"With their complementary backgrounds, Mitchell and Riley prove to be an excellent team in their dialogue on Christian bioethics. They present valuable insights and helpful theological perspective for the newcomer to bioethics, and the seasoned ethicist will profit from it as well. A fine guide!"

Paul Copan
Professor and Pledger Family Chair of Philosophy and Ethics
Palm Beach Atlantic University

"Ben Mitchell and Joy Riley invite readers into their dialogue on profoundly important yet intensely practical issues raised in health care, medical technology, and cutting-edge research. The conversation draws on the history and practice of medicine, theological guidelines, philosophical insights, and case studies to help Christians develop awareness and wisdom about bioethical dilemmas. Riley and Mitchell demystify ethical concepts, medical terminology, and biotechnology. This highly approachable book is a noteworthy gift to Christians—laity, pastors, students, and clinicians alike."

Paige Comstock Cunningham
Executive Director
The Center for Bioethics and Human Dignity

"Though helpful to all, I particularly encourage pastors to use *Christian Bioethics: A Guide for Pastors, Health Care Professionals, and Families* to prepare their parishioners for the moral maze of today's culture. Helpful for both sermon preparation and counseling, Mitchell and Riley's practical, biblical wisdom provides guidelines for addressing common bioethical dilemmas. The church should be able to provide these answers."

Gene Rudd, M.D.
Senior Vice President
Christian Medical and Dental Associations

Christian Bioethics

A Guide for Pastors, Health Care Professionals, and Families

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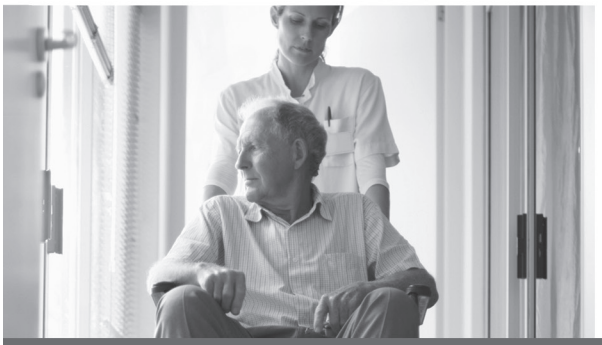


Christian Bioethics

A Guide for Pastors, Health Care Professionals, and Families

C. BEN MITCHELL, PHD & D. JOY RILEY, MD

DANIEL R. HEIMBACH, *Series Editor*

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VP

In Memoriam

Edmund D. Pellegrino, MD

A formative influence in contemporary medical ethics
who possessed an all-too-rare combination of fidelity to his faith,
brilliance in his thinking, and deep concern for humanity,
especially those who called him their physician.

Contents

Part IV: Remaking/Faking Life

Series Preface

The greatest challenge to the life and witness of the church in our age is widespread moral confusion and denial of moral authority. This condition has been greatly influenced by a number of factors, including postmodern denial of objective truth, secularization of common life, pluralization of worldviews, and privatization of religion—all accompanied by growing hostility toward anything Christian. In fact, claims of objective moral authority and understanding are openly contested by our culture more than any other aspects of Christian faith and witness. Those who are redefining justice, character, and truth are working hard to deconstruct essential social institutions to justify a variety of ends: pursuing sensuality, elevating lifestyle over protecting innocent human life, stealing what others have fairly acquired, ridiculing the rule of law, abandoning the needy for self-fulfillment, and forsaking lifelong commitments. They reject the Judeo-Christian values on which the institutions of Western civilization were erected (i.e., marriage, property ownership, free-market enterprise, justice, law, education, and national security) and without which they cannot endure. Never in the history of the church has there been a more critical need for scholarship, instruction, and application of Christian ethics in ways that equip Christian men and women to engage the surrounding culture in prophetic moral witness.

This series aims to promote understanding and respect for the reality and relevance of God's moral truth—what Francis Schaeffer called "true truth"—in contrast to truth claims that are false or distorted. We hope these books will serve as a resource for Christians to resist compromise and to contend with the moral war raging through our culture and tormenting the church. Some authors in

this series will address the interpretation of biblical teachings; others will focus on the history, theological integration, philosophical analysis, and application of Christian moral understanding. But all will use and apply God's moral truth in ways that convince the mind, convict the heart, and consume the soul.

In *Christian Bioethics: A Guide for Pastors, Health Care Professionals, and Families*, C. Ben Mitchell and D. Joy Riley introduce the field of bioethics to readers considering how Christians ought to deal with moral questions arising from circumstances faced when seeking medical treatment or possibilities generated by new advances in medical technology.

We live in an era of highly technical medicine, and while this can be comforting, it may also be confusing. How should Christians make life and death decisions? How do we move from an ancient text like the Bible to twenty-first-century questions about organ transplantation, stem-cell research, and human cloning? What kind of care do we owe one another at the end of life? Should we try to prolong life, and when should we accept mortality? Using a dialogue format, Mitchell, an ordained minister and university professor, and Riley, an experienced physician, talk openly and thoughtfully about how they as Christians think about a range of thorny ethical issues arising in their field of bioethics.

Combining their backgrounds in theology, ethics, and medicine, Mitchell and Riley engage real-life moral questions in a manner easily understood by laypersons and yet useful to clinicians, pastors, and students. This is a book to resource conversations in the home, lessons in the church, and understanding in the classroom. Mitchell and Riley invite readers to eavesdrop as they discuss the training of doctors, interpreting the Bible, and a range of pressing moral issues like abortion, assisted suicide, genetic engineering, and in vitro fertilization. While readers will find this volume to be biblically based, scientifically current, and accessible, they will also find it provides a healthy dose of empathy, engaging hearts as well as minds.

Daniel R. Heimbach
Series Editor

Acknowledgments

No book writes itself, and this one is no exception. We are both indebted to numerous individuals who have shaped our personal and professional lives and, therefore, this book. Ben's academic training in philosophy and medical ethics took place at the University of Tennessee at Knoxville (UTK). UTK had one of the earliest programs in clinical ethics of any university in the United States. It was begun in the early 1970s in Memphis under the tutelage of the late David Thomasma and migrated to Knoxville under the able direction of Glenn Graber, whose doctoral work had been done under William Frankena at Michigan. At UTK, Graber pioneered the case-based approach to clinical ethics that built upon the tradition of using cases for instruction in clinical medicine. Hence, nearly every chapter in this volume begins with a case for reflection.

Joy's informal training began at home, with parents Ely and Mary, who instilled in their children the truth that a good name is to be desired above riches. Her formal philosophy and medical ethics training began at the University of Louisville, with Richard L. Barber. Faculty members and attending physicians—too many to name individually—at the University of Kentucky College of Medicine and The Jewish Hospital of St. Louis, Washington University, modeled deep respect for and excellent care of patients. It was the mentors at Trinity International University who had the greatest impact, however: C. Ben Mitchell, Nigel M. de S. Cameron, Robert Orr, Edmund Pellegrino, John Kilner, and David Fletcher, among others. Dr. Cameron's use of the phrase, "making, taking, and faking life," made a lasting impression.

In addition to these formative influences, this volume has been improved by the series editor, Dan Heimbach, who offered many valuable questions and insights along the way. An unidentified reviewer deserves thanks also for the careful reading and thoughtful comments he or she made. Finally, it has been a genuine pleasure to work with Broadman and Holman's Chris Cowan. He has been very patient in the face of several delays. He has shepherded the process from the beginning with professionalism and grace. Thank you very much, Chris.

The volume is enhanced by the addition of visuals. For advice and assistance with those, we would like to thank Dr. Louis T. Riley, Dr. Christine Toevs, and Carol Harkness, a professional artist in the Nashville area. David W. Hobbs, project manager at LifeWay Christian Stores assisted with some of the graphics, as did his colleague, William Peter, a customer information analyst. L. Ian Riley of Ian Riley Photography provided graphics and photography. We would be remiss if we did not also thank Macy Alligood, an alumna of Union University, for her assistance in running down a boatload of footnotes.

As always, we must take blame for any errors in this volume. Additionally, we do not claim this to represent medical or legal advice. Despite any shortcomings, we trust it will be a helpful guide for thinking about the rocky crags we all must navigate in health care as we sail toward home.

Introduction

Phil and Sara have been happily married for two years. They are new Christians and have come to you for counseling because they were recently told they are infertile. Phil's sperm production is very low, and the doctor told them that if all else failed, they could use donor sperm and IVF to get pregnant.

They had several immediate questions: what in the world is donor sperm? What do the letters I-V-F stand for? Once those questions were answered, they would either have to find a suitable sperm donor themselves or purchase sperm from an anonymous donor at a sperm bank where they are told they could choose from a catalog of possible donors in hopes of having a child who might have some of the physical characteristics of the donor such as hair color, height, body type, and so on. This would give them better "quality control," as someone put it.

How would you counsel this couple? What emotional and spiritual issues are they likely to face? What ethical concerns do reproductive technologies, including sperm donation and in vitro fertilization, raise? Is the language of "quality control" problematic? Why or why not? Welcome to the real world of medical ethics.

Theology is as old as God. Although perhaps not quite as old, medicine has been around a long time. Historical evidence suggests that attempts to relieve human suffering through surgical interventions date back to around 9000 BC. And by 2000 BC the ancient law code of Hammurabi mandated that "if a surgeon performs a major operation on an 'awelum' (nobleman) with a lancet and caused the death of this man, they shall cut off his hands." So medical law and ethics have been around for a long time too.

"But this is the twenty-first century!" you exclaim. What does that have to do with making moral decisions about medical dilemmas in the real world? Great question. And that's the burden of this book: to help readers discover how biblical theology, Christian ethics, and contemporary science and medicine intersect in the real world where people are making life-changing decisions.

To help you make these discoveries, the two of us will let you in on our conversation. One of us is trained as a philosopher-theologian; the other is a physician. We both have degrees in medical ethics and long experience in the life of the church. Because we want our discussion to be helpful to pastors, family members, chaplains, physicians, students, and patients who are making decisions about their own medical treatment, we have tried to offer an accessible account of the medical, theological, and moral aspects of some of the ethical questions that arise in the care and treatment of real people. We've also tried to look into the future and think about where some of our medical technologies are taking us.

Theologian Nigel Cameron has helpfully categorized the issues in bioethics under the rubric of "taking life," "making life," and "remaking life." The order of these categories represents the order in which the ethical issues have arisen historically.

Taking Life

Euthanasia, assisted suicide, and abortion have long been within the purview of the ethics of medicine. Although Christians vary in their views of these issues, it is safe to say that Christians are life affirming. In fact, a vast majority of Christians would argue, for reasons to be seen in this book, that euthanasia and assisted suicide are inconsistent with the biblical witness on the sanctity of human life and the role of compassionate care in medicine. Likewise, most Christians believe that abortion on demand is wrong.

Typically, Christians are at the forefront of life-honoring alternatives. The early church, for instance, rescued children from infanticide by providing them with homes and building orphanages. Many contemporary Christians support pregnancy care centers that provide alternatives to abortion by offering pregnant mothers education, resources, and shelter as they await the delivery of their children. The hospice and palliative care movement was

begun by a Christian nurse and physician, Dame Cicely Saunders, as a means of caring compassionately for those who are facing terminal illnesses.

Making Life

The ethical questions surrounding procreation fall under the category of "making life." Assisted reproductive technologies (ARTs) pose significant moral questions for Bible believers. Louise Brown, the world's first "test tube" baby was born in 1978. Since then in vitro fertilization (IVF) has been controversial. Additional reproductive arrangements, like surrogate motherhood, artificial insemination using donor sperm, and sperm or egg donation, introduce third parties or their gametes into the reproductive relationship. The Bible teaches that procreation is to take place within the context of a one-man, one-woman conjugal union. Bringing third parties into the procreative relationship is fraught with ethical, legal, social, and familial concerns. The relationship of Abraham, Sarah, and Hagar in the Old Testament illustrates the tensions that may be present in even low-tech reproductive relationships (Genesis 16). Adoption, however, has always been viewed as an ethical option for Christian couples facing infertility.

Remaking/Faking Life

Researchers are increasingly exploring new ways to mimic God's design. These new scientific technologies are usually regarded as laudable when used for healing purposes. Thus, the use of implantable computer chips to assist the blind to see is consistent with the goals of medicine. High-tech prostheses to replace limbs lost in accidents are likewise uncontroversial.

Using pharmaceuticals, like steroids, or genetic engineering to create higher than normal IQs or faster than normal athletes not only raises profound ethical questions about justice in academics or sports respectively, but also challenges our understanding of what it means to be human and who has the authority to alter our species.

Some suggest today that the use of life-prolonging technologies might enable us to live forever either in our physical bodies or uploaded into some vast neural network like the Internet. Again,

while few question the use of technology for therapeutic purposes, many worry that enhancement technologies reveal a kind of hubris sometimes described as "playing God." After all, the Christian affirmation is that we are already immortal through the resurrection of Jesus Christ (1 Corinthians 15) and that our physical bodies will be transformed like his through our own resurrection and freed from the ravages of disease and death. The wise use of new technologies—medical or otherwise—must be part of Christian discipleship.

How to Use This Book

You will note that each chapter begins with a real case. The cases have come from news stories, casebooks, or our own experience. Although we do not attempt to deal with the cases directly, or even with every aspect of the cases, we do try to offer biblical, theological, and medical parameters to help you identify and think through some of the issues that arise in the cases. Each case ends with questions for reflection. We hope you will take the time individually, in small groups, or in classes to discuss the case study using those questions as a guide. After reading the chapter, it would be helpful to return to those questions to see if any answers have changed or if other questions arise.

We should be clear about our starting points. First, we are both committed to a Christian worldview. Among other things that means all truth genuinely deserving of the designation "truth" is God's truth. So we are not relativists. We believe that the true, the good, and the beautiful are found most clearly in the triune God of the Bible and seen most sublimely in the face of Jesus of Nazareth.

Second, we are both committed to historic orthodoxy. That is, we believe what the Christian church has affirmed down the ages in the Apostles' Creed:

> *I believe in God, the Father almighty,*
> *Creator of heaven and earth.*
> *I believe in Jesus Christ, his only Son, our Lord,*
> *who was conceived by the Holy Spirit,*
> *born of the virgin Mary,*
> *suffered under Pontius Pilate,*
> *was crucified, died, and was buried;*

he descended to the dead.
On the third day he rose again;
he ascended into heaven,
he is seated at the right hand of the Father,
and he will come to judge the living and the dead.
I believe in the Holy Spirit,
the holy catholic Church,
the communion of saints,
the forgiveness of sins,
the resurrection of the body,
and the life everlasting.
Amen.

Because we affirm that all truth is God's truth and because we believe this is God's world, we see science and faith, medicine and theology as friends, not enemies. That's not to say that all the tensions between them have been fully resolved, but it is to say that we think each of these realms of knowledge has some important information to offer us about the real world in which we live. And, just as importantly, we believe we neglect these sources of truth to our own peril and to the detriment of those we care about.

Finally, we believe that answers are available to some of the thorny questions that emerge at patients' bedsides. The resources God has supplied give us access to right, wrong, good, and bad ways of dealing with ethical questions in medicine and patient care. If we didn't believe that, we'd hardly have any reason to offer yet another book on bioethics.

Our prayer is that by the time you have read this book you will have a better idea how you would help Phil and Sara and the other people whose cases you will find in this volume.

Now, let's start at the beginning. . . .

Part I

Christian Bioethics

Chapter 1

Which Doctors? Whose Medicine?

Case: It's Over, Debbie

The call came in the middle of the night. As a gynecology resident rotating through a large, private hospital, I had come to detest telephone calls because invariably I would be up for several hours and would not feel good the next day. However, duty called, so I answered the phone. A nurse informed me that a patient was having difficulty getting rest. Could I please see her. She was on 3 North. That was the gynecologic-oncology unit, not my usual duty station. As I trudged along, bumping sleepily against walls and corners and not believing I was up again, I tried to imagine what I might find at the end of my walk. Maybe an elderly woman with an anxiety reaction or perhaps something particularly horrible.

I grabbed the chart from the nurses' station on my way to the patient's room, and the nurse gave me some hurried details: a twenty-year-old girl named Debbie was dying of ovarian cancer. She was having unrelenting vomiting apparently as the result of an alcohol drip administered for sedation. Very sad, I thought. As I approached the room, I could hear loud, labored breathing. I entered and saw an emaciated, dark-haired woman who appeared much older than twenty. She was receiving nasal oxygen, had an

IV, and was sitting in bed suffering from what was obviously severe air hunger. The chart noted her weight at eighty pounds. A second woman, also dark-haired but of middle age, stood at her right, holding her hand. Both looked up as I entered. The room seemed filled with the patient's desperate effort to survive. Her eyes were hollow, and she had suprasternal and intercostal retractions with her rapid inspirations. She had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, "Let's get this over with."

I retreated with my thoughts to the nurses' station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw twenty mgs of morphine sulfate into a syringe. Enough, I thought, to do the job. I took the syringe into the room and told the two women I was going to give Debbie something that would let her rest and to say good-bye. Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously and watched to see if my calculations on its effects would be correct. Within seconds her breathing slowed to a normal rate, her eyes closed, and her features softened as she seemed restful at last. The older woman stroked the hair of the now-sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved.

It's over, Debbie.

—Name withheld by request[1]

Questions for Reflection

1. Why was the doctor called to see the patient? What did the doctor know about her?

[1] "A Piece of My Mind. It's Over, Debbie," *Journal of the American Medical Association* 259, no. 2 (January 8, 1988): 272.

2. What did Debbie mean when she said, "Let's get this over with"?

3. Comment on the physician's attitude toward this patient and her situation.

4. Describe the communication that occurred between doctor and patient, nurse and doctor, doctor and woman at the patient's bedside. What are the possible endings of this case?

5. What concerns might a Christian doctor or patient have in this situation that non-Christians may not have?

Discussion

C. Ben Mitchell (CBM): When I first encountered this story in graduate school, like most other readers I immediately thought this was a case of euthanasia. *Surely,* I thought, *the doctor must have given Debbie an overdose of morphine and killed her.* I now know that the case is open to multiple interpretations. The most important line is Debbie's, when she said: "Let's get this over with." Did she mean, "Please give me a life-ending drug"? Did she mean, "Please stop poking on me and give me some medication so I can get some sleep"? The case was meant to be ambiguous, of course. But in its context—in the late 1980s, in the world's most prestigious medical journal—the author was pushing the debate about assisted suicide and euthanasia. And he or she did. There was a huge response to this case in the letters to the editor pages of the journal and elsewhere. "It's Over, Debbie " continues to be used in medical schools and ethics programs across the country because it is so provocative.

The Hippocratic Oath

Debbie's case raises many interesting questions, including what the role of a physician is in treating his or her patients. Historically physicians took an oath that forbade them from intentionally ending

a patient's life through active means. It was called the Hippocratic Oath. It may surprise you to learn that most doctors do not take the oath today. But surely, you might say, a doctor's professional obligations would keep him from killing a patient. Actually, physicians' understanding of their professional obligations have changed dramatically over the last several decades.

As we begin to think about the ethics of medicine we must first understand who doctors are, who they *should* be, and what moral obligations doctors should feel with respect to their patients.

Dr. Riley, what can you tell us about the Hippocratic Oath and the tradition of which it is a part?

D. Joy Riley (DJR): Most people are familiar with the term "the Hippocratic Oath." They may have heard that doctors take the oath and presume physicians practice according to the ethical guidelines contained in it. In fact, although neither medicine nor medical ethics began with Hippocrates, much of Western medicine—at least for 2,500 years—does have its roots there. Unfortunately, though, most physicians know little about the oath.

Hippocrates of Cos (460–c. 370 BC), was a physician and the son of a physician. He is credited with a number of writings on medicine, though his followers were probably the authors of the Hippocratic Oath. The oath had three parts. First, the various deities were invoked. Second, the physician committed to care for his teacher and his teacher's family. Finally, he pledged to fulfill certain responsibilities toward his patients.

> I swear by Apollo the physician and Æsculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment,
>
> I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction,
>
> I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a

> stipulation and oath according to the law of medicine, but to none others.
>
> I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.
>
> I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art.
>
> I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad,
>
> I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.

One way of thinking about the Hippocratic Oath is to see it as the covenant of an early physician's craft guild, medical society, or licensing authority. It was also the Better Business Bureau seal of approval, separating an ethical physician from the charlatans of the age. As such, it functioned to reform the practice of medicine.[2] Several features are worth noting. Hippocratic physicians refused to administer poisons for euthanasia or to perform abortions. They apparently were general practitioners since they referred patients to others for surgery. They foreswore sexual involvement with their patients and promised confidentiality. These were physicians a patient could trust.

[2] Allen Verhey, "The Doctor's Oath—and a Christian Swearing It," in *On Moral Medicine*, 3rd ed., ed. M. Therese Lysaught and Joseph J. Kotva Jr., with Stephen E. Lammers and Allen Verhey (Grand Rapids, MI: Eerdmans, 2012), 226.

CBM: So a physician in the Hippocratic tradition entered a covenant with the gods, his teachers, and his patients. Yet the original oath was pagan? Did Christians and Jews ever embrace the oath?

DJR: Yes, the original Hippocratic Oath called on the deities of the Greek world. In addition, Ludwig Edelstein, the distinguished medical historian, suggests that physicians who took the oath were also followers of the philosopher, mathematician, and mystic Pythagoras.[3] They were mostly polytheists.

Because it was generally recognized that the Hippocratic Oath required appropriate commitments by the doctors who took it, a Christianized form of the oath was circulated by the tenth century AD. In it the "Greek divinities are replaced by 'God the Father of our Lord Jesus Christ,' the prohibition of abortion is strengthened, and the stricture against 'cutting for the stone' is dropped."[4]

About the same time that the Lateran Council II (1139) allowed monks to practice medicine within certain limits,[5] one of the great Jewish physicians was born. Maimonides, who lived 1135–1204, was a philosopher as well as a physician and Talmudist. He summarized the Hippocratic dictum as "be of benefit and do no harm." Maimonides reflected on the behavior of physicians and concluded, "There is a general rule, and I have seen great physicians acting on it, that the physician should not treat the disease but the patient who is suffering from it."[6]

Whatever the preamble of the oath(s) taken, physicians of various faiths throughout the centuries have adopted many of the Hippocratic Oath's valued stances. I am sure you understand why Christians would be interested in medicine and caring for the sick.

CBM: I do indeed. Historically, the people of God have been leaders in medicine and the building of hospitals because they believe all truth is God's truth and that medicine offers great good. For instance, the second-century BC apocryphal book *Ecclesiasticus* teaches that medicine owes its origins to God: "Honor the

[3] Albert R. Jonsen, *A Short History of Medical Ethics* (New York: Oxford University Press, 2000), 4.
[4] Ibid., 17.
[5] Ibid.
[6] Ibid., 22.

physician . . . from God the physician gets wisdom. . . . God brings forth medicines from the earth and let a prudent man not ignore them" (39:1). Of course, Luke, author of Acts and the gospel that bears his name, was a physician. The early church not only endorsed medicine but championed care for the sick because Jesus of Nazareth healed the sick during his ministry on earth (see Matt 9; 10:8; 25:34–46).

Admittedly, the Greeks and Romans made great contributions to early medicine, but as Albert Jonsen, University of Washington historian of medicine, maintains: "The second great sweep of medical history begins at the end of the fourth century, with the founding of the first Christian hospital at Caesarea in Cappadocia, and concludes at the end of the fourteenth century, with medicine well ensconced in the universities and in the public life of the emerging nations of Europe."[7] This extraordinary, formative period in medicine was characterized by intimate involvement by the church. Jonsen argues:

> During these centuries, the Christian faith . . . permeated all aspects of life in the West. The very conception of medicine, as well as its practice, was deeply touched by the doctrine and discipline of the Church. This theological and ecclesiastical influence shaped the ethics of medicine, but it even indirectly affected its science since, as its missionaries evangelized the peoples of Western and Northern Europe, the Church found itself in a constant battle against the use of magic and superstition in the work of healing. It championed rational medicine, along with prayer, to counter superstition.[8]

As a means of caring for those who were ill, Saint Basil of Caesarea founded the first hospital (c. 369). Christian hospitals grew apace, spreading throughout both the East and the West. By the mid-1500s there were 37,000 Benedictine monasteries alone that cared for the sick.

[7] Ibid., 13.
[8] Ibid.

Furthermore, as Charles Rosenberg shows in his volume, *The Care of Strangers: The Rise of America's Hospital System*,[9] the modern hospital owes its origins to Judeo-Christian compassion. The vast expansion of faith-based hospitals is seen in the legacy of their names: Saint Vincent's, Saint Luke's, Mount Sinai, Presbyterian, Mercy, and Beth Israel. These were all charitable hospitals, some of which began as foundling hospitals to care for abandoned children.

Similarly, in Europe, great hospitals were built through the influence of the church. Indeed, an ancient French term for hospital is *hôtel-Dieu* ("hostel of God"). In 1863, the *Société Genevoise d'Utilité Publique* called on Swiss Christian businessman Jean Henri Dunant to form a relief organization for caring for wartime wounded. Thus, one year later the Geneva Convention made the Red Cross a universal sign of medical care. In Britain, Dame Cicely Saunders founded the hospice movement by establishing Saint Christopher's Hospice in the south of London in 1967.

Things have certainly changed. Most religious hospitals today are religious in name only. What about the use of the Hippocratic Oath? Is it still in use? Did you learn about the oath in your own medical training?

DJR: Somewhat surprisingly, most medical schools do not use the Hippocratic Oath today. Those who do offer some kind of "updated" version of it. My own experience in medical school is probably fairly typical. After four years of training (and an extra year of a student pathology fellowship for good measure), I graduated from medical school. Our institution's version of the oath was printed on the back of our graduation program, and we were asked to stand and read the oath in unison. Few if any of us had seen it in advance. There had been no examination or discussion of the oath beforehand.

I may have been a bit more familiar with it than some of my peers since before medical school I had taken a number of undergraduate philosophy courses, including a medical ethics class. I also

[9] In 1800, with a population of only 5.3 million, most Americans would only have heard of a hospital. Philadelphia's Pennsylvania Hospital was founded in 1751, New York Hospital in 1771, and Boston General did not open until 1821. But by just after the mid-century mark, hospitals were being established in large numbers, and most of them were religious. Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic, 1987), esp. chap. 4.

took the one elective course in medical ethics our medical school offered. During medical school we were taught by some excellent, caring, competent, and ethical physicians. But they offered little didactic teaching on the kinds of ethical principles contained in the oath of Hippocrates.

Our school was not unusual. A survey of US medical schools in the mid-1990s showed only one school used the original oath. The data from that survey are included in table 1.

Table 1
Survey of 157 medical schools in the mid-1990s: 1 school used the original Oath 68 schools used some version of the Oath 8% prohibited abortion 14% prohibited euthanasia and assisted suicide 43% included some notion of MD accountability 3% forbade sexual contact with patients

What happened? Medical ethics, traditionally the arena of physicians, was opened up to other voices in the twentieth century. In 1968, Senator Walter Mondale called a congressional hearing to discuss "the social implications of advances in medicine and the biosciences." This was not welcomed by the scientific and medical communities. They saw it as an intrusion. Dr. Owen Wangansteen, professor at the University of Minnesota, said, "If you are thinking of theologians, lawyers, philosophers and others to give some direction, . . . I cannot see how they could help. . . . The fellow who holds the apple can peel it best."[10]

That attitude, however, did not prevent the birth of bioethics as we know it. Interestingly, when people began to look for experts who understood something about the moral values involved in life-and-death decision making, they identified several theological voices.

Birth of Bioethics

CBM: That's right. Among the first was Paul Ramsey. Ramsey was the Harrington Spear Pain Professor of Religion at Princeton

[10] Cited in Paul Ramsey, *The Patient as Person: Exploration in Medical Ethics*, 2nd ed. (New Haven, CT: Yale University Press, 2002), xvii.

University and the author of *The Patient as Person*, published in 1970. This work, presented the previous year as the Lyman Beecher Lectures at Yale, raises many important questions about informed consent, research involving children, changing the definition of death, and organ transplantation, among other problems. In his preface to that book, Ramsey states, "At this point physicians must in greater measure become moral philosophers, asking themselves some quite profound questions about the nature of proper moral reasoning, and how moral dilemmas are rightly to be resolved. If they do not, the existing medical ethics will be eroded more and more by what it is alleged *must* be done and technically *can* be done."[11]

Another early leader was Richard A. McCormick, who wrote about theology and bioethics from his Catholic view and experience. Like the followers of Hippocrates, McCormick saw theological language as a way of thinking about the ethics of medicine and used Christian categories in his discussion of the morality of medicine "since goodness-badness is basically vertical and has its aortal lifeline to the God-relationship."[12]

As a Catholic thinker McCormick rejected what he saw as two extremes. He denied that "faith gives us concrete answers to the problems of *essential* ethics," or norms that apply to all persons. He also refuted the position that "faith has no influence whatsoever on bioethics."[13] He argued for reason informed by faith.

McCormick believed our culture was becoming increasingly inhospitable to the vulnerable, especially the "defective" or "maladapted." He argued that faith could protect from such an attitude because faith "does sensitize us to the meaning of persons, to their inherent dignity regardless of functionability."[14] Christian faith engenders certain dispositions toward others, particularly that of charity. Finally, he thought life was "a basic but not absolute good."[15] As he put it: "Excessive concern for the temporal is at some point neglect of the eternal. An obligation to use all means to preserve life would be a devaluation of human life, since it would

[11] Ibid., xlviii.

[12] Richard A. McCormick, "Theology and Bioethics," *Hastings Center Report* 19, no. 3 (May/June 1989): 5–10. Reprinted in Stephen E. Lammers and Allen Verhey, eds., *On Moral Medicine*, 2nd ed. (Grand Rapids, MI: Eerdmans, 1998), 65.

[13] Ibid., 67.

[14] Ibid., 68.

[15] Ibid., 70.

remove life from the context or story that is the source of its ultimate value."[16]

The third theologian to make major contributions to the field of bioethics was Joseph Fletcher, professor of moral theology at Episcopal Theological School (Cambridge, Massachusetts). His background was in social justice. He is perhaps best known for his book *Situation Ethics*. After he turned his focus to medical ethics, he became a professor of medical ethics at the University of Virginia.[17]

DJR: Frankly, I think one of the reasons medical schools today do not regard the oath as authoritative could be due to the influence of Joseph Fletcher and others like him. As early as 1949, in the Lowell Lectures at Harvard, Fletcher said, "[W]e shall attempt, as reasonably as may be, to plead the ethical case for our human rights (certain conditions being satisfied) to use contraceptives, to seek insemination anonymously from a donor, to be sterilized, and to receive a merciful death from a medically competent euthanasiast."[18]

Albert R. Jonsen called this "revolutionary," and this description was accurate. No longer was it the physician or the church who "held authority over the body and mind of the patient." It was the patient's right and his alone to make his own medical decision.[19] The idea of patients' rights gathered steam as the twentieth century progressed. Joseph Fletcher personified this development, but he was not alone. The result has been a shift in the character of medicine away from professionalism toward a market-based medicine, complete with customers who are supposedly "always right." What was perceived as paternalism has now given way to consumerism.

CBM: Most of us have grown up in the era of "consumer medicine." If doctors are not to be viewed as members of the "service industry," how should we understand their role?

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[16] Ibid.

[17] Jonsen, *A Short History of Medical Ethics*, 94–95.

[18] Joseph Fletcher, *Morals and Medicine* (Boston: Beacon, 1954), 25, cited in Jonsen, *A Short History of Medical Ethics*, 94.

[19] Jonsen, *A Short History of Medical Ethics*, 94.

DJR: Physicians have been variously considered as parent figures, fighters (think *M*A*S*H**), and, increasingly, as technicians. William F. May describes—and rejects—these three metaphors in his important book, *The Physician's Covenant*. Paternalism in medicine is an anemic substitute for something greater because, according to May, that model "keenly experiences the absence of divine providence and substitutes a providence of its own."[20] Similarly, if physicians are seen primarily as fighters, suffering and the fear of death contend to be the *summum malum* (the supreme evil). He correctly argues, I think, that viewing physicians primarily as technicians does not end well either: "The cumulative impact of the training filters out the personal, not merely the patient as person but the physician as person."[21] May concludes, then, that the best metaphors for understanding the physician's role in the physician-patient relationship are those of covenant and teacher. He states, "A covenantal ethic positions human givers in the context of a primordial act of receiving a gift not wholly deserved, which they can only assume gratefully."[22] This provides a richer, and, I believe, a more appropriate view of the physician's role than any of the other metaphors.

CBM: This brings us back to the case of Debbie. What is your interpretation of the physician's behavior in "It's Over, Debbie"?

DJR: I find the physician's behavior problematic in several ways. (To simplify the discussion with respect to pronouns, I will refer to the physician as "he.") The physician is paternalistic in that he seems to think he knows what Debbie wants on the basis of a single uttered sentence. There is no discussion of her statement, "Let's get this over with," much less any meaningful consent from the patient. In this case the physician is a warrior, and wakefulness seems to be the enemy. It appears that sleep in some form—for the patient, the patient's mother(?), and the physician—is the victory to be obtained. The physician authoritatively takes charge. The nurse is only there to fill the syringe. As the technician the physician administers the drug. He administers a large dose of

[20] William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics*, 2nd ed. (Louisville: WJK, 2000), 54.

[21] Ibid., 103.

[22] Ibid., 114.

morphine, which like clockwork produces a kind of sleep followed by respiratory depression and, presumably, death—for a woman the physician had met for the first time only moments before. The "problem" has been conquered efficiently, even if it meant ending the patient's life.

CBM: Obviously, if one finds *parent*, *warrior*, and *technician* unacceptable metaphors for *physician*, then another metaphor is necessary. How would you suggest we think about the role of physicians?

DJR: The late physicians Edmund Pellegrino and David Thomasma stressed the need for virtuous physicians. Because doctors have the power to diagnose and treat and because patients are vulnerable and experiencing unease, trust is a necessary foundation for their relationship. A patient needs to be able to trust that the physician will use his/her knowledge, training, and skill to do what will benefit, not exploit, the patient. And physicians need to be worthy of that trust.

> In an ethic of trust, the physician is impelled to develop a relationship with the patient from the very outset that includes becoming familiar with who and what the patient is and how she wants to meet the serious challenges of illness, disability, and death. It is essential that the physician help the patient to anticipate certain critical decisions. . . . The physician must prepare the patient for these eventualities before they become urgent or the patient loses competence. Patients should be able to rely on the physician for the proper timing, sensitivity, and degree of detail appropriate in each case. These cannot be written into a contract.[23]

Trust, according to Pellegrino and Thomasma, goes beyond duty or rule-based ethics, although it is "consistent with the contemporary context of autonomy, participatory democracy, and the moral pluralism of the interacting parties in professional relationships."[24]

[23] Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 76. See also their volume, *The Christian Virtues in Medical Practice* (Washington, DC: Georgetown University Press, 1996).

[24] Ibid., 77.

It is based in virtue, which begets character. It begins in a relationship and is built over time, "earned and merited by performance and fidelity to its implications."[25]

For the physician several virtues are essential. The first is compassion, a "suffering with" the patient. Prudence guides doctors in proper action, toward the proper end of medicine. That proper end is twofold. "The ultimate end is the health of individuals and society, while the more proximate end is a right and good healing action for a specific patient."[26] Justice includes not simply giving one his/her due but doing so in a spirit of friendship or charity. Another virtue to be cultivated by physicians is fortitude, or "sustained courage."[27] Medical temperance is described by "constant vigilance about protecting persons from undertreatment, abandonment, and inappropriate overtreatment,"[28] a virtue sorely needed in this day. Pellegrino and Thomasma round out their discussion of the virtues with integrity and self-effacement. Doctors should work hard to be trust-*worthy* and humble.

CBM: That is a helpful summary. Much more has been written about the virtuous physician, and the idea is certainly worthy of more in-depth study. You and I both knew Dr. Pellegrino and heard him speak multiple times over the years. He was an excellent and prolific writer and a virtuous clinician. Today's physicians in training may not be able to know him personally, but the paper trail he left could never be mistaken for mere breadcrumbs.

Conclusion

We are a long way from Hippocratic medicine. Medical ethics has undergone a sea change. We need to regain the higher moral ground to achieve the proper ends of medicine. That begins with a physician-patient relationship built on trust. This requires both virtuous physicians and virtuous patients. Physician education should include not only superb scientific training but also excellent ethical instruction. Most importantly, those who care for vulnerable patients should be men and women of good character.

[25] Ibid.
[26] Ibid., 86.
[27] Ibid., 109.
[28] Ibid., 124–25.

Remembering where moral medicine has come from may be a useful way of guiding the future.

The Hippocratic Oath, though little used today, has impacted the practice of medicine over centuries and continents. How does that happen? How do we proceed from an ancient text to contemporary decisions? The next chapter offers a way forward.

Additional Resources

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