacrifice on our behalf as a payment for our sin—finding freedom, ultimately, in our knowledge that he has released us from the disabling effects of the Fall. It is through Christ's resurrection that we recognize the power and grace available to us that allow us to face our fears, including the fear of passing on mitochondrial disorders to our children, and respond in ways that glorify him.

Summary

MRT lauds itself as a compassionate option for parents who risk passing on a mitochondrial disorder to their children, allowing these families a chance to have a biologically related child

who is free from mitochondrial defects. However, this option is indifferent to the humanity of the embryo. Current MRT practices place the desires of parents over the uniqueness of their children, creating children to meet parents' own design, while committing them to ongoing research. Sharing genetic information between three individuals, discarding multiple embryos, and harvesting multiple eggs from donors all are signs of commodification. Rather, we should, like Ramsey, recognize that "there may be some things that men should never do."¹⁰⁹ Modifying the human genome through MRT that sacrifices some embryos for others is one such technology that we should refuse. Instead, a proper response is to advocate for research that does not place higher value over particular lives than it does that of the disabled embryo, or whose effects on future generations is unknown. Research should also support families in their current struggles, embracing the unique worth of all who are created in God's image despite their disability, inviting them into refreshing fellowship within the household of Christ as we yearn for the restoration of broken bodies in God's New Creation.

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ORIGINAL ARTICLE

ON THE ETHICS OF GLOBAL ALLOCATION OF COVID-19 VACCINES: A KENYAN PERSPECTIVE

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Abstract

The end of the COVID-19 pandemic is likely to be achieved through large-scale vaccination of the global population. So far vaccination against COVID-19 has been shown to reduce mortality and morbidity, minimize economic and social burdens, and ensure that people resume their everyday activities. Fair and equitable access to COVID-19 vaccines is critical in ensuring ethical distribution globally. This paper discusses ethical allocation of COVID-19 vaccines, focusing on models that have been proposed for global allocation, as well as provides a discussion on a Christian response to the pandemic.

Keywords: COVID-19 Pandemic, SARS-CoV-2, Vaccines, Global allocation, Vaccine Hesitancy, Equity, Justice

Introduction

The SARS-CoV-2 virus emerged in Wuhan, Huabei province, China in 2019. This virus was identified as the causative agent for the coronavirus disease COVID-19 (Sheahan and Frieman 2020, 37). The virus is thought to have emerged from a Wuhan seafood market through zoonotic transmission. The virus rapidly spread to other cities in China and soon after, through human-to-human transmission, it spread globally (Umakanthan et al. 2020, 754). Following rapid increases of cases outside China, COVID-19 was declared a global pandemic by the World Health Organization (WHO) in March 2020 (WHO 2020c). The WHO provided public health recommendations that have continued to be revised as new information about the disease emerges in an effort to contain the spread of the disease (WHO 2021a). These recommendations were soon adopted by several countries. The continued spread of the virus led to more strict recommendations, which saw most countries take unprecedented lockdown measures in a bid to further contain the disease. When these strict measures failed to contain the disease, it became apparent that there was a dire global need for preventive immunization strategies.

Prior to the emergency of SARS-CoV-2, there had been ongoing vaccine research against other coronaviruses that cause diseases such as severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) (Ball 2020). The ongoing rapid development of COVID-19 vaccines has been made possible as a result of years of research on related viruses, faster ways of vaccine development, and availability of sufficient resources. By 2021, several

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vaccine developers had conducted large clinical trials that were showing promising results (COVID-19 Vaccine Tracker 2021).

Challenges Affecting Global Allocation of COVID-19 Vaccines

The goals for COVID-19 vaccinations include reducing disease severity, reducing burden on healthcare systems, and reducing transmission to allow for reopening of global economies and resumption of normal life (Gupta and Morain 2021, 137–39). The control of COVID-19 cannot be achieved without developing an effective immunization strategy globally. In their paper on planning of COVID-19 vaccines, DeRoo, Pudalov, and Fu (2020, 2458) note that to achieve the above objectives, safe and effective vaccines need to be delivered rapidly to the population. However, they reiterate that for broad immunological protection to be realized the vaccines must not only be available, but increased vaccine uptake will be as important. This has been echoed by Wouters et al. (2021, 1023, 1031), who indicate that enough and affordable vaccines need to be produced and distributed globally.

Vaccine Hesitancy

Hesitancy is defined as “delay in acceptance or refusal of vaccines despite availability of vaccine services” (MacDonald 2015, 4163). There has been reluctance and refusal to take up the COVID-19 vaccines among groups and individuals. This has been attributed to several concerns about side effects, effectiveness, the fast pace of vaccine development, safety, and lack of concern about COVID-19 infection (Solís Arce et al. 2021, 1389–90). Some people hesitant to receive vaccines cite religious reasons and instead pray and use religious items of purification and/or healing such as holy water (Garcia and Yap 2021, e529).

Even prior to the COVID-19 outbreak, vaccine hesitancy was a global concern that was declared by the WHO as one of the ten threats to global health (WHO 2019). Vaccine hesitancy is a limiting factor to the prevention of COVID-19 infection globally. This has been compounded by the politicization of COVID-19 vaccination efforts. The politicization has been attributed to a number of factors, and has included statements made by various political leaders around the globe—including in the US—stemming from uncertainties surrounding the COVID-19 vaccines. Such utterances from influential figure are likely to be construed as the truth by people who share the same political beliefs.

Additionally, media coverage also perpetuated a lot of misinformation about COVID-19. Some media platforms termed the disease as normal flu, political flu, and flu panic (Bolsen and Palm 2022, 85). Social media also contributed to the ubiquity of misinformation about the pandemic globally. False claims and conspiracy theories were being circulated through the use of smart phones. This spread of unreliable and unscientific information through such channels with limited gatekeeping contributes to endangering the public and exacerbating the spread of the virus and has been linked to high levels of vaccine hesitance (Broniatowski et al. 2020, S5315–16). Effective communication is central in the management of health crises. Despite the many sources of information that are available to the public, governments have a responsibility

to provide strategic authoritative information and to give reassurance and guidance to the public in the fight against the spread of COVID-19.

To successfully reduce mortality and morbidity from vaccine-preventable infectious diseases such as COVID-19, there is a dire need for widespread acceptance of vaccines (Dubé et al. 2013, 1763). Widespread vaccination will not only offer direct protection to vaccinated individuals but also provide protection to the whole community, even those who are not vaccinated (Fine, Eames, and Heymann 2011, 911–12).

To overcome vaccine hesitancy, governments should invest in targeted education programs to improve vaccine uptake and adherence to other preventive measures (Kaim et al. 2021, 1, 6). In addition, it will be prudent to provide information on the safety of the vaccines to dispel fears. The government can also involve other stakeholders such as community leaders and community health workers, who play an important role in tackling misinformation about COVID-19 vaccines.

Lessons learned from previous experiences with vaccination preprograms can be applied in addressing COVID-19 vaccine hesitancy. For instance, Aguolu and colleagues conducted a review of studies on interventions to address measles and human papilloma virus (HPV) vaccine hesitancy. The review demonstrated that educational interventional and on-site vaccinations improved awareness and knowledge and were associated with acceptability and uptake of the vaccines. Vaccine message framing that included information on benefits of receiving versus not receiving vaccines tailored for target population was also associated with increased vaccine uptake. In addition, financial incentives, including free vaccination both for healthcare providers and end users, were found to have been associated with HPV vaccine initiation and completion (Aguolu et al. 2022, 334–36).

Funding For Covid-19 Vaccine

While vaccine development has been underinvested in the past, this has not been the case for COVID-19 vaccines. The urgent need for vaccines has led to an upsurge of not only financing of clinical trials by governments, non-profit organizations, international financial institutions, philanthropic organizations, and individuals (Hooker and Palumbo 2020), but also investment in infrastructure for vaccine development and distribution (Wouters et al. 2021, 1031).

Despite such investments, funding has remained a major limiting factor in the distribution of vaccines, especially in low-income countries. Kenya, for instance, has greatly benefited from funding by the World Bank to cover its COVID-19 management expenses. The first vaccines to arrive in Kenya were sent through the COVAX Facility in March 2021. Vaccine roll-out was planned to be done in three phases. Kenya's target is to vaccinate 30% of its population and was expecting that COVAX supply would cover 20%, while local funding would cover the remaining 10%. The initial plan was to prioritize frontline workers, who included healthcare workers, the police force, and teachers. This was later revised to include adults aged 58 and above. Phase two was to include those vulnerable above 18 with comorbidities, and phase 3 would involve vaccination of adults above 18 years as vaccine supplies increased. This would

translate to a total population of about 26 million Kenyans to be vaccinated by the end of 2022 (MOH 2021, 4).

Addressing challenges to meeting such targets, the Kenyan Ministry of Health (MOH) identifies budgetary constraints that have strained communication, community awareness creation, and capacity building. This is despite the funding received from international donors and national budget allocations for COVID-19 response. More specifically, such limited funds along with challenges related to geographical access have affected allocation of vaccines in hard-to-reach areas, disproportionately affecting communities in those places (MOH 2021, 7).

To address financial constraints and support vaccination access for limited resource settings, AstraZeneca and Johnson & Johnson stated that they would keep their vaccines affordable for the duration of the pandemic, especially for low- and middle-income countries (Wouters et al. 2021, 1024–25). AstraZeneca likewise pledged to supply millions of vaccine doses to a number of countries in Europe and the US at no profit (Kemp 2020). Such pricing may change once the pandemic subsides; however, given the nature of the COVID-19 pandemic, the expected timeframe for an end was unpredictable when these companies made their affordability commitments (Hooker and Palumbo 2020).

Other manufacturers targeted their COVID-19 vaccine primarily for premium private markets, meaning that this might only make them accessible to wealthier clients. Following previous practices, pharmaceutical companies charge different prices in different countries depending on what governments would be able to afford (Hooker and Palumbo 2020). The prices for COVID-19 vaccines are determined by multiple factors, including differences in technology and associated manufacturing costs, funding and funder's demands, licensure processes, intellectual property rights, and political pressures for low pricing. Vaccine costs for countries may be a recurring expense depending on the duration of the protection they offer and their ability to offer protection against new variants (Wouters et al. 2021, 1027). Governments will need a sustainable source of revenue to cover the vaccine program expenses.

Vaccine Production Capacity

Furthermore, beyond the availability of funding for vaccine procurement, there are limited resources for vaccine manufacturing as well as limited capacity for vaccine production. More specifically, the sub-Saharan African region has been shown to have limited vaccine production capacity (Bright et al. 2021, 5). This means that low- and middle- income countries (LMICs) will rely heavily on both international donations and supply of vaccines from programs such as COVAX.

As the world's biggest vaccine producer, India arranged collaborative agreements with several COVID-19 vaccine manufacturers and has the capacity to produce large batches of COVID-19 vaccines for global distribution. This has made COVID-19 vaccines accessible to LMICs such as Kenya through the COVAX program. Despite its capacity, by May 2021 India had only vaccinated 2% of its total population of 1.3 billion people. Shortages of doses were reported through the country once all adults 18+ years became eligible for vaccination (Ellyatt 2021). Coupled with the COVID-19 second wave that India experienced in May 2021, vaccine

manufacturing companies may have been overwhelmed and halted exportation of vaccines to focus on vaccinating India's own population. The country was set to resume exportation of vaccines to COVAX and neighboring countries from October to December 2021 (Arora and Das 2021). This resumption of exports increased access for LMICs who had not been able to vaccinate a majority of their population due to the previously mentioned factors.

Models for Ethical Global Allocation of COVID-19 Vaccines

Vaccinating a large number of people globally will reduce infection and thereby prevent virus mutations that may make vaccines less effective. The challenge is to make the vaccines available globally and not just to wealthy countries. By the end of 2021, approximately 273 million cases of COVID-19 had been confirmed globally with approximately 5.3 million deaths related to COVID-19 disease. More than 7.7 million vaccine doses had been administered (WHO 2021b). Approximately a year later, in November 2022, there were approximately 645.2 million confirmed cases with 6.6 million deaths related to COVID 19 globally (CSSE 2022).

Towards the end of 2021, the United Arab Emirates was leading in vaccination rate with approximately 88% of its population fully vaccinated. Other countries such as the UK had fully vaccinated about 67% of its population. The US had about 58% of its population fully vaccinated, while India had fully vaccinated only 30% of its population. Only 5.7% of the population in LMICs had received at least one dose out of the 54% of the world population that had been partially vaccinated (Mathieu et al. 2021). By November 2022, 68.5% of the world population has received at least one dose of a COVID19 vaccine while only 24.6% of people in LMICs have received at least one dose of the vaccine (Mathieu et al. 2022). These differing rates in vaccination by country reflect inequity in access to vaccines globally.

To ensure equitable access to the vaccines, the WHO, in collaboration with Gavi and the Coalition for Epidemic Preparedness Innovation (CEPI), established a global collaborative program: the COVID-19 Vaccine Global Access (COVAX) Facility. The aim of the program was to collaboratively develop, procure, deliver, and ensure fair and equitable global distribution of COVID-19 vaccines. COVAX's approach was to have vaccines allocated in phases, prioritizing healthcare workers, older adults, and other high-risk individuals before vaccinating other sections of the population. The WHO recommended two models or frameworks that were accepted by COVAX. First, fair allocation of vaccines would occur by allocating enough vaccine quantities to cover 20% of the population in participating countries. A follow-up phase would then expand coverage to other populations (WHO 2020a, 23–29).

COVAX's main goal of ensuring equitable access to COVID-19 vaccines has been challenging to achieve, as wealthy countries procured large quantities of vaccines directly from developers, thus limiting the supply available for the COVAX program. According to Wouters et al., "governments in high-income countries, representing 16% of the global population, have struck pre-orders covering at least 4.2 billion doses of COVID-19 vaccines. These countries secured at least 70% of doses available in 2021 of five leading vaccine candidates, on the basis of known deals" (2021, 1028). Securing vaccines in this manner led to wealthy nations vaccinating their own populations ahead of priority populations and high-risk populations in LMICs (Wouters et

al. 2021, 1028). Further exacerbating access issues, wealthy nations purchased more doses than they needed for their populations. For instance, by September 2021 the EU secured 3 billion COVID-19 vaccine doses (i.e., 6.6 doses per person), the US brokered deals for 1.3 billion doses (nearly 5 doses per person), and Canada secured 450 million doses for a population of less than 40 million (more than 11 doses per person). Similarly, the UK had agreements for over 500 million doses (approximately 7.5 doses per person), and Australia ordered 170 million doses for a population of 25 million people (nearly 7 doses per person). LMICs like Kenya with little purchasing power were left scrambling for whatever little vaccine supply was left. Comparatively, Kenya secured only 3 million for 48 million people (1 dose per 16 people) (Mathieu et al. 2021).

In addition to the COVAX models, alternative frameworks were proposed. In their paper on an ethical framework for global vaccine allocation, Emanuel et al. highlighted three important values that must be considered when distributing COVID-19 vaccines: “benefiting people and limiting harm, prioritizing the disadvantaged and equal moral concern” (2020, 1309–10). The authors proposed an alternative framework they referred to as the Fair Priority Model directed to COVAX, vaccine developers, and governments.

The Fair Priority Model proposed three phases to be considered for global vaccine allocation. Phase 1 aims at reducing premature deaths that may or may not have been a result of COVID-19 using the criterion of “Standard Expected Years of Life Lost (SEYLL) averted per dose” (1310). This phase promotes equal respect for lives in all countries by allocating vaccines to countries where they will save the most life years. Phase 2 seeks to measure and reduce the socio-economic impact of the disease using SEYLL, Gross National Income (GNI) per vaccine dose, and the poverty gap. This means that vaccines will continue to be allocated even after death reduction to cushion against further economic decline. Finally, Phase 3 aims at reducing infections to allow for global economic recovery by first prioritizing countries most affected by the pandemic and eventually distributing vaccines to all other countries (1310–11).

Emanuel et al. proceeded to identify several key flaws with the COVAX phased-approach model. First, while they seem to agree that the COVAX proposal to allocate vaccines based on percentage addresses the principle of equal moral concern, they indicate that such a model does not consider the differences in suffering for different populations, and that as a result international assistance should be given to those who are suffering the most. Instead, they argue that the primary measure for allocation ought to be the number of premature deaths that a vaccine would prevent (1310). Secondly, they argue that allocation based on the populations most at risk (e.g., healthcare workers and the elderly) does not take into consideration the level of risk in different geographical environments. Healthcare workers in developed countries are not at equal risk with those in limited-resource countries. Furthermore, they argue that such an approach is biased toward benefiting well-developed countries with higher numbers of the population identified as most at-risk (1311–12).

Anticipating potential criticisms to the Fair Priority Model, Emanuel et al. indicate that arguments may be made that fair allocation of vaccines should be conditioned on infrastructural capacity and assurance that countries will be able to distribute the vaccines to the population to minimize

death and mitigate economic harm. In response, the authors argue that “a fair distribution of emergency supplies ultimately aims at helping individuals and as long as individuals benefit, fair global distribution among countries should neither require that international distribution of vaccines be perfectly just nor seek to punish unrelated injustices” (1312). They also consider arguments that “the Fair Priority Model unfairly disadvantages countries that have effectively suppressed viral transmission without a vaccine and rewards those who have responded ineffectively” (1312). The authors point out that “a fair distribution of vaccine among countries must mitigate future health, economic, and other harms spawned by COVID-19. It should not be backward looking, punishing or rewarding countries for their COVID-19 response or aiming to redress past injustices” (1312).

Finally, Emanuel et al. address potential concerns about the use of health metrics being “too uncertain and demanding to calculate,” noting that “in a novel, rapidly evolving pandemic, any approach sufficiently sophisticated to meaningfully operationalize ethical values will require approximations as well as judgments about the relative weight to assign different metrics, such as SEYLL and the poverty gap” (1312). In addition, they argue that “the proposed metrics are routinely used in global health, and basing vaccine distribution on these metrics will encourage collection and reporting of accurate data on changes in mortality and poverty related to COVID-19” (1312).

The COVAX model has encountered many challenges with the vaccine distribution process. This includes relying primarily on the Serum Institute of India (SII), which was licensed to mass produce vaccines for the COVAX facility. When SII paused its vaccine production to address the COVID-19 surge in India, COVAX fell behind its distribution goals for June 2021 by about 190 million doses (Ducharme 2021). If COVAX had access to sufficient funds from global economic leaders such as the US and other wealthy countries from the initial establishment, it would have had the ability to make deals with other manufacturers, thereby boosting vaccine supplies and avoiding many of the delays in global vaccine distribution among LMICs that were experienced (Ducharme 2021).

Some countries accused COVAX of poor communication and inefficient bureaucracy when trying to get information on the status of national vaccines orders. Additional complaints arose about prolonged delays in expected delivery of vaccines. Libya and Uruguay, for instance, gave up waiting for their vaccine orders placed through COVAX and paid for a second supply of vaccines, this time directly dealing with the pharmaceutical companies (Goldhill 2021). Further complicating factors, LMICs had challenges distributing the vaccines once they were received from COVAX. In addition to the prolonged delays in delivery, vaccines were often received with little notice, throwing the local supply and distribution chains into chaos. Lack of storage facilities such as deep freezers needed for maintaining potency of the vaccines led to numerous reports of wasted doses (Mueller and Robbins 2021).

It is unfortunate that we had not learned from experiences with highly infectious diseases such as Ebola in West Africa and the H1N1 pandemic. Had the COVAX facility been established and well funded prior to the COVID pandemic, the unjust and inequitable global distribution of COVID-19 vaccines may not have been experienced. To prevent such inequities from occurring

in the future, global solidarity is imperative. High-income countries should participate in COVAX, guarantee funding for COVAX, and support transfer of intellectual property rights to LMICs for them to be able to also manufacture vaccines within their countries (Clinton and Yoo 2022).

Despite these challenges, COVAX has played a big role in helping to balance the global inequities in allocation and distribution of COVID-19 vaccines, especially in limited-resource settings. By early 2022, COVAX had distributed 1,678,517,990 vaccines, of which 61% were distributed to 148 countries and territories participating in COVAX (Yoo et al. 2022, 315, 322).

A Christian Response to the COVID-19 Pandemic

Pandemics are not a new phenomenon in the face of Christianity. The Bible speaks of a broken world since the time of the fall of humanity, with its resulting curses and the subsequent spread of sin beginning in Genesis 3. The Bible does not shy away from the topic of death either. Most relevant for our purposes, it also mentions a number of plagues, pestilences, or pandemics killing people. Some of the plagues were directly sent by God as punishment for disobeying the Covenant (Lev 26:25). In Exodus, God sent ten plagues upon Egypt when Pharaoh refused to let the Israelites leave (Exod 7:14–12:36). Later in the New Testament, in Revelation 6:8, one of the four apocalyptic seals reveals a rider who brings the power to kill by plague.

Yet, God is not blind to human suffering. Through Christ Jesus, God participates in our humanity and shares our grief, suffering, and sorrows. Jesus himself died a painful death on the cross for our sins. The Bible teaches us about suffering while providing an explanation for why God allows suffering, such as in Romans 5:3–4: “Not only so, but we also glory in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, hope” (NIV). Additionally, we are encouraged to trust in God and not to be fearful in the face of suffering (Isa 41:10). While it is understandable for human beings to be afraid, especially in times like this, God promises his unwavering support for his children during these challenging seasons.

In his book *Virus as a Summons to Faith*, Brueggemann (2020, 35–45) explains how it is important for us to turn to God in prayer and have trust in him hearing our prayers. He provides a comparison of the current situation with the COVID-19 pandemic with the suffering that the Israelites went through. While in Egypt, the Israelites would pray and expect God to answer their prayers simply because he had made a covenant with them, and therefore they expected God to automatically honor his promises. But, Brueggemann explains that we should not expect to see immediate answers simply because we have prayed and trusted in God; rather, we are expected to repent of our sins and live a life in obedience to God’s commandments. By doing so, our lives are then renewed and transformed. As a result, disasters such as the COVID-19 pandemic are defeated through God’s power (Brueggemann 2020, 57ff).

Reflecting back on the creation story, humans were created in the image of God and with unique capacities to make artifacts that are distinct from other animals. They were given the mandate to be the sole custodians of God’s creation. In the face of the COVID-19 pandemic, Christians have continued to turn to Jesus and have responded to global needs as a reflection of Jesus’

great commandment on love for God and others (Mark 12:30–31). Humankind has been given a dominion mandate to take care of God’s creation. Christians therefore have a duty to care for the sick and most vulnerable in society, caring for both their physical and spiritual needs.

As part of this greatest commandment, Christians have a duty to advocate for the weak and voiceless in society. We have a biblical duty to protect our neighbors—“Do not do anything that endangers your neighbor’s life. I am the LORD” (Lev 19:16). As Christians we affirm that people have intrinsic value because we are all created in the image of God and therefore should have equal chances of receiving treatment and preventive interventions. Christians and other religious communities must purpose to hold stakeholders such as governments, the WHO, the CDC, and pharmaceutical companies accountable to ensure that vaccines are made accessible and that they are fairly and equitably distributed to everyone across our global societies, including the vulnerable communities in hard-to-reach areas and especially in limited-resource settings. Loving our neighbors should not be limited to political boundaries. For instance, Christians in wealthy nations should call out their governments for purchasing excess vaccine doses and call for them to donate vaccines to LMICs. In addition, they could ask their governments to make contributions to the COVAX facility, which would then use the funds to purchase more vaccines for LMICs.

Christians are called to discern the truth on earth and make decisions in response. Christians should recognize the gifts God has given to scientists and medical professionals. Our duty is to support those who have these gifts as they focus on taking care of the sick and finding better treatment and preventive strategies against COVID-19. Science and medicine, just like other professions, are gifts given to humankind to enhance earth’s fruitfulness and ultimately glorify God the Creator. Physicians have a mandate to heal, and as a result those who have been healed can continue with their assigned earthly mandates.

It is unfortunate that during the initial stages of the pandemic some religious leaders were not in full support of the public health preventive measures. Some of the leaders continued hosting regular religious events with congregants in complete disregard of the lockdown measures and restrictions on crowd gatherings that were recommended. Activities from various religions have been associated with community spread of COVID-19, some resulting in hospitalization and death (McKie 2020, McGee 2020, and Rasid 2020). One such example involved several large public gatherings affiliated with churches in South Korea which resulted in the significant spread of COVID-19 cases (Kwon 2020).

The WHO made several recommendations early on during the pandemic as a way for the church to provide support against the virus. Religious leaders were urged to help in observing the measures put in place to ensure safety during religious events, share evidence-based public health information, and to strengthen social support structures such as mental and spiritual health among others (WHO 2020b). Religious leaders also play an important role in the COVID-19 vaccine rollout. Such leaders in collaboration with other stakeholders can engage with often skeptical local communities and involve them in the processes of vaccine allocation. This will not only encourage buy-in and support but also promote acceptance of vaccines and address stigma and misinformation that have been a great impediment in the acceptance and

uptake of vaccines. Religious leaders and healthcare workers are a trusted source of information for most people. Barrier analysis studies conducted by World Vision demonstrated the influence of church leaders on acceptance of vaccines, indicating that vaccines are more acceptable if recommended by religious leaders and community workers (World Vision 2021).

Additionally, churches and other religious establishments can play a vital role in the distribution network itself, serving as vaccination centers for local communities in a similar way that churches are frequently used as shelters during other disasters. Likewise, church leaders are known to have strong influence on their communities and in some places even on local governments. As active partners with community workers and healthcare workers, such religious leaders can provide influence and assistance to overcome local logistical difficulties in COVID-19 vaccine allocation and distribution, especially in hard-to-reach areas. In addition, they can hold governments accountable and ensure that allocation of vaccines is done fairly and equitably.

When vaccines were made available in Kenya, the Ministry of Health developed a distribution plan that prioritized essential workers, including healthcare workers and security personnel. The vaccines were also distributed to one hospital facility per county, the national referral hospitals, and a few selected private health facilities (MOH 2021, 13ff). This meant that even though one was eligible for a vaccine, you had no chance of getting the vaccines until much later when distribution started in other county and sub-county hospitals. Those living far from the selected vaccination hospitals had to travel long distances to get vaccinated, and there was no guarantee that one would get a vaccine even once they got to the vaccination centers as doses that were allocated to the centers themselves were limited. As more vaccines were purchased and made available, the Kenyan government expanded vaccination centers to include church facilities. This made it easier for the public to access the vaccines since there are numerous churches spread all over the country, even in remote villages.

In Kenya, an Interfaith Council with representation from different denominations was established to develop a program for public sensitization and capacity building for religious leaders. In addition, they developed protocols for gradual reopening of worship places and celebration of other religious activities in compliance with the COVID-19 public health preventive directives that were in place (Kahiu 2020).

The COVID-19 crisis is a call to prayer for Christians to turn to the Creator of the universe in such times of certainty just as we do in times of joy. We should pray for physicians, scientists, politicians, and all stakeholders involved in COVID-19 response. In addition, we should pray for families that have lost loved ones. It is through prayer that Christians grow in their relationship with God and in their awareness of God's compassion amid this crisis. It is through prayer that Christians learn total reliance on God's love amid the pandemic.

Conclusion

The COVID-19 pandemic should be a lesson for the world to take precautions and prepare to make the world safer from future pandemics. It is clear that a coordinated prevention and treatment effort is needed for the pandemic to end. It is incumbent that stakeholders, including

governments, funders, and vaccine developers, work together to ensure that there is adequate vaccine access, especially to the most vulnerable globally.

The injustice in vaccine access and distribution observed over the course of the pandemic should be strongly condemned and never repeated. A coordinated global effort based on equity sharing of vaccines and other resources is needed if indeed the pandemic is to end. LMICs also need to step up and explore ways of bridging the resource gap together to enhance their own capacity to develop vaccines for not only COVID-19 but other diseases that have afflicted their populations for decades.

Despite the devastation that the pandemic continues to cause, it has been an opportunity to bring different communities together in caring for each other and showing compassion for one another. The way in which Christians treat others, especially during this stressful time, should be a reflection of God's nature. Christians demonstrate that we were created in God's image through faithful execution of our calling. God's interaction with creation through the divine activities of creating, preserving, and governing corresponds to the tasks that humankind, specifically Christians, perform to fulfill their mandates in relationship to earth.

Disclaimer

The views and opinions expressed in this article are my own and do not necessarily reflect the official policy or position of any government institution.

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BOOK REVIEWS

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Sometimes a book has pages filled with the reality of truth. *The Way of Medicine: Ethics and the Healing Profession*, by Farr Curlin and Christopher Tollefsen, is one such work. In a relatively short and readable volume, the authors explore and analyze the how's and why's of medical practice, from the ancient model of Hippocrates to the modern "service-provider model." Using case examples, moral theory, foundational ethics, and experience, they charge after the conflicts between the modern model and the more ancient "way of medicine," which they espouse as "a practice oriented toward the patient's health as one basic human good" (p. 54). Their central questions are: "what is medicine?" and "what is medicine for?" They answer these by embracing clinical practice as a *profession*, not a job.

The intent of the authors is to redefine how we see the sick. They are not consumers of our product or our clients. They are *patients*: suffering persons in the midst of an illness, in need of relief, which physicians are called upon to provide as well as they can. In a chapter exploring the "Doctor-Patient Relationship," Curlin and Tollefsen bring into focus both the dangers of paternalism and the emergence of autonomy. They show how physicians are often swayed from using beneficence as their dominant ethical principle. They defend the idea that medicine is essentially a relationship among persons.

The rest of the book explores the nuances of some important ethical issues confronted by physicians at the bedside: autonomy and authority, the principle of double effect, sexuality and reproduction, abortion and unborn human life, and conscience-based medical practice. They do an excellent job of identifying the facts, the ethical issues, and the rationale for their opinions. For those, however, not persuaded by their "way of medicine," Curlin and Tollefsen might come across as rather biased, leaving little room for the modern service-provider model.

Indeed, the authors of *The Way of Medicine* stand firmly in the trenches of the Hippocratic approach, with a strong sense that it has always been how medicine was best practiced, and how it still should be. They strongly endorse medical practice committed to the physician-patient relationship, founded on trust, integrity, and mutual respect for the dignity of one another. They show that in contemporary medicine and the service-provider model, there is little room for such virtues. Younger physicians who have never experienced the "way of medicine" may not understand nor feel comfortable changing or even adjusting their clinical practice. Perhaps more examples of how to do so without becoming disillusioned might help the authors' thesis. After all, this book resonates more with the "senior" physician with decades of experience

David H. Beyda, review of *The Way of Medicine: Ethics and the Healing Profession*, by Farr Curlin and Christopher Tollefsen, *Ethics & Medicine* 37, no. 2-3 (2021): 147-148.

rather than junior residents or attendings. Having medical students read this book before they encounter the service-provider model might be the best way to give them a lens to see what medicine should be. Medical practice is based on empirical facts, but seeing our patients as real people is based on our values.

The strength of this book is its honest, authentic, and genuine acceptance of a “way of medicine” focused on a profession of caring rather than the mere job of providing a service. For clinicians asking themselves whom they are serving, what they are doing, and what medicine is for, this will give them fodder for thought. They may need to look at themselves in the mirror and ask, “Am I a provider or a healer?” Answering the latter may be a hard taskmaster for some or even a fool’s errand for others. Yet for those brave enough to see themselves how others see them, this book might just give them a lens to focus on the task. The most important tool we bring to the bedside is ourselves: humble physician-healers practicing medicine with and for our patients.

Reviewed by David H. Beyda, MD, Chair and Professor, Department of Bioethics and Medical Humanism, University of Arizona, College of Medicine-Phoenix

The Rise and Triumph of the Modern Self: Cultural Amnesia, Expressive Individualism, and the Road to Sexual Revolution

Carl Trueman, Crossway, 2020.

ISBN 978-1-4335-5633-3, 425 Pages, Hardcover, \$34.99.

Carl Trueman, a church historian by training and, in recent years, a cultural analyst, has given the evangelical world—and others willing to listen—a sophisticated historical and philosophical genealogy of the current cultural crisis in the West. It is a “how we arrived at our present situation” book, filled with evidence and intellectual connections over about 300 years. Trueman searches for the roots, not only of our sexual mores and practices, but of the broader ideas that form what many would label the reigning worldview.

Trueman’s book contains four major sections: (1) the framework of his analysis, drawn from the works of Charles Taylor, Philip Rieff, and Alasdair MacIntyre; (2) the early historical development of Expressive Individualism, the worldview Trueman identifies as the foundational problem; (3) the later development of Expressive Individualism, starting in the twentieth century; and (4) the modern culmination of the historical process, focusing primarily on the Sexual Revolution.

At the heart of Trueman’s entire discussion is Expressive Individualism, the idea that not only are individuals autonomous (as exemplified by Kant and the Enlightenment) but that they should express that autonomy in their choice of “life project” or identity (after Rousseau and the Romantics). In Part One, Trueman draws on Taylor, Rieff, and MacIntyre to provide a workable framework or analytic lens for assessing this worldview.

Taylor contributes his mimesis/poiesis relationship and the “immanent frame” (opposed to transcendent) as ways of tracing the emergence of the “modern self.”¹ Trueman then states that “Philip Rieff . . . is significant for this study because of his application of psychology to the patterns and pathologies of cultural change in the last one hundred years” (p. 42). In particular, he considers the influence of Sigmund Freud and Wilhelm Reich in this regard. Rieff also contributes the category of “third world” as a cultural *Zeitgeist*.² Finally, MacIntyre is helpful to Trueman for his discussion of virtue ethics in connection with social assumptions.³

Building on these foundations, Part Two traces the historical core of Expressive Individualism and its specific manifestation in the realm of sexuality from Rousseau to the New Left of the 1960s. With individual autonomy an assumed foundation from the Enlightenment, individuals must be free to pursue their goals, as much as possible, unhindered by church or state and guided by reason. In the late eighteenth and early nineteenth centuries, Rousseau and the Romantics did not attempt to undermine the Enlightenment but to complete it. Wordsworth, Shelley, and Blake highlight the “rise of the modern self” as both an introspective phenomenon and an external expression. As Trueman puts it, “the psychological inner life” is Rousseau’s

Marc A. Clausen, review of *The Rise and Triumph of the Modern Self: Cultural Amnesia, Expressive Individualism, and the Road to Sexual Revolution*, by Carl Trueman, *Ethics & Medicine* 37, no. 2–3 (2021): 149–151.

preoccupation (pp. 107–8). More crucially, Trueman points to Rousseau’s argument “that it is society and the relations and conditions that society embodies that decisively shape and . . . decisively corrupt individuals” who might otherwise live happily in dignity (another central shibboleth for the modern age) in a “state of nature” (p. 115). To sum up, regarding dignity and the psychologizing of the self, “individuals [have] integrity and a value that derives from their inward self-consciousness and individuals have a value in themselves and not derived from their extrinsic position in the social hierarchy” (pp. 126–27). It is this inner dignity that must be encouraged and expressed. The other Romantics follow Rousseau’s course but add the dimension of “freedom from religion” and “freedom for love,” namely, sexual love (pp. 148–58).

Trueman then turns to Nietzsche, Marx, and Darwin to exemplify the historical shift in moral philosophy from its traditional transcendental forms to those variants rooted in naturalism. Nietzsche emphasizes “self-creation” and the so-called “transvaluation of values,” while Marx “stresses conditions and the constitution of the world” (p. 176). According to Trueman, human nature is plastic for Marx, subject to change as economic systems change. Moreover, besides the therapeutic, everything becomes political (p. 179), an idea that profoundly influences our current culture. Finally, Darwin’s influence was to allow “no room for inferring that [human nature] had any special destiny or significance” (p. 185). Darwin thereby leaves no room for objective morality, making it incumbent on the individual to create his own identity.

In Part 3, Trueman completes his historical analysis in the twentieth century by examining Freud, his Marxian follower Wilhelm Reich, and the Neo-Marxist/Critical theorist Herbert Marcuse. Together, these individuals and their followers sexualize politics and politicize sexuality, or at least lay the foundations for such trends. Freud advocated freedom from sexual repression, Reich promoted liberation for sexual expression at the societal level, and Marcuse functioned as a sort of “guru” of the New Left among its younger members concerning sexuality. Not coincidentally, the Sexual Revolution of the 1960s coincided with Marcuse’s heyday of influence.⁴

In Part 4, the final section, Trueman argues that we now see the culmination of all these influences in Expressive Individualism. The “Triumph of the Erotic” (ch. 8) represents the logical outcome of these movements in history. “Sex now pervades every aspect of life,” Trueman writes, including the LGBTQ+ movement, expressions of sexuality in commercial life, education, court cases, media and entertainment, religion, even Christian Evangelicalism, as well as the culture at large (pp. 272–73).⁵ In addition, Trueman perceives the “triumph of the therapeutic,” invoking the work of Rieff, as permeating culture, not just in the area of psychology proper, but in all parts of life. He discusses the Supreme Court (its invocation of “dignity” in *Obergefell* and other cases), ethics (Peter Singer), and student protests (“microaggressions” and “safe spaces”). In a limited sense, the Neo-Marxists of the Frankfurt School succeeded in their “march through the institutions.” Trueman finishes with a succinct discussion of where we should go from here, for which he apologizes as not fulfilling.

Trueman’s work is unique, not so much in its genre of addressing worldviews of various types, but in the particular content of Expressive Individualism. Charles Taylor and other

recent Christian writers have contributed elements to this analysis. But no one else has “put the pieces together” as well as Trueman. He masterfully traces the historical antecedents that led to Expressive Individualism, though he might have done even better by beginning with the Enlightenment. Overall, the book is well-written and readable by both general readers and scholars alike.

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13. See, e.g., Mollie Frost, “Doctors with Disabilities Reflect on Challenges,” *ACP Internist* (February 2020), <https://acpinternist.org/archives/2020/02/doctors-with-disability-reflect-on-challenges.htm>.

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Ethics in Pharmacy Practice: A Practical Guide

Dennis M. Sullivan, Douglas C. Anderson, and Justin W. Cole, Springer, 2021.
ISBN 978-3-030-72168-8, 234 Pages, Hardcover, \$109.99

Along with nurses and medical doctors, pharmacists have long been recognized, and honored, by the public as professionals exhibiting honesty and high ethical standards. Serving as the medication expert in the healthcare system, both other medical professionals and patients alike rely heavily on the pharmacist's knowledge and skills related to an increasingly complex landscape of medications and the diseases (or situations) that such are intended to prevent or treat. And it is expected—assumed even—that the pharmacist will leverage such expertise in the best interest of the patient—as a fiduciary, if you will—exercising a competent, selfless, and wise approach to each patient's care. Such is the reasonable expectation of all healthcare professionals. As a pharmacist of more than thirty-five years, and a several-years professor of professional ethics in pharmacy, I hold no less of an expectation of myself or anyone who is likewise licensed to practice in this noble profession.

To be sure, considering the rapidly increasing number and types of new medications released to the market each year, and the challenging ethical dilemmas that accompany the use of many of these medications, it is paramount that pharmacists are well-prepared (both pre-licensure and throughout their careers) to address these dilemmas. Yet, especially compared with the profession of medicine, pharmacy is a relatively young profession. Relatedly, the associated integration of significant scholarly and practical ethics-related instruction in pharmacy curricula is younger still, and this is further evidenced in part by the lack of published textbooks in pharmacy ethics. The most notable resources on this short list include a textbook by Veatch, Haddad, and Last, which, via analyses of case studies, attempts to aid the student-pharmacist in recognizing the existence of multiple ethical perspectives (and theories) that might influence an individual's decision regarding a specific ethical dilemma.⁶ Although the reader is exposed to a variety of ethical constructs, the text provides limited practical guidance for the decision-making process, leaving the notion of deciding rightly as an illusive outcome.

Another text, by Buerki and Vottero unwraps and expounds on the elements of the Code of Ethics of the American Pharmacists Association (a potentially useful pursuit) and outlines a step-wise process for ethics-related decision-making.⁷ However, like the previous text, it only assists the reader in reaching “a” conclusion, not necessarily “the right” conclusion about specific ethical dilemmas. Enter the present work by Sullivan, Anderson, and Cole, a textbook that leans on the centuries-old Hippocratic tradition of medicine and recognizes that, indeed, ethical decision-making is a challenging endeavor, but posits that the outcomes of such endeavors need be neither vague nor purely theoretical. There are, in fact, decisions to complex ethical dilemmas that find their basis in the study and application of normative ethics, and such decisions, rightly

Jeffrey D. Lewis, review of *Ethics in Pharmacy Practice: A Practical Guide*, by Dennis M. Sullivan, Douglas C. Anderson, and Justin W. Cole, *Ethics & Medicine* 37, no. 2–3 (2021): 152–154.

deduced, by their nature are both practical and defensible and would be broadly affirmed by other professionals.

Within the pages of this welcome addition to the ethics-related resources for pharmacy practice the authors provide a clear and concise historical framework for medical, indeed healthcare, ethics based on the Hippocratic tradition and walk the reader through the maturation of this tradition into our present-day understanding of medical principlism. They spend an appropriate and necessary portion of the text describing how medical principlism fits into the schema of commonly referenced and employed ethical theories (especially in healthcare), yet stands alone in its ability to serve as the construct for practical decision-making in the course of daily pharmacy practice.

Subsequently, as a means of demonstrating the validity of their positions, the authors unpack some of the more challenging, medication-associated ethical dilemmas of our day (e.g., abortion, contraception, assisted suicide, palliative care) and help the reader apply (and appreciate the application of) the theory of medical principlism to decision-making within these highly charged topics. The authors use the concluding portion of the textbook to present a series of brief case studies of several ethical issues that pharmacists regularly face in the course of practice (e.g., dealing with difficult patients, forged prescriptions, medical marijuana, etc.) and guiding the reader via a series of thought-provoking questions through the process of identifying and managing the competing duties present in each scenario (i.e., making a decision by employing the theory of medical principlism).

In the end, and of great value to the profession of pharmacy (and, by extension, the healthcare team and the patients we serve), the authors stated goal, “to teach the reader *how* to think, based on ethical principles, not necessarily *what* to think” (p. 2) is appreciably realized. This textbook is not just guiding readers to reasonable (or normative) ethical decisions associated with the dilemmas of our day—indeed, such would greatly short-change the pharmacists of tomorrow. It is, instead, providing both a decision-making framework and an appropriate ethical foundation for approaching dilemmas of any age. The dilemmas of today could not have been fully imagined just a couple of decades ago, and I sense that the decisions facing pharmacists tomorrow will be no less unexpected, and almost certainly weightier, than we can presently imagine.

I would commend consideration of this textbook by all instructors of student-pharmacists as the foundational resource for preparing tomorrow’s professionals for the successful navigation of the ethical dilemmas that they will surely face. Additionally, this textbook has been written in such a manner that it would prove a valuable read and serve as a future reference for all practicing pharmacists, regardless of their tenure in the profession. As a means of personal professional development, this should make it to the top of the books-to-read stack of all my pharmacist-colleagues. Our patients and our communities will surely benefit from just such an investment of time and contemplation.

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Losing Our Dignity: How Secularized Medicine is Undermining Fundamental Human Equality

Charles C. Camosy, New City Press, 2021.

ISBN: 978-1-56548-471-9, 222 pages, Paperback, \$22.95.

The COVID-19 pandemic of the past two years has stretched healthcare resources to the breaking point, generating considerable anxiety and, at times, distorting the thinking of medical professionals. According to Fordham University's Charles Camosy, a distinguished Roman Catholic theologian and ethicist, the pandemic has revealed a deep flaw in our healthcare culture, primarily in how it has understood the human dignity of patients, especially the elderly and most vulnerable in our midst.

In *Losing Our Dignity*, Camosy's central driving thesis is that the authority and power of modern medicine "have put an increasing number of human beings outside the circle of protection based on fundamental human equality" (p. 13). This loss of human equality and dignity is based primarily on cognitive disadvantages among neurologically diverse individuals, from those with Down syndrome to others with Alzheimer's disease. In the eyes of an increasingly secular world, such people have less to offer, therefore less dignity.

Professor Camosy gives abundant evidence for the loss of respect for human dignity in healthcare. He cites bioethicist Ruth Macklin, who claims that dignity is a "useless concept." Psychologist Steven Pinker would later reinforce this idea in his 2008 article, "The Stupidity of Dignity."⁸ Both would claim that the concept of dignity is easily replaced by autonomy, without the unneeded baggage of religion (p. 31). Hostility towards faith-informed perspectives in medicine has become so entrenched that many voices would exclude them altogether. Religious applicants are discriminated against in medical school admissions, and religious objections to certain controversial medical procedures are not just discouraged; they are forbidden. For example, a Canadian court recently ruled that physicians must participate in assisted suicide for their patients or lose their license to practice medicine (p. 33).

Subsequent chapters develop the thesis of a loss of respect for dignity with concrete examples. Chapter 2, "Jahi McMath and Brain Death," cites the tragic case of a 13-year-old girl in California who suffered massive neurological injury as a complication of a routine surgical procedure. The girl's parents fought vigorously against a medical diagnosis of brain death and kept her biologically alive on a ventilator with daily tube feedings for four more years. Professor Camosy's summary states, "The debate over Jahi's life shows the fragility of the supposed consensus over brain death. The concept is imprecise, leaky, and at times even incoherent" (p. 57).

This reviewer believes that Professor Camosy may have overstated his case here. He uses a controversial case study to attack the very morality of brain death itself. Yet the "supposed

Dennis M. Sullivan, review of *Losing Our Dignity: How Secularized Medicine is Undermining Fundamental Human Equality*, by Charles C. Camosy, *Ethics & Medicine* 37, no. 2-3 (2021): 155-157.

consensus” on brain death is the legal standard for death throughout the United States, adopted by law in all 50 states. Brain death, or better, death by neurological criteria, rests on a strong philosophical foundation. A recent statement by the Pellegrino Center states it well: “Brain death . . . is a single event, consisting in the total disintegration of that unitary and integrated whole that is the personal self.”⁹ It is true that the clinical criteria for determining brain death are undergoing reevaluation and may need revision. But this does not negate the philosophical coherence of the concept as a whole.

A similar problem arises with Professor Camosy’s description of the Terri Schiavo case in Chapter 3. Terri, who was 26 years old at the time of her neurological injury, died many years later, at age 41, amid a bitter national legal and ethical controversy over the persistent vegetative state (PVS) and the withdrawal of artificial nutrition and hydration. Despite Professor Camosy’s passionate claims to the contrary, public records from the patient’s autopsy show that the diagnosis of PVS was indeed accurate.¹⁰ The author seems to say that continuing nutrition and hydration was morally obligatory in this case. However, patients and their surrogates (in this case, Terri’s husband) have a right to refuse medical treatments. The author’s argument might have been stronger with a discussion of advance directives. If a living will or other advance directive had been present in this example, the legal turmoil and widespread ethical angst might never have emerged.

In Chapter 4, “The ‘Roe Baby’ and Abortion,” Professor Camosy is on firmer ground, where he nicely summarizes the 1973 *Roe v. Wade* decision by the U.S. Supreme Court. However, after discussing the case particulars, he makes the interesting claim that the *Roe* decision was more about protecting physicians than protecting women’s rights or the unborn. He puts it this way: “Simply put, the authority of medicine and of physicians, along with a concern to protect them from prosecution, cannot be overstated as motivating factors behind the *Roe v. Wade* decision and the marginalization of prenatal human beings” (p. 99). Other commentators might not completely agree with this conclusion. For example, Professor Camosy does not mention the constitutional right of privacy established, rightly or wrongly, by earlier precedents (such as *Griswold v. Connecticut* in 1965).

The author offers other illustrative cases to reflect on the loss of respect for human dignity in medicine, including a disturbing look at elder care and the growing dilemma of treating patients with Alzheimer’s disease and other cognitive disabilities in our increasingly crowded and resource-limited nursing homes (ch. 6).

On balance, Professor Camosy’s indictment of modern medicine seems one-sided and overly polemical. He insists on an “us versus them” framework, where secular medicine is the culprit, irredeemably hostile to religion and spiritual values. One iconic Catholic voice pointed this out in the 1980s: Richard John Neuhaus. His seminal book, *The Naked Public Square*, put forth his recommendation for solving this problem. He did not propose that we should privilege Christianity as the principal moral voice; instead, he simply argued that it should have a place at the table, which would be enough.¹¹

Surprisingly, Professor Camosy does not appeal to the Catholic natural law tradition as an arbiter of this dispute. Good faith allows clinicians from many worldviews to meet in an ethics

committee to deliberate, with a common morality as their agreed-upon starting point. It is even more surprising that Camosy never mentions the 2400-year legacy of the Hippocratic Oath. Modern medical principlism still owes a great debt to the deontological character of the Oath, though diluted in recent years.

Charles Camosy has done an admirable job in his book, *Losing Our Dignity: How Secularized Medicine is Undermining Fundamental Human Equality*. He has stated the problem well: modern healthcare is losing its respect for human dignity. However, many of us are more optimistic that we can make progress by working together, despite our differences.

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Invitation to Christian Ethics: Moral Reasoning and Contemporary Issues

Kenneth Magnuson, Kregel Academic, 2020.
ISBN: 978-0825434457, 672 pages, Hardcover, \$44.99

Christian ethics and moral decision-making can be complex and intimidating to non-theologians. In addition, the authoritative scriptures do not directly address every possible ethical issue. This problem is especially true in bioethics, which evolves continuously based on medical, scientific, and technological advancements. How should Christians view such issues as artificial intelligence, gene editing, and bodily enhancements? Pastors, healthcare professionals, and lay congregants need help. *Invitation to Christian Ethics: Moral Reasoning and Contemporary Issues*, by Kenneth Magnuson, gives moral guidance to the Christian community to navigate these problems. While not perfect, it offers a solid philosophical and practical approach to Christian ethics.

Magnuson, a professor of Christian ethics at Southwestern Seminary, does not present this work as a textbook. Instead, his target audience is anyone who claims the name of Christ, regardless of profession. In his preface, he states, “Christian ethics involves the intersection of several disciplines, including theology, biblical studies, philosophy, history, law, sociology, and science, as well as pastoral care, counseling, and preaching” (p. 10). His writing style is therefore clear and understandable while retaining academic rigor.

Invitation to Christian Ethics brings together essential pieces of the philosophical disciplines to its approach to ethics. The book is broken into five sections. Part One is an introduction to ethical theory, philosophy, and teleology. Part Two discusses the use of Old and New Testament scriptures in ethics. Part Three then applies these concepts to examine a biblical view of human sexuality and how it impacts bioethics. Part Four then dissects the *imago Dei* as an argument for the value of human life. Finally, Part Five closes the work by applying the author’s Christian ethics framework to ecology and sociology.

Magnuson’s approach offers several key insights into modern ethical discourse. The first is that Christian ethics is unique because it harmonizes deontology, virtue ethics, and teleology. In contrast with other authors, he argues that Christian ethics is incompatible with consequentialism, because the end results of Christian moral decision-making may not bring about overall happiness. Avoiding this pitfall requires a combination of reflection and moral deliberation using all of these philosophical perspectives.

The author then provides a second critical insight: the Bible is an authoritative resource for Christian decision-making and a reliable source for all ethical decisions. In the process, he reasonably addresses common arguments against such a conclusion. He defines the “moral field” for ethics to include God as Creator, human beings, and the world that created beings

Robert Drew, review of *Invitation to Christian Ethics: Moral Reasoning and Contemporary Issues*, by Kenneth Magnuson, *Ethics & Medicine* 37, no. 2–3 (2021): 158–160.

inhabit. Moral responsibility is not simply a command or a moral principle, but comes from a personal and relational God. He further argues the Bible clearly distinguishes between particular commands, limited to specific persons or situations, and universal or general commands, applying to all people at all times (pp. 74–80). This approach helps the reader harmonize the ethical teachings of both the Old and New Testaments.

A third significant insight of this text is an overall practical approach to moral decision-making. Magnuson highlights ethicist Scott Rae, whose model includes seven steps: 1) Gather the facts, 2) Determine the ethical issues, 3) Determine the virtues/principles that impact the case, 4) List alternatives, 5) Compare the alternatives with the virtues/principles, 6) Consider consequences, and 7) Make a decision (p. 52).¹² Magnuson builds on this approach, dividing his expanded model into three categories with added clarifiers. The first part, “Pre-Reflection,” considers worldview, biblical perceptions, and contextual matters. The next part, “Reflection and Deliberation,” places Rae’s first three steps into the reflection category and puts steps four to six into the deliberation category. To all this, Magnuson adds an understanding of purpose and virtue, which drives alternatives and consequences. Finally, Magnuson’s third part, called “Make a Decision,” begins with a preliminary decision open to evaluation and critique. By stretching out Rae’s model and adding clarifiers, Magnuson has slowed down the process of moral decision-making while pursuing efficiency, clarity, and application to real-world circumstances.

Throughout the rest of the book, Magnuson applies these insights to the issues of marriage and sexuality, human personhood, and dominion and stewardship. When it comes to marriage and sexuality, Magnuson concludes that God created marriage and sex as a gift for His glory and for the human good; it is more than mere pleasure. He then uses this understanding to consider divorce and remarriage, homosexuality, and gender.

Regarding human personhood, the author begins with an argument for the full humanity of human beings from conception onward, and then applies that conclusion to infertility, abortion, and even medically-assisted death. In the book’s final section, Magnuson uses his insights regarding human value to discuss capital punishment, just war, race relations, and stewardship of the environment.

Magnuson aims to derive all of his conclusions from Scripture. In his view, the Bible is the ultimate source for Christian reflection and direction, shown on every page. Nonetheless, he is careful to address opponents to this position fairly and to weigh their arguments. He therefore allows the reader to consider both sides of the argument and to decide for themselves.

Overall, Magnuson’s summary of Christian ethics is helpful and valuable. However, this reviewer feels that his additions to Rae’s decision-making model lack precision and may lead to vague conclusions that might interfere with a common consensus for ethical outcomes. Magnuson’s model also seems to lead to different moral decisions with changes in culture, working against the pursuit of truth and guidance he hopes to achieve.

In summary, *Invitation to Christian Ethics: Moral Reasoning and Contemporary Issues*, by Kenneth Magnuson, is a solid contribution to the philosophical and practical discussion around Christian ethics and its application to bioethics. The author establishes a clear pathway for

individuals to engage in Christian ethics, while maintaining the promise, presence, and power of other prominent bioethicists. This text would be a solid addition to the library of any theologian, scholar, or ethicist trying to discern the vast and complicated aspects of Christian ethics.

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Disability and the Church: A Vision for Diversity and Inclusion

Lamar Hardwick, InterVarsity Press, 2021.

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Known as the “Autism Pastor,” Lamar Hardwick is an essential voice in a rising field: the theology of disability. In *Disability and the Church: A Vision for Diversity and Inclusion*, the author is true to the subtitle, casting a pastor’s vision for positive change in the church. As an insider, he brings refreshing honesty to the challenges of ministry among the disabled. He calls the reader to foster authentic, not merely symbolic, inclusiveness toward this underserved community. Hardwick prophetically urges churches to be “gatekeepers of the type of kindness and gentleness that those in the disability community need to experience in order to come out from hiding and to shed the stigma of shame that society has placed on them” (p. 11).

Interweaving his personal story with biblical and theological tropes, Hardwick deftly forges a theological vision, both personal and didactic. The text creatively mingles biblical exegesis with sensitivity to disabilities. For instance, the parable of the lost sheep leads him to wonder why disabled persons are disproportionately absent from most churches relative to their numbers in society. Based on Paul’s breaking of the walls between Jews and gentiles, Hardwick explores the barriers that exclude the disabled. He redresses this condition by meditations on peace, unity, individuality, reconciliation, and sacrifice as core theological themes that apply to the task of inclusion.

Christ’s practice of table fellowship explicitly included the disabled in his parables. He challenged those who sought the highest position at a banquet to “always assume the position of humility rather than the position of honor” (p. 53). Honoring the disabled means not merely recognizing them but expecting such members to offer areas of profound competence.

Hardwick’s testimony after his own diagnosis of autism led him to wrestle with “belonging to what I felt to be two separate communities” (p. 69). This awareness of “double-consciousness” helps to explain the alienation between the disability community and the church. As a pastor who is both African-American and autistic, this theme of W. E. B. Dubois is indeed a poignant inclusion.

In 1990, when the Americans with Disabilities Act excluded churches, this was a historic missed opportunity. Many churches ignored fundamental access concerns and tacitly accepted the exclusion of the disabled. Hardwick gives practical advice for dismantling such barriers. He lists four characteristics of churches that are making progress: 1) a philosophy of people over programs, 2) a celebration of the disabled rather than mere tolerance of their presence, 3) “circles over rows,” emphasizing personal over impersonal arrangements of church life, and 4) pastoral approval over mere pastoral apathy (pp. 96–97).

Dennis L. Durst, review of *Disability and the Church: A Vision for Diversity and Inclusion*, by Lamar Hardwick, *Ethics & Medicine* 37, no. 2–3 (2021): 161–162.

The depth of the problem is evident through some startling statistics. In 2010, 19% of the population in the United States was listed as disabled. Worldwide, only 5–10% of this population is currently being reached with the Christian gospel, making the disabled a significant “unreached people group” (pp. 102–3).

Hardwick’s pastoral focus is central to the book, and he offers constructive guidance to preachers wishing to address disability from the pulpit. Preaching themes include broadening the community’s borders, real community over mere charity, disability as an added rather than diminished value, and disability from a first-person perspective. Multiple-point practical action steps are sprinkled throughout the work, leading the reader to surmise that many of the sections began as a sermon or lesson plan. The preacher’s penchant for alliteration peeks through in section headings. Case in point: Pray for Peace, Provide Protection, and Practice the Ministry of Presence (pp. 131–36). While such jargon of the evangelical church may be readily recognizable to ministers and long-term church folk, these phrasing choices might seem trite to others reading the text.

As both a pastor and a professor, I resonate deeply with Hardwick’s explorations of Scripture, especially highlighting seven substantive passages “where persons with disabilities are at the center of God’s agenda to advance his kingdom” (p. 154). The author shows that his concern is thus not peripheral to the message of Christianity but has been marginalized by unintentional cultural forces in the life of the modern church. To address this systemic problem, he rightly insists: “We need disabled pastors, professors, and theologians to provide the church with a new context for reading Scripture and developing doctrine that is born through the lives and lenses” of the disabled community (p. 160).

For the readership of *Ethics & Medicine* who are active church leaders, this book is a vital tool for consciousness-raising and a font of ideas to make the church more inclusive. For medical professionals, however, *Disability and the Church* may not provide adequate bioethical reflection. Missing still is a critique of the medical field for its deficits in caring for the disabled. Based on conversations with parents of autistic children, I sense that resources remain inadequate to meet these families’ needs, which may be true for those with other disabilities. When disabled medical professionals speak out in the fashion that Lamar Hardwick has on behalf of the pastoral ministry, this may remove even more barriers to the treatment of the disabled.¹³

REFERENCES

1. See, e.g., Mollie Frost, “Doctors with Disabilities Reflect on Challenges,” *ACP Internist* (February 2020), <https://acpinternist.org/archives/2020/02/doctors-with-disability-reflect-on-challenges.htm>.

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