

CRACKS IN THE WALL: CONFRONTING THE LEGALIZATION OF PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA

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Post-mortem analysis of the 2016 election focused on cracks in the so-called “blue wall” of Democratic-leaning northern industrial states and, to a lesser extent, potential cracks in the “red wall” of Republican states, where demographic changes portend closer results in future elections. All of which goes to show that in a closely divided country, electoral coalitions are not always durable.

Major shifts in social policy, however, often prove more enduring. Thus, 2016 may well be remembered as the year that seismic cracks appeared in the wall against physician-assisted suicide (PAS),¹ signified on Election Day by Colorado’s vote in favor—by a 2-to-1 margin—of a referendum to legalize PAS.² The Colorado vote followed California’s enactment of PAS legislation, which came into effect in June,³ and preceded by one week the passage of similar legislation by the District of Columbia Council. Meanwhile, in Canada, legislation enacted in June legalized both PAS and euthanasia—direct killing by physicians of a range of seriously ill or disabled patients.⁴ Given these developments, opponents of PAS now face the sober prospect of more widespread legalization. Moreover, the medical community at large—not merely those opposed to PAS—must now confront the ethical and practical effects of condoning suicide as a “normalized” medical practice.

Where the Law Now Stands

Oregon was the first North American jurisdiction to legalize PAS (1994), and for a time, the practice seemed confined to the Beaver State. The U.S. Supreme Court, overruling decisions from the U.S. Courts of Appeals for the Second Circuit and the Ninth Circuit, unanimously declared in 1997 that there is no federal constitutional right to PAS, while leaving the issue of legalization to the states.⁵ Four years earlier, in *Rodriguez v. British Columbia*,⁶ the Canadian Supreme Court, in a 5–4

decision, rejected a similar claim to PAS under the nation’s Charter of Rights and Freedoms. Efforts to enact laws similar to Oregon’s, through legislation or referendum, failed in several states, including California, Michigan, and Maine.

Starting in 2008, the picture began to change. That year, by referendum vote of 59 to 41 percent, Washington State joined its neighbor in endorsing PAS.⁷ Vermont in 2013 became the first state to legalize PAS through legislation, enacting a bill (amended in 2015) that was criticized for including fewer safeguards against potential abuse than the Oregon and Washington laws.⁸ Meanwhile, Massachusetts narrowly rejected a PAS referendum in 2012.⁹ State courts in New Mexico¹⁰ and Montana continued the trend of denying claims to a constitutional right to PAS, although the Montana court found that a physician’s acquiescence to a patient-initiated request for a dose of lethal medication (to be self-administered) would not create criminal liability under existing state law.¹¹

In 2016, the picture changed again, perhaps irrevocably. While it took two decades for three states (OR, WA, VT) to legalize PAS, California, Colorado, and the District of Columbia took the step in the space of six months. Moreover, the New Jersey Assembly passed a PAS law in October, and as of this writing, awaits action in the Garden State’s Senate.¹² Emboldened by these victories, Compassion and Choices (formerly the Hemlock Society) has announced a “full-scale effort” to legalize PAS in New York,¹³ and continues legalization efforts in twenty other states. In short, PAS is no longer an experiment restricted to socially liberal confines of the Pacific Northwest (and its New England soulmate, the Green Mountain State); it is now legal in states where 58 million Americans reside. New Jersey and New York would add 30 million to that total.

In Canada, the change has been far more radical. Notwithstanding the 1993 precedent in *Rodriguez*, Justice Lynn Smith of the Supreme Court of British Columbia held in 2012 that provisions of the Canadian Criminal Code which

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from the director's desk

BY PAIGE C. CUNNINGHAM, JD, PHD (CAND.)
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How do we resolve bioethical issues that affect us individually and societally, and about which we may profoundly disagree? This was the task the Presidential Commission for the Study of Bioethical Issues (PCSBi) set out to address in its final report this May. In “Bioethics for Every Generation: Deliberation and Education in Health, Science, and Technology,” the PCSBi proposes joining democratic deliberation and education in “a virtuous circle, reinforcing one another to create a more democratic and just society.”¹

The Commission’s guidelines for deliberation reflect its focus on practical and policy-related issues. (The contrast with its predecessor is remarkable. Led by two full-time chairs, Leon Kass and Edmund Pellegrino, the President’s Council on Bioethics pursued “fundamental inquiry into the human and moral significance of developments in biomedical and behavioral science and technology.” The chair and co-chair of the current commission are university presidents who did not take leave.)

The report defines democratic deliberation as “a method of decision making in which participants discuss and debate a question of common concern, justifying their arguments with reasons and treating one another with mutual respect, with the goal of reaching an actionable decision for policy or law, open to future challenge or revision.”²

Elsewhere, Commission Chair Amy Gutmann and Dennis Thompson explain the nature of “public reasons”: “When citizens make moral claims in a deliberative democracy, they appeal to reasons or principles that can be shared by fellow citizens who are similarly motivated,” that is, those who are also motivated to bring their own public reasons to a deliberative process in terms that are “accessible to their fellow citizens.”³

While making arguments in terms that are understandable and perhaps accepted by others may be an important posture as a matter of prudence, it is a far different thing to *require* that participation in deliberative democracy necessitates said motivation and rhetorical stance. Is the speaker to be bound by the subjective experiences and attitudes of the listener? A listener who might agree that the argument is well-supported might nonetheless reject its appropriateness because they dislike the moral conclusion, despite the mandate for “mutual respect.” The “accessibility” demand might very well exclude any number of sincere, thoughtful citizens who think about bioethical issues in essentially theological or religious terms, and who do not wish, or lack the skill, to express matters of deep faith while confined to the bland vocabulary of public deliberation.

There seems to have been a deliberate effort to sidestep the contributions of religion, spirituality, and theology, and their significance for most people’s lives. Even though religious belief is reportedly on the decline in the U.S. (52% of Americans say religion is “very important” in their life),⁴ eighty-three percent of Americans still identify as Christian, with only 13% percent reporting no religion.⁵ Yet, the report mentions ‘religion’ barely three times, twice to describe members of public bioethics organizations, and once to suggest that a community organization or church might offer a class in “world religions.” The only reference to ‘spiritual’ or ‘spirituality’ is a 2000 AARP survey revealing that a top learning motivation of people over the age of fifty is “spiritual growth.” References to “theological bioethics,” “theological ethics,” or even plain vanilla “theology”? Zero.

The distancing of deliberative democracy from religious discussion is even more puzzling, given that “people who are highly religious are . . . more likely to volunteer [and] more involved in their communities.”⁶ If the people who are most likely to show up at a community forum are highly religious, why should something that is core to their identity be ignored or, at worst, excluded? Would a religious person offering a religious perspective, even a well-presented one, be accused of not “giving a reason”?

Last year, the Commission invited public comment on deliberation and bioethics education. In response,

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CBHD filed a letter highlighting the necessity of including not just deliberative competence, but normative competence in bioethical dialogue.⁷ The pursuit of a kind of generalized public morality (the likely outcome of democratic deliberation) could sideline contributions of those with deeper metaphysical, axiological, and theological commitments. If the policy under discussion affects religious people, then religious perspectives should be specifically included. Issues such as fetal tissue research, dispensing of the “morning-after pill” to minors, and organ donation come to mind. Exclusion of theological or more broadly religious perspectives points toward deliberation that is *political*, rather than *public*.

Despite the overtures to include those who might be affected by a proposed policy (which could mean the majority of Americans), the ground rules for democratic deliberation privilege an elitist posture that favors a seemingly neutral perspective of public morality and values, while ignoring the theological roots and trunk upon which the moral fruits of virtue grow.

Furthermore, the outcome of deliberation appears to be skewed in favor of those conducting it. The report cites favorably and at length the “national-level deliberation” in the UK over three-parent embryos, described as “mitochondrial donation.”⁸ The 13-month process that resulted in Parliament’s approval in 2015 demonstrated “general support.”⁹ However, the process has been critiqued for its misrepresentation of science, including safety for the resulting children, and its inadequate ethical discussion of the ban on germline engineering and cost/benefit analysis.¹⁰ The Human Fertilisation and Embryology Authority (HFEA) selected the focus groups and opinion polls that supported legalization. An independent poll showed only 20% of the public agreed with the HFEA plan.¹¹

Let me be clear. CBHD is committed to charitable critique, collegial scholarship, accessible language, and mutual respect. We aim to persuade with cogent arguments and compelling ethical analysis. But there are times when the best arguments

are overtly and richly theological. If democratic deliberation excludes those reasons from the conversation, it will be a barren public square indeed. ●●

- 1 Presidential Commission for the Study of Bioethical Issues, *Bioethics for Every Generation: Deliberation and Education in Health, Science, and Technology*, May 2016, 17. http://bioethics.gov/sites/default/files/PCSBI_Bioethics-Deliberation_0.pdf.
- 2 Ibid, 3.
- 3 Amy Gutmann and Dennis Thompson, *Democracy and Disagreement* (Cambridge, MA: Harvard University Press, 1996), 55. The Commission report, not surprisingly, relied extensively on the work of its chair Amy Gutmann in deliberative democracy and democratic education (citing her work 25 times in 152 endnotes).
- 4 Gallup Poll, www.gallup.com/poll/1690/religion.aspx.
- 5 Gary Langer, “Poll: Most Americans Say They’re Christian,” *ABC News*, July 18, 2016. <http://abcnews.go.com/US/story?id=90356&page=1>.
- 6 “Religion in Everyday Life,” *Pew Research Center: Religion & Public Life*. April 12, 2016. <http://www.pewforum.org/2016/04/12/religion-in-everyday-life/>.
- 7 The letter can be accessed at <https://cbhd.org/content/comment-letter-deliberation-bioethics-education>.
- 8 PCSBI, 23.
- 9 PCSBI, 24.
- 10 David King, “Manipulating Embryos, Manipulating Truth.” Council for Responsible Genetics, *Gene-Watch* 27, no. 3 (Sep-Nov 2014). <http://www.councilforresponsiblegenetics.org/genewatch/GeneWatchPage.aspx?pagelid=543&archive=yes>.
- 11 King, “Manipulating Embryos.” See also http://www.comresglobal.com/wp-content/uploads/2015/06/Care_Three-Parent-Embryo-Survey_2nd-February-2015.pdf.

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prohibit counseling, aiding, or abetting suicide violate the Canadian Charter when applied to a fully-informed competent adult patient who has been diagnosed with a serious illness, disease, or disability that is causing intolerable physical or psychological suffering that cannot be alleviated by medical treatment acceptable to that person. Justice Smith determined that jurisprudential development since *Rodriguez* of the concept of "disproportionality" justified departure from precedent.¹⁴ The provincial Court of Appeal disagreed, ruling in 2013 that *Rodriguez* remained binding.¹⁵

By unanimous vote in February 2015, the Supreme Court of Canada reversed the Court of Appeal and affirmed Justice Smith's ruling. "It is a crime," the Court wrote,

to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.

The Court proceeded to hold that

the prohibition on physician-assisted dying¹⁶ is void insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease, or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

The Court suspended its decision in *Carter* for twelve months to allow Parliament to enact new legislation on physician-assisted dying.¹⁷

Notably, the judgment in *Carter* was not confined to PAS: in addition to invalidating the Criminal Code's prohibition on aiding suicide as applied to the defined class of patients, it likewise invalidated the provision stating

that no person is entitled to consent to the infliction of his own death. Thus, when Parliament enacted legislation in June 2016, it explicitly defined "Medical Assistance in Dying" (MAID) to include

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what is commonly known as "voluntary euthanasia" (the administration by physician or nurse of a lethal substance at the request of the patient) as well as PAS (the provision of a lethal substance to be self-administered by the patient). By so doing, Canada has taken the first major step toward the "Benelux" (Belgium, Netherlands, Luxembourg) model of euthanasia. Parliament considered, but for now rejected, other Benelux practices, including allowing euthanasia by advance directive, euthanasia for mature minors, and broader eligibility for euthanasia based on mental illness.¹⁸ After considerable controversy, Parliament also added to the Supreme Court's criteria a requirement that the death of a patient be "reasonably foreseeable"—a provision already under court challenge as unduly restrictive in light of *Carter* and thus unconstitutional. One restriction imposed by Parliament pointedly did not appear controversial—"MAID" is limited to residents of Canada. Thus "euthanasia tourism" will not be permitted.¹⁹

Questions Going Forward

For Canadians, two global questions immediately present themselves. First, having adopted the Benelux model for euthanasia, is it reasonable to expect that Canada can avoid the expansion of criteria for euthanasia experienced in those countries? Second, having established that medical practitioners are *permitted* to commit acts of euthanasia, will those who object to such practices be obliged to participate, even in indirect fashion?

Regarding the first question, there are ample reasons to believe that Canada, having started down the "Benelux road," will continue the journey to its ineluctable end. The criterion of "reasonably

foreseeable" death led to a bitter standoff between Canada's Senate, which generally opposed the language, and the House of Commons, where the bill originated. While the Senate eventually acquiesced, a lawsuit challenging the provision was filed almost immediately, on behalf of a twenty-five-year-old woman with spinal muscular dystrophy. Her lawyers—the same civil liberties group that prevailed in *Carter*—claimed that the law "deliberately excludes a class of people: those who are suffering with no immediate end in sight." Furthermore, while the Government's bill excluded euthanasia for minors and by advance directive, it committed to further review of these issues, a clear signal that its legislation is not the final word on criteria for euthanasia.²⁰

Furthermore, there is no realistic prospect that the conscience rights of those who oppose euthanasia will be honored or protected. The Canadian Medical Association in August 2015 concluded that all physicians must provide information to their patients on "MAID," and how they may access such "services." The Provincial-Territorial Expert Advisory Group of Physician-Assisted Dying appointed in the wake of the *Carter* decision concluded in its November 2015 final report that while healthcare providers retain the freedom of conscientious objection,

they are required to provide information about *all* end-of-life options, including physician-assisted dying. Conscientiously objecting health care providers are also required to either provide a referral,

a direct transfer of care to another health care provider, or to contact and transfer the patient's records through a third party, agency or service which would have a duty to ensure the safe and timely transfer of care of the patient to a non-objecting provider.²¹

In effect, a healthcare provider may object to euthanasia, but cannot exempt herself from the new reality that euthanasia is “part of the continuum of services and supports to Canadians at the end of life.”²²

In the United States, the picture is murkier. For the foreseeable future, the path to legalization (or rejection) of PAS will continue on a state-by-state trajectory. Moreover, since state courts have shown no willingness to establish a constitutional right to PAS, the battle will remain with legislators and, where available, the process of initiative and referendum. The federal government could intervene, at least in limited fashion: Congress retains the right to review legislation enacted in the District of Columbia, including the District's recently-enacted law on PAS, but many observers count this as unlikely. More realistically, Congress and federal regulators could ensure (through imposing conditions on states and other entities that receive federal healthcare funding) that no federal programs or policies endorse or encourage PAS, or violate the rights of conscience of those healthcare providers who refuse to participate in PAS. Such measures might have limited practical effect in limiting the practice of PAS, but would clarify what, to date, has been a largely undefined federal policy regarding the practice.

Could Congress go further to restrict PAS? The answer is not clear. The Supreme Court ruled in 2006 (*Gonzales v. Oregon*)²³ that former Attorney General John Ashcroft exceeded his authority by issuing a directive that physicians who prescribed lethal drugs for PAS could lose their federal license to prescribe controlled substances. Ashcroft determined that assisted suicide is not a “legitimate medical purpose,” and thus that prescribing drugs for that purpose violated federal regulations on controlled substances

dating to 1971. While deciding that neither Congress nor the regulation in question gave the Attorney General the authority to make such a ruling, the Court left open the question whether Congress itself could impose such a limitation on the prescription of lethal substances, or whether a more formal administrative rule-making process could do so. Thus far, Congress has shown little interest in restricting PAS in states where it has been legalized. Moreover, the Supreme Court's decisions on end-of-life issues dating to 1990 show a strong proclivity to leave fundamental policy on such matters to the states; Congressional attempts to override such policy decisions would inevitably provoke litigation that could reopen the question of a “constitutional right” to PAS.

Ultimately, the fate of PAS in the United States will depend on cultural views regarding the practice, views that will be shaped largely, though not completely, by the attitudes and practices of the healthcare professions. While the events of 2016 have made PAS more widely available, our “data points” to assess the current practice are derived almost entirely from Oregon and Washington. In Oregon,

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approximately 1,000 patients have ended their lives since 1998, with a moderately increasing trend each year. The trend is similar in Washington, where approximately 750 have died from PAS since 2009. (These are the “official” figures, and would not account for unreported cases of PAS or even more active forms of euthanasia.) Further, while a small number of physicians write a majority of PAS prescriptions, the number of participating physician is also trending upwards: 106 physicians wrote such prescriptions in Oregon in 2015, compared to 40 in 2005. In Washington, 142 physicians

prescribed lethal substances.²⁴

One point from data and anecdotal evidence is clear: requests for assisted suicide are not limited, by law or practice, to the archetype case of a terminally ill patient in the last stages of life, suffering intractable and unremitting physical pain. Publicized cases such as that of Brittany Maynard—largely credited with spurring the legalization of PAS in her native California—suggest that the motive for seeking PAS is to control the manner of one's death. Ms. Maynard established residence in Oregon in order to be able to end her life before such suffering became an issue, and Oregonians who seek PAS have similar motives.²⁵ PAS is not a medical option of last resort when all other avenues to relieve suffering have failed (setting aside the question of whether and how many such cases now exist), but an avenue of control and choice, the exercise of which is bounded by no objective criteria of pain, suffering, or related burdens. While the scope of legalization in the United States is far less than in Canada, the pretense of “objective” safeguards in both countries is exposed by the ultimate power of purely subjective criteria, defended on grounds

of patient autonomy and dignity.

Two Concluding Anecdotes

Papal biographer and prolific author George Weigel reports that in the summer of 2016,

three elderly members of my summer parish in rural Québec received a diagnosis of cancer at the local hospital, a small-town facility an hour's drive from cosmopolitan Ottawa and even farther from hyper-secular Montréal. Yet after the diagnosis had been delivered, the *first* question each of these people was asked was ‘Do you wish to

be euthanized?" That is what the new Canadian euthanasia regime has accomplished in just a few months: It has put euthanasia at the *top* of the menu of options proposed to the gravely ill.²⁶

Could such insouciant queries become standard in American medicine?

In pondering this question, I consider the attitudes among some of the medical students I teach at Georgetown University. Not a few have expressed their support for PAS because of suffering they have witnessed, not merely among the terminally ill, but including those with a gravely disabling condition such as amyotrophic lateral sclerosis. How will these future physicians and their colleagues advise patients who present with such conditions? Will they feel obliged personally—or *be* obliged by law or medical practice guidelines—to present the option of PAS? Will they be able to separate their feelings that assisted death might be a *preferred* option from their obligation to care diligently for those who refuse that option? Will they be tolerant of colleagues who continue to adamantly oppose physician participation in killing?

The "cracks in the wall" evident in 2016 bring these questions into sharp relief. They should be at the forefront of the inevitable debate over further legalization of PAS and euthanasia. ●●

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- 1 "Physician-assisted suicide" is to be preferred over terms such as "physician aid-in-dying" (PAD) or the new Canadian term, "Medical Assistance in Dying" (MAID). "PAS" is correct from a legal perspective, as laws authorizing the practice provide exemptions from existing prohibitions against assisting in suicide. PAS is also the term commonly employed by proponents and opponents of the practice for several decades. Finally, terms such as "aid-in-dying" are euphemisms designed for three purposes: (1) to include measures to actively bring about death under the general umbrella of end-of-life decisions (EOLD) that may include the refusal of life-sustaining medical treatments; (2) concomitantly, to distinguish the choice to end one's life at the point of incurable illness or disability from the choice of a "healthy" person to commit

suicide; (3) to provide an umbrella term capable of redefinition and expansion to cover various forms of active euthanasia.

- 2 The Colorado "End of Life Options Act," Proposition 106, passed by a margin of 65 to 35 percent. Ballotpedia State Desk, "Colorado End of Life Options Act, Proposition 106," Ballotpedia, [https://ballotpedia.org/Colorado_End_of_Life_Options_Act,_Proposition_106_\(2016\)](https://ballotpedia.org/Colorado_End_of_Life_Options_Act,_Proposition_106_(2016)) (accessed November 17, 2016).
- 3 The California "End of Life Option Act," A.B. 15, signed by Governor Brown on October 5, 2015, came into effect June 9, 2016. California Legislative Information, "AB-15 End of Life," https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15 (accessed November 17, 2016).
- 4 Bill C-14, legislation to regulate "MAID," received Royal Assent on June 17, 2016. See Government of Canada, "Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)." Accessible at <http://justice.gc.ca/eng/tp-pr/other-autre/adra-amr/adra-amr.pdf>
- 5 *Washington v. Glucksberg*, 521 U.S. 702 (1997), *rev'g* *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc); *Quill v. Vacco*, 521 F.3d 793 (1997), *rev'g* 80 F.3d 716 (2d Cir. 1996).
- 6 3 S.C.R. 519 (1993).
- 7 The Washington Death with Dignity Act, Initiative 1000, passed on November 4, 2008, and went into effect March 5, 2009. Washington State Department of Health, "Death with Dignity Act," <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct> (accessed November 17, 2016).
- 8 Act 39, Patient Choice and Control at the End of Life, was enacted in May 2013. Certain patient safeguards, such as a fifteen-day waiting period and a requirement for psychiatric evaluation if there is indication of impaired judgment on the part of the patient, were due to expire in 2016. However, legislation signed in May 2015 removed the sunset provisions, and those safeguards remain in effect. Death with Dignity, "Death with Dignity in Vermont: A History," <https://www.deathwithdignity.org/death-with-dignity-vermont-history/> (accessed November 17, 2016).
- 9 The Massachusetts "Death with Dignity" Initiative, Question 2, was defeated in 2012 by 52 to 48 percent. Ballotpedia State Desk, "Massachusetts 'Death with Dignity' Initiative, Question 2 (2012)," Ballotpedia, [https://ballotpedia.org/Massachusetts_%22Death_with_Dignity%22_Initiative,_Question_2_\(2012\)](https://ballotpedia.org/Massachusetts_%22Death_with_Dignity%22_Initiative,_Question_2_(2012)) (accessed November 17, 2016).
- 10 *Morris v. Brandenburg*, 376 P.3d 836 (N.M. Sup. Ct., 2016).
- 11 *Baxter v. State of Montana*, 354 Mont. 234, 224 P.3d 1211 (2010).
- 12 Assembly Bill No. 2451, patterned closely after the Oregon PAS law, passed the New Jersey General Assembly in October 2016. The Health Committee of the state Senate advanced a companion bill in November.
- 13 Compassion and Choices, "New York," <https://www.compassionandchoices.org/new-york/> (accessed November 17, 2016).
- 14 *Carter v. Canada* (Att'y General). [2012] B.C.S.C. 886 (Can. B.C.).
- 15 For a comprehensive review and critique of Justice Smith's ruling in *Carter*, see John Keown,

"A Right to Voluntary Euthanasia? Confusion in Canada in *Carter*," *Notre Dame Journal of Law, Ethics & Public Policy* 28, no. 1 (2014): 1–45. <http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1718&context=ndjlepp> (accessed November 17, 2016).

- 16 There was no provision in Canadian law to prohibit "physician-assisted dying" as such; the relevant provision, section 241 of the Canadian Criminal Code, prohibits counseling, aiding, or abetting suicide.
- 17 *Carter v. Canada* (Att'y General). 2015 SCC 5 [2015] 1 S.C.R. 331. Accessible at <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do> (accessed November 17, 2016).
- 18 The Netherlands for instance permits euthanasia in cases of unbearable suffering with no prospect of improvement. News sources recently reported that this has criterion has been extended to include alcohol addiction. Tom Embury-Dennis, "Man in the Netherlands Euthanised Due to His Alcohol Addiction," *Independent* (November 30, 2016), <http://www.independent.co.uk/news/world/europe/man-holland-netherlands-dutch-euthanised-alcohol-addiction-alcoholic-netherlands-a7446256.html> (accessed November 30, 2016).
- 19 For further discussion of these and other provisions of the Canadian legislation, see Legislative Background: MAID.
- 20 Harvey Max Chochinov and Catherine Frazee, "Finding a balance: Canada's law on medical assistance in dying," *The Lancet* 388, No. 10044 (Aug. 6, 2016): 543–545.
- 21 Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, "Final Report" (November 30, 2015), 3, 43–45. Accessible at http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf
- 22 *Ibid.*
- 23 546 U.S. 243 (2006).
- 24 Oregon Public Health Division, "Oregon Death with Dignity Act: 2015 Data Summary" (February 4, 2016). Accessible at <https://public.health.oregon.gov/ProviderPartnerResources/Evaluation-Research/DeathwithDignityAct/Documents/year18.pdf>; Washington State Department of Health, "Washington State Department of Health 2015 Death with Dignity Act Report." Accessible at <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf>
- 25 Liz Szabo, "'Death with Dignity' Laws and the Desire to Control How One's Life Ends," *Washington Post* (October 24, 2016), https://www.washingtonpost.com/national/health-science/death-with-dignity-laws-and-the-desire-to-control-how-ones-life-ends/2016/10/24/6882d1e6-9629-11e6-bc79-af1cd3d2984b_story.html (accessed November 17, 2016).
- 26 George Weigel, "The Culture of Death, on the March in Colorado," *National Review* (September 29, 2016), <http://www.nationalreview.com/article/440497/proposition-106-colorados-euthanasia-bill-would-dehumanize-medical-care> (accessed November 17, 2016).

AMULYA MALLADI, *A HOUSE FOR HAPPY MOTHERS*

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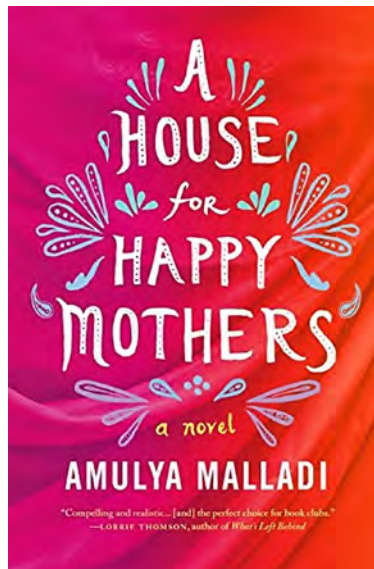
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A *House for Happy Mothers* is a novel about women who are neither happy nor mothers. This is a story about women who are resigned and resolute child bearers for hire: women renting their wombs and, in the process, subjugating their emotions and their relationships. These gestational surrogates are required to live in the Happy Mothers fertility and surrogacy clinic for the last four months of the pregnancy. Though not written as a tome on the bioethics of global surrogate motherhood, the author does cover the relevant issues in varying depths, making this an appropriate text for bioethics/global medicine courses.

The book chronicles the experiences of Madhu and Priya, a Silicon Valley couple, unable to conceive and carry a child to term, who utilize Asha, a woman from the clinic in India to be impregnated with what would be their biological offspring. The story is told in vacillating narratives of the surrogate mother and the hiring mother, and is arranged by sections corresponding to the stages of pregnancy: conception; first, second, and third trimesters; and labor and delivery. That these are considered stages for the hirer as well as for the surrogate emphasizes that both the surrogate and the contracting couple are affected by 'the arrangement' (a term that diminishes the impact of surrogacy). Giving equal narrative voice to both hirer and surrogate may lead one to suggest the surrogate is equal to the hirer; however, Malladi skillfully uses provocative dialogue to suggest that economically, physically, and emotionally, this is not the case. This is illustrated in the following dialogues.

Obviously this was not the ideal way to have a baby. The easiest way would be to get knocked up—but

that hadn't quite worked out for them. And now after three miscarriages and three failed IVF treatments, each costing about \$10,000, surrogacy had become the only way out. The only way to have a child, a family. "Priyasha, don't be stupid; if you can't have a baby, maybe you're not meant to have a baby," her mother had said. "Have you thought about that instead of running around impregnating some strange woman with your child?" (2)



These early dialogues bring up issues of reproductive technology costs and divine sovereignty. The desperation of the hirer is demonstrated:

Come on, Madhu, this is our last chance. . . . Our only, only, last chance. I want this. "No," Madhu had said. "Priya, this isn't some handcrafted Indian sari you buy at the fair-trade store. This is a baby. You can't just rent a body." But Priya had sent him e-mail after e-mail with information about how safe it was, how effective it had been for others like them, and most important, how the money they would

give the surrogate would help her family and improve the quality of her life. (3)

Malladi also shows the emotional struggle involved:

They didn't see it as exploitation of the poor, as Sush did; they saw it as a way for them to have a grandchild while helping another family have a better life. (8)

One hope was giving hope to another hope; there was something inevitable about it, as if the universe had planned it. (10)

Asha wondered if there had ever really be a choice for her. Could she have said no? (19)

It seemed wrong to do this for money, but Asha wouldn't do it if their finances were better, would she? . . . they needed money, and this was an easy—or, say, viable—way to earn it. . . . That had been Asha's mother-in-law's argument. "It's for a good cause, and it's better than selling a kidney, isn't it?" (22)

The decision to use a surrogate and the resultant relationship is presented as a win-win situation, with both parties somewhat harmed, but the outcome outweighing those harms. The story gives voice to the challenges of being barren and saddled with all the emotions that come with that label, such as feeling like a failure or of dealing with the expectations of family. The surrogate, in addition to the emotions that come from the expectations of being the economic savior of her family and the anticipation of giving up a child she has carried to term, also has the hormonally-based emotions of pregnancy. Economically, the surrogate has little voice, not feeling empowered to ask for more money when it is clear the physician owner of the clinic is

making lots of money.

Malladi deftly introduces all of the relationships that cannot be ignored with a decision to use a surrogate. In addition to the husband-wife relationships of both the hiring and the surrogate couples, the book shows the relationships between the hiring woman and childbearing woman; the childbearing woman and her existing children, in-laws, community/society, the clinic physician, and the other women in the clinic; and the hiring woman and her mother, in-laws, friends/community, and the clinic physician. Additionally, relationships of both husbands with their parents and siblings, as well as the relationships among the women in the clinic during their required stay of the last four months of the pregnancies are included as this story unfolds. As described, this house is more comfortable than the women's homes. The poverty of their lives and the hard work necessary to navigate

it make the unhappy house attractive by comparison. They do not have to work during their stay, are given massages on demand, are provided adequate nutrition without having to prepare meals for themselves, and have a television to watch. Additionally, many of the women receive gifts from the hiring couples.

The 'nurture versus nature' argument is raised as the narratives explore the decision to use a surrogate: "You can adopt, but God knows what you bring into the house. . . . It takes years. It costs so much money. And you don't know what blood you bring home." (27) This argument is between members of the same culture, as is the surrogacy arrangement. Even though the surrogate is from India, the hiring couple is also from India (though they live in the U.S.) and ethnically from the same Indian culture but from markedly different social and economic cultures. Thus, the author shows that a

surrogate can be exploited by a member of their own ethnic culture. The entire story is told against the backdrop of the normalcy of everyday life: married-life arguments, problems with in-laws, job layoffs due to area economy and their subsequent effect on relationships, and parties/gatherings with friends.

Malladi has created a real 'page-turner' where, depending on your bent, you may side with the surrogate or the childless woman. "Nine months of carrying a baby against a lifetime of *immense joy*: it was no contest." (30) ●●●

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TRANSFORMATIONS IN CARE

METAPHORS IN MEDICINE: TOWARD TRANSFORMATION IN CARE

MICHAEL COX, PHD (CAND.)

CBHD RESEARCH ANALYST

The first college president I worked for was Sister Lilian. . . . Shortly after becoming president, she was diagnosed at the age of thirty-nine with advanced ovarian cancer, and she spent two of the hardest years of dying that I've ever witnessed She looked like a Holocaust survivor before she died. She had intestinal obstructions. She was in and out of the hospital. I can remember sitting behind her, kind of offering physical strength as she retched over an emesis basin.

And knowing that I was teaching in our nursing department, she said to me, "Carol, please tell your students when I first got sick, it didn't matter how people treated me because I knew who I was." [She was] President of our college [with a] PhD in Microbiology. [She was] from Worcester, Massachusetts and had all that New England reserve that got trampled over royally the sicker she became. [She was] one of the most gentle, loving, kind human beings I've ever had the good fortune to know. She said, "As I've grown weaker, I've become whatever people make of me." And she said, "If a doctor or nurse walks into my room and treats me

like meat on a platter, I become meat."

I wanted to cry. I remember that my profession can take a Lilian and transform her into a slab of meat by virtue of [one's] approach. . . . The more vulnerable people are, the more we become their world of meaning. So, [if someone] interacts with me like [they] don't care [especially] if . . . my days are shorter rather than longer [when] I have questions of meaning and worth, [then] I'm going to feel compromised.¹

With this story Carol Taylor (PhD, MSN, RN) highlighted one facet of CBHD's 2016 conference theme "Transformations in Care": as she died, Lilian's life was transformed and this transformation was not only caused by her cancer but was facilitated by the medical professionals attending to her.

Transformations in Care

The conference addressed issues that have, are, and will inevitably continue to transform the nature of the medical care offered. For example, Taylor noted that transformations to the medical profession have been brought about by profits,

politics, and policies—external factors that shape and guide the practice of medicine.

In his address, Michael Balboni (PhD, ThM, MDiv) discussed similar social forces that drive the contemporary practice of medicine and have transformed it in recent decades: the market economy, bureaucracy, and science. It is helpful to frame these forces as controlling metaphors that offer both a plot and roles to actors. First, the 'market economy' suggests that medical professionals, in exchange for money from customers (i.e., patients), offer the product of service. As a 'bureaucracy,' medical professionals fill the role of efficient data managers, reducing patients to ID numbers—data to be managed. While doctors and nurses should certainly be technically competent, as a controlling metaphor 'science' reduces the practice of medicine to experimentation: medical professionals are the scientists and patients are little more than bodies. The medical profession has not been able to resist these metaphors as they have come to permeate our culture.

Cheyn Onarecker's (MD, MA) opening address not only praised the benefits of advances in medicine but also lamented how the profession has changed. External

Michael Cox, PhD (Cand.), "Metaphors in Medicine: Toward Transformation in Care," *Dignitas* 23, no. 3 (Fall 2016): 9-13.

transformations such as those described by Taylor and Balboni have reshaped the ways that care is delivered, which has, at worst, the potential result that these metaphors dehumanize both patients and providers. Vulnerable patients can be "trampled over royally" as customers, ID numbers, or "slabs of meat."² But medical professionals, too, are reduced to providers, managers, and scientists. This is far from the ideal where both actors are persons interacting with one another in a meaningful moment of clinical encounter.

This highlights another layer of transformations brought about by these powerful cultural metaphors. Rather than systemic, these transformations are personal and interpersonal. They occur in the patient herself and in those moments when two people encounter one another, when a patient is attended to by the medical professional. For good or ill,

these transformations are facilitated by the professionals who interact with the patient. Dr. Taylor's remembrance of Lilian's final days illustrates that persons are transformed in such encounters and that interactions between medical professionals and patients are spaces where one may either be reformed or deformed—with the stakes as high as the patient's vulnerability.

These two levels of transformation—external and internal—raised a central question discussed throughout the conference: How can Christian medical professionals pursue proper formation—especially amidst the inertia of such social forces?

The Metaphors of Medicine

The medical profession certainly has a rich vocabulary to counter the powerful cultural forces enacted by the metaphors of the market economy, bureaucracy,

and science. I would highlight two controlling metaphors mentioned at the conference which, taken together, provide a re-orienting vision of the medical profession. Like the social forces above, these metaphors provide roles for actors to play, which will be explored in turn.

For his part, Balboni offered the controlling metaphor of *suffering*, one that allows us to recover much of our heritage as Christians offering care. The characters of this metaphor play the role of host and guest. "This is the Christian tradition: A hospital is a place [to receive] hospitality," Balboni expanded the metaphor, reviving the roles latent in the metaphor: "the physician is a host and the patient is the guest, a stranger. Patients are patients, those who, in Latin, are suffering and . . . called into the virtue of exercising patience."³

Lauris Kaldjian (MD, PhD) responded to Balboni's metaphor with his own, *benefaction*. Kaldjian recounted Karl Barth's reading of the Good Samaritan as a paradigm "that has empowering implications for a Christian doctrine of service in healthcare, a doctrine that should encourage clinicians to abandon all pretense to superiority in the clinician-patient relationship."⁴

Barth's reading "turns the tables on our common notions of giving and receiving and thereby reframes the dynamic of the clinician-patient relationship."⁵ Barth goes to great lengths to describe both the role of the suffering person as the representative of Christ who is the benefactor, and the role of the Samaritan as the receiver of benefaction. "The afflicted fellow-man offers himself to us *as such*. And *as such* he is actually the representative of Jesus Christ."⁶ It is also significant that Barth, through his use of the first person, implies that this is a subjective encounter where *I*, as the one who goes and does likewise (Luke 10:37), am ever the recipient of Christ's gift of mercy through such acts of service. Thus, the suffering person is not someone who *I* serve as a benefactor. Rather, the suffering person is someone who reveals the suffering Christ to *me*. Kaldjian suggested:



Top: Robert D. Orr and Carol Taylor, bottom: Cheyn Onarecker, deliver their plenary addresses at CBHD's 2016 annual summer conference.

to love my neighbor means to accept her service to me. And that service is to show me in her person my sin and misery and the love of God through Jesus Christ. . . . In short, my neighbor reveals my lostness and in that way he tells me that I can only live by God's grace.⁷

By extending service to the neighbor, I see my condition in my neighbor and recognize that Jesus is the only one who can help *me* in my plight. Barth states it thus:

The wretched fellow-man beside me simply reveals to me in his existence my own misery. For can I see him in the futility and impotence of his attempt to live without at once . . . recognising myself? . . . [I]f I can still see him without seeing myself, then for all the direct sympathy I may have for him, for all the zeal and sacrifice I may perhaps offer him, I have not really seen him. . . . He is still not my neighbor. . . . The neighbor shows me that I myself am a sinner. How can it be otherwise, seeing he stands in Christ's stead, seeing he must always remind me of Him as the Crucified? How can he help but show me, as the reflection of myself, what Christ has taken upon Himself for my sake?⁸

This entails, according to Barth, that the man-left-for-dead does not present the Samaritan (i.e., "me") primarily with a *task* but with an *event*, a Samaritan event. Stated another way, this is not a task to accomplish but an event of the Kingdom to be participated in. Thus, I do not offer acts of service by fulfilling the tasks of caring for my neighbor. Rather, I partici-

"the distinctive Christian contribution to healing was the element of compassionate care . . . which focused on the sick and particularly on the sick poor."

pate in events where the Kingdom of God comes near by meeting my neighbor's need and seeing in him both my own need and the only one who can alleviate my suffering, namely, Jesus Christ.

For Kaldjian, this empowers "healthcare professionals to see every one of their patients in a new light," namely,

Playing the Part: The Early Church and Living Metaphor

The theological commitments underlying the metaphors of *suffering* and *benefaction* were deeply held and put into practice by the early church. Indeed, Barth's interpretation of the parable of the Good

to abandon any inclination toward the self-inflating belief that we who serve are the benefactors and those we serve are the fortunate recipients of our benefaction. . . . It is only after we appreciate what Christ has done for us that we can appropriately turn our hearts and minds to the task of service as we help our patients, remembering that our patients, if seen rightly, have already been of benefit to us.⁹

Samaritan builds upon and expounds early Christian interpretation.¹⁰ Gary Ferngren (PhD) explored this historical perspective in his address, "Christianity and the Rise of Western Medicine."

Ferngren asserted that "the Greeks gave us . . . rational medicine, naturalistic medicine. But the Christian church gave us the elements that make medicine a benefit to those who are really needy, especially those who don't often receive it."¹¹ After exploring the contributions of Greek medicine in the ancient world, Ferngren then described how Christians adapted this particular philosophy of medicine to their own ideology. "During times of plague . . . the sick and dying were thrown out into the streets—sometimes by members of their own family. . . . Christians by contrast, saw this as an opportunity to provide care for the sick and the dying." Indeed, "the distinctive Christian contribution to healing was the element of compassionate care . . . which focused on the sick and particularly on the sick poor." In Ferngren's estimation, "most historians of hospitals would



Top-right: Kevin T. FitzGerald, top-left: Linda R. Duncan, bottom-right: Michael Balboni, bottom-left: Lauris Kaldjian, deliver their plenary addresses at CBHD's 2016 annual summer conference.

agree that hospitals represented the most significant institutional outworking of Jesus' parable of the Good Samaritan in Western culture. Hospitals were directed to the sick poor. There was no place for them to go other than to the streets."

also a place where the poor or those who had no family could go to receive care while dying. Within one hundred years after Basil's first hospital was founded, there were around one hundred hospitals throughout the Roman Empire.¹²

In sum, "the church created the only organization in the Roman world that systematically cared for its sick."¹³ In this way the Church enacted Kingdom events by playing the parts scripted by the metaphors of suffering and benefaction

Out of Christian care for the poor and dying grew the first hospitals. Basil of Caesarea founded what he called a "poor house" to care for lepers in 370 AD. The "Basileum" (as it is more commonly known) quickly welcomed other poor sufferers. The first hospital in Rome was "founded by a woman, Fabiola, who was a friend of Jerome As a Christian, she did something that no one else would do: to go out in the streets, pick up the poor and homeless and bring them into her institution." Christian hospitals were

In sum, "the church created the only organization in the Roman world that systematically cared for its sick."¹³ In this way the Church enacted Kingdom events by playing the parts scripted by the metaphors of *suffering* and *benefaction*—the parts of patient and caregiver enacted as guest and host and as benefactor and servant. By taking seriously the call to care for the suffering and poor, the early church cemented these metaphors as the historical foundation of the institution of benevolent healthcare.

Motivation and Metaphors

But the metaphors of *suffering* and *benefaction* offer much more than an interesting historical perspective of the medical profession. Rather, they offer an ideology that can be reclaimed.

First, it should be noted that, even though some vestige of meaning remains in contemporary semantics of healthcare, these metaphors are "dead" to most contemporary English users. Living metaphors elucidate an unknown thing (A) by a known thing (B). For example, the controlling metaphor, "*Time is money*," indicates that one can understand (A) *time* in the categories with which (B) *money* is understood. So, in contemporary English usage, time is spent and saved, invested and wasted. But metaphors can also die.¹⁴ I suggest that this is the case with some central metaphors of healthcare. The death of metaphors such as *patient* or *hospital* makes space in our collective cognition that is filled with the controlling metaphors of our culture such as *market economy* or *efficiency* or *science*.¹⁵

Second, though these metaphors are dead, it is significant that the original ideology remains latent within the terms. This latency has potential to vivify the particular ideologies of the Christians who were first compelled to care for those in need of care. Rescripting the roles of patient and caregiver offers motivation to Christian healthcare professionals by providing a robust Christian approach to the practice of medicine. Kaldjian illustrated this with two medical sub-fields especially vulnerable to exhaustion:

[W]orking in hospice and palliative care is exhausting. But the people who end up working in this kind of area have a sense of purpose or calling that is accompanied by motivations deep enough to sustain them so that in their exhaustion they do not succumb to feelings of depersonalization or lack of accomplishment.¹⁶

I suggest that reclamation of these metaphors can provide "motivations deep enough to sustain" medical professionals. It is in reclaiming the latent ideology of these metaphors that Christians have an



Top: Gary B. Ferngren, bottom: Paige C. Cunningham, at CBHD's 2016 annual summer conference.

opportunity to participate in Kingdom events by understanding their primary roles as *host* to the sufferer—the one who can reveal Christ himself.

But we should not make the mistake of thinking that because this ideology is a *Christian* ideology, it requires faith in Christ to participate in the Kingdom events enacted by these individuals. It matters not whether medical professionals are Christians. The scripts of these metaphors, though first employed by Christians, can be enacted by anyone—Christian or not. Barth, in his discussion of the Good Samaritan, notes that

as the Bible sees it, service of the compassionate neighbour is certainly not restricted to the life of the Church in itself and as such. It is not restricted to those members of the Church who are already called and recognisable as such. It is not restricted to their specific action in this capacity. Humanity as a whole can take part in this service. . . . [E]ven those who do not know that they are doing so, or what they are doing, can assume and exercise the function of a compassionate neighbour.¹⁷

Moreover, Christians have a significant—even *holy*—responsibility in our coming alongside of fellow medical professionals and patients. For it is in the coming-alongside a sufferer that the Kingdom comes near. Christians, as citizens of that Kingdom, should have eyes to see it coming, willingness to play these parts in these Kingdom events, and even boldness to name it as such.

In Healthcare as It Is in Heaven

As a Kingdom event, the ideology of *sufferer* and *benefaction* threatens the powers of “profits, politics, and policies.” But it also presents a danger to practitioners.

As a biblical scholar, I must continually attend to one particular and dangerous occupational hazard: the temptation to become enamored with the text—whether its beauty, language, history, theology, or even my knowledge of it—while overlooking the God who not only breathed it and teaches and rebukes and corrects

and trains in righteousness through it (2 Tim 3:16), but also calls me to submit to him as he does these things in me. The occupational hazard is to approach the text as an object without encountering it as a subject—or—to encounter God in his word and fail to submit to his claim over my life. In my experience the risks increase in proportion to professional competence.¹⁸

If these distinctly Christian metaphors of *suffering* and *benefaction* are reclaimed by individual healthcare professionals, then Christian medical professionals must attend to a similar hazard. Even when the roles as scripted by these metaphors are played well, one may yet become enamored with other goods such as developing technical efficiency in offering cures and therapeutic interventions, developing scientific expertise, or communicating with careful attention. Such pursuits are good and necessary for professional competence. But they can also provide professionals with a risk: I may fail to see that I am the one in need of transformation and that this transformation is offered in every encounter with a patient. For in every such encounter, I have opportunity to meet the suffering, resurrected, and ascended Christ and in doing so, enact a Kingdom event. Truly, it is in the daily grind of encountering the needy and suffering that I can grow accustomed to these Kingdom events—the normalcy of which threatens to *deform* me. But it is in my participation in such Kingdom events, in my going and doing likewise (Luke 10:37), that I can, by God’s grace, be transformed through the consistent, daily encounters with Christ himself.

Indeed, it is when I acknowledge in every encounter with the sufferer that *I* am in need of care that I experience the most significant transformation in care. ●●

- 1 Carol Taylor, “Transformations in Health Care for Better or for Worse” (plenary address, The Center for Bioethics & Human Dignity’s 2016 Annual Conference, “Transformations in Care,” Deerfield, IL, June 17, 2016).
- 2 Cheyn Onarecker, “Transformations in Care: Framing the Discussion” (plenary address, The Center for Bioethics & Human Dignity’s 2016 Annual Conference, “Transformations in Care,” Deerfield, IL, June 16, 2016).

- 3 Michael Balboni, “The Hidden Curriculum and the Future Socialization of Medical Professionals” (plenary address, The Center for Bioethics & Human Dignity’s 2016 Annual Conference, “Transformations in Care,” Deerfield, IL, June 18, 2016).
- 4 Lauris Kaldjian, Response to Michael Balboni, “The Hidden Curriculum and the Future Socialization of Medical Professionals” (The Center for Bioethics & Human Dignity’s 2016 Annual Conference, “Transformations in Care,” Deerfield, IL, June 17, 2016).
- 5 Kaldjian, “The Hidden Curriculum.”
- 6 Karl Barth, *Church Dogmatics* I/2, (New York: T&T Clark International, 2004), 429, emphasis added.
- 7 Kaldjian, “The Hidden Curriculum.”
- 8 Barth, *Church Dogmatics* I/2, 431.
- 9 Kaldjian, “The Hidden Curriculum.”
- 10 Barth states, “The primitive exegesis of the text was fundamentally right” (419)—and this in contrast to the “current exegesis” (from Barth’s perspective, of course), which he explores in detail on 417–419.
- 11 Gary Ferngren, “Christianity and the Rise of Western Medicine” (plenary address, The Center for Bioethics & Human Dignity’s 2016 Annual Conference, “Transformations in Care,” Deerfield, IL, June 17, 2016).
- 12 Ferngren noted that what makes these hospitals unique in the ancient world is their philanthropic nature—their care to those in need. This care frequently included only palliative care (such as it was) and a place to die.
- 13 Ferngren explores this thesis at length in his book, *Medicine and Health Care in Early Christianity* (Baltimore: Johns Hopkins University Press, 2009).
- 14 I recognize the difficulty of the term *dead metaphor*. However, the term fits the current discussion in the same way as Lakoff’s example of *pedigree*. Etymologically the English term derived from French *pie de grue*, translated as “foot of a crane.” *Pedigree* has taken on its own life quite apart from any resemblance of family tree diagrams to crane feet. When using the term, contemporary English users simply do not envision the metaphor rendering it “dead”—which should not be confused with meaningless. Lakoff hopes to complicate the use of the term *dead metaphor* and only approves of its usage in such instances as this, which parallels English terms such as *patient* and *hospital*. (See George Lakoff, “The Death of Dead Metaphor,” *Metaphor & Symbolic Activity* 2, no. 2 (1987): 143.)
- 15 Other terms that could also be pursued along these lines are *nurse* and *therapist*.
- 16 Kaldjian, “The Hidden Curriculum.”
- 17 Barth, *Church Dogmatics* I/2, 423.
- 18 This dynamic frequently occurs in the gospels when Jesus is confronted by law-teachers. See for example, Jesus’ response to the teacher who understood the scriptures but failed to encounter and submit to God’s claim to *his life* in the scriptures in Mark 12:28–40: “You are not far from the Kingdom of God” (34). Indeed, the open-ended ending of parable of the Good Samaritan leaves the reader wondering: “Will this law-teacher ‘go and do likewise?’”

TOP BIOETHICS NEWS STORIES: JUNE – AUGUST 2016

BY HEATHER ZEIGER, MS, MA
RESEARCH ANALYST

“More U.S. Babies with Zika-Related Birth Defects Reported by Health Agency” by Bill Berkrot, *Reuters*, June 30, 2016

Three more babies have been born in the United States with birth defects likely linked to Zika virus infections, while another lost pregnancy was linked to the virus, according to figures updated by health officials on Thursday. That brings the U.S. totals, as of June 23, to seven babies with microcephaly or other Zika-related birth defects such as serious brain abnormalities, and five lost pregnancies from either miscarriage, stillbirth or termination. (<http://tinyurl.com/hxrcuky>)

Zika is a mosquito-borne virus that is linked to microcephaly and other neurological defects in unborn babies. Ignorance over how the virus is transmitted, whether it affects adults, and whether it causes other birth defects has fueled fears over travel to infected parts of the world. The U.S. recently called for certain areas of Florida to stop collecting blood at blood donation centers until it can be tested for Zika. In the midst of the questions over just how damaging Zika can be, abortion advocates, both in the U.S. and in infected countries, have called for fewer restrictions so that babies who may show signs of birth defects can be aborted.

“Supreme Court Firmly Backs Abortion Rights, Tosses Texas Law” by Lawrence Hurley, *Reuters*, June 28, 2016

The U.S. Supreme Court on Monday [June 27] struck down a Texas abortion law imposing strict regulations on doctors and facilities in the strongest endorsement of abortion rights in America in more than two decades. (<http://tinyurl.com/hms6cnv>)

A Texas law required that doctors who

provide abortions have admitting privileges at a local hospital and that abortion clinics meet the standards for out-patient ambulatory care. The Court struck down this law in a 5-to-3 vote as unconstitutional on the grounds it placed an undue burden on women seeking an abortion.

“After Wrangling, Canadian Parliament Adopts Law on Assisted Death” by David Ljunggren, *Reuters*, June 17, 2016

Canada’s Parliament on Friday [June 17] adopted a law allowing medically-assisted death for the terminally ill, brushing aside critics who wanted the legislation to cover people with degenerative diseases. (<http://tinyurl.com/jpmm3mq>)

“Calif. End-of-life Law, Inspired by Brittany Maynard, to Go into Effect” by Cathy Lynn Grossman, *USA Today*, June 8, 2016

Somewhere in California on Thursday [June 9], a terminally ill person may lift a glass and drink a lethal slurry of pulverized prescription pills dissolved in water. And then die. That’s the day the nation’s most populous state implements a law, passed in 2015, making physician-assisted dying accessible to 1 in 6 terminally ill Americans. (<http://tinyurl.com/zrbl9hs>)

Laws in California and Canada went into effect allowing for physician-assisted suicide this past summer. Both were met with obstacles with Canadian groups calling for the law to be extended to people with degenerative diseases, and doctors in California suing to suspend the law because it lacks appropriate safeguards to prevent its abuse.

“Federal Panel Approves First Use of CRISPR in Humans” by Sharon Begley, *STAT News*, June 21, 2016

A federal biosafety and ethics panel on Tuesday [June 21] unanimously approved the first study in patients of the genome-editing technology CRISPR-Cas9 . . . to create genetically altered immune cells to attack three kinds of cancer. (<http://tinyurl.com/jpqrllol>)

“Chinese Scientists to Pioneer First Human CRISPR Trial” by David Cyranoski, *Nature*, July 21, 2016

Chinese scientists are on the verge of being first in the world to inject people with cells modified using the CRISPR-Cas9 gene-editing technique. . . . The clinical trial received ethical approval from the hospital’s review board on 6 July. (<http://tinyurl.com/zgyn5kx>)

CRISPR-Cas9, the gene-editing technology that has the ability to remove and replace genetic material at multiple locations in the genome, continues to make headlines. This time a company in the U.S. and one in China have received approval to use CRISPR to edit a patient’s blood cells and then re-inject them. (The U.S. trial is contingent upon FDA and local IRB approval.) This will provide immunotherapy against certain cancers. On a similar note, a Pew Research Center survey found that, in general, the U.S. public is worried about biomedical technologies including gene editing, and an even greater number are against using these technologies for enhancement.

“Mylan Offers Discount on EpiPen amid Wave of Criticism” by Toni Clarke and Ransdell Pierson, *Reuters*, August 25, 2016

Mylan NV said on Thursday [August 25] it would reduce the out-of-pocket costs of its emergency EpiPen allergy injection for some patients amid a wave of criticism from lawmakers and the public over the product’s rapidly escalating price. (<http://tinyurl.com/zlnundb>)

Mylan NV has come under fire after increasing the price of the EpiPen from \$100 to \$600 in a move that appears to have been primarily as a means of enhancing their profit margin. This is just one of several high-profile examples of companies increasing the cost of life-saving drugs purported to enhance corporate profits. Another company, Gilead Sciences, has come under scrutiny for avoiding millions of dollars in taxes. Gilead is the maker of two hepatitis C drugs whose full courses cost \$84,000 and \$94,500.

“NIH Plans to Lift Funding Ban on Human-Animal Hybrids” by Antonio Regalado, *MIT Technology Review*, August 4, 2016

Should the U.S. government use tax dollars to fund scientists fusing human stem cells into early animal embryos in order to create “chimeras” that are part human and part pig? Or part mouse? The U.S. National Institutes of Health says the answer is yes. (<http://tinyurl.com/zxwrwdp>)

Last fall the NIH announced that they would not fund research involving the production of human-animal chimeras until they obtained more information. Private companies had already been engaging in this research. Now the NIH says that it will lift its current funding moratorium on human-animal chimeras, allowing for human pluripotent stem cells to be placed in animal embryos. One aim would be to create pigs with human organs to be used for organ donations that might avoid the risks and rejection issues associated with traditional xenotransplantation. The NIH intends to bar the use of primates, or allowing any chimeras to reproduce.

“Audacious Project Plans to Create Human Genomes from Scratch” by Sharon Begley and Ike Swetlitz, *STAT News*, June 2, 2016

Scientists revealed on Thursday [June 2] that they plan to launch a project to synthesize human and

other complete genomes from off-the-shelf parts, a prospect that ignited a storm of controversy last month when a closed door meeting to discuss such an undertaking was held. (<http://tinyurl.com/hk975ho>)

The Human Genome Project, completed in 2001, involved reading the nucleotides that make up DNA in the human genome. Since then, the cost of gene sequencing has decreased substantially. Now several scientists and entrepreneurs want to make a synthetic human genome. One of the goals is to drive down the cost of synthetic biology techniques. Their proposal was met with some resistance as some critics believe that the project is too expensive for the actual gains it will produce. Cost projections and stewardship issues aside, this initiative raises a host of other ethical considerations that have not been addressed.

“Zika Virus Transmission Risk During Olympics Is Low, CDC Says” by Gillian Mohney, *ABC News*, July 13, 2016

The risk of Zika virus transmission during the upcoming Olympic games in Rio will be low due to colder weather, the U.S. Centers for Disease Control and Prevention said today. (<http://tinyurl.com/gvq2t83>)

“Olympic Drug Cops Will Scan for Genetically Modified Athletes” by Eric Niiler, *Wired*, July 28, 2016

In fact, drug regulators are usually playing catch up to drug users. But next month at the Rio Olympics, officials will roll out a test for a doping method that athletes might not even be using yet—genetic manipulation of the body’s own cellular machinery, or gene doping. (<http://tinyurl.com/jkkm72p>)

The Summer Olympics in Rio came and went with some bioethics controversies. One was the question of safety amidst Zika fears. Despite the U.S. Centers for Disease Control’s assurances that it is safe to travel to Brazil, some athletes and spectators chose to abstain from traveling to Rio. The other controversy was whether athletes should be tested for

gene doping. While many experts believe that athletes are probably not genetically enhancing themselves yet, the World Anti-Doping Agency (WADA) says that this is the next step in doping and would like to be proactive in catching cheaters.

“Life Expectancy in Syria Fell by Six Years at Start of Civil War” by Haroon Siddique, *The Guardian*, August 24, 2016

Worst affected was Syria, where men and women were expected to live to 75 and 80 respectively in 2010, but 69 and 75 by 2013. Infant deaths in the country rose by 9.1% over the same period, in stark contrast to the average 6% yearly decline in the decade to 2010, according to the study. (<http://tinyurl.com/glwzgzg>)

“The Virtual Surgeons of Syria” by Avi Asher-Schapiro, *The Atlantic*, August 24, 2016

Throughout Syria, more than 500,000 people are now under siege. The vast majority are penned in by pro-government fighters, their survival hinging on the medical know-how of the doctors, nurses, or medical students who happen to be trapped with them. In clinics like the one in Madaya, medical expertise is increasingly hard to come by, and remote medicine is often the only way patients with complex ailments can receive a semblance of care. (<http://tinyurl.com/h8vs4vk>)

Disaster ethics is an area of bioethics that deals with the unique ethical questions that occur in war-torn areas or places hit by a natural or human-made disaster. One of the biggest problems in the context of Syria’s civil war is the destruction and collapse of the medical infrastructure. This war-torn country has been left with few hospitals, scant medical supplies, and only a small contingent of doctors. One study showed that Syria’s overall life expectancy decreased in only three years’ time—between 2010 to 2013. Experts say the numbers are likely much worse now. Medical workers in Syria have turned to virtual assistance from physicians and surgeons abroad, but must do so at the risk of being caught.

updates & activities

INTERSECTIONS: "A FORUM FOR THE CHRISTIAN LIFE IN OUR MEDTECH AGE"

CBHD launched a new resource through our Everydaybioethics.org website specifically designed for pastors and church leaders. *Intersections* is intended to draw attention to the broad range of bioethical issues and conversations that are happening in the midst of our congregations as well as in society at large, not in the formal language of academic bioethics, but in the language of theology and Church ministry. Initial posts include guest contributions from David Dockery, Joni Eareckson Tada, David VanDrunen, and Scott Rae. For more information or to join the conversation, visit: <http://everyday-bioethics.org/intersections>.

THE CHRISTIAN BIOWIKI

Throughout the Spring semester and early summer, CBHD research staff and interns updated several of the entries for the Christian BioWiki, our online guide to the bioethical statements and positions of Christian denominations and movements throughout the world. We invite you to visit and contribute to this developing resource at <http://christianbiowiki.org>.

MEDIA RESOURCES



CBHD.org on
Twitter: @bioethicscenter



Bioethics.com on
Twitter: @bioethicsdotcom



Everydaybioethics.org on
Twitter: @edbioethics



The Bioethics Podcast at
thebioethicspodcast.com



Facebook page at
facebook.com/bioethicscenter



LinkedIn page at
[in.linkedin.com/thebhd](https://in.linkedin.com/company/thebhd)



YouTube channel at
youtube.com/bioethicscenter



The Christian BioWiki
christianbiowiki.org

STAFF

MICHAEL COX, PHD (CAND.)

- Presented "So That We Might Be Kept Alive: Towards an Old Testament Hermeneutic for Bioethics" as a parallel paper presentation at CBHD's summer conference
- In June, presented a paper, "Ethnicity in the Next Fifty Years: Some (Not So Far-Fetched) Possibilities," to a PhD Seminar on *Ethnicity: Modes of Inquiry and Analysis*.
- Achieved Candidacy for the degree of Doctor of Philosophy at Trinity Evangelical Divinity School in Theological Studies, Old Testament. Michael's dissertation explores a biblical theology of community boundaries.

PAIGE CUNNINGHAM, JD, PHD (CAND.)

- In June, guest-lectured in CBHD's Intensive Bioethics Summer Institute and spoke on "Temporary Wombs: Ethical Issues in Uterus Transplantation" for a combined session of all summer institute courses.
- At the end of June, presented a paper at the *Innovations in Faith-Based Nursing* conference at Indiana Wesleyan University on "Innovations in Assisted Reproduction: Human Dignity, the 'Child of Choice,' and Christian Engagement."
- Was interviewed on "Brian and Kathleen Mornings" (Moody Radio Cleveland) on several occasions to discuss custody battles over frozen embryos and the ethics of biomedicine and enhancement technologies.
- Discussed the ethics of clinical trials and synthetic human genomes on "Let's Talk

with Mark Elfstrand" and was interviewed by *World* magazine on the religious and ethical implications of synthetic genomes.

- Contributed a piece on fetal brain and tissue procurement for her "Biohazards" column in the Fall issue of *Salvo*.
- In July and August spoke twice as a part of "The Gospel & Culture" series at College Church in Wheaton, Illinois, describing how the gospel applies to issues in abortion and bioethics.

MICHAEL SLEASMAN, PHD

- In June, taught the Advanced Bioethics Summer Institute, and guest-lectured in several other bioethics courses leading up to CBHD's summer conference.
- Presented "SciFi & Technology Assessment: What Is an Appropriate Role for Speculative Ethics in Assessing Emerging Technologies?" as a parallel paper presentation at CBHD's summer conference.
- In August, presented "Intrinsicity beyond Artifact: A Theological Inquiry into Mere Instrumentalism and the Axiology of Nature" at the International Academy for Bioethical Inquiry summer symposium.

HEATHER ZEIGER, MA

- In April, published "Pigs with Human Hearts, and Other Wild Tales from the Future of Organ Donation," on *Quartz* (<http://qz.com/660662>).
- Contributed pieces on euthanasia and "The Changing Face of Physician-Assisted Suicide" to the Fall issue of *Salvo*.

ON THE CBHD BOOKSHELF

For those interested in knowing what books and articles the Center staff have been reading and thought worth highlighting. **Notes that the resource includes material by members of the Center's Academy of Fellows. ***Notes that the resource includes material by members of the Center's Advisory Board.

Barat, James. *Our Final Invention: Artificial Intelligence and the End of the Human Era*. (Thomas Dunne Books, 2013).

Bieber Lake, Christina. *Prophets of the Posthuman: American Fiction, Biotechnology, and the Ethics of Personhood*. (University of Notre Dame Press, 2013).

**Kilner, John. *Dignity and Destiny: Humanity in the Image of God*. (Eerdmans, 2015).

**Mercer, Calvin, and Tracy Trothen, eds. *Religion and Transhumanism: The Unknown Future of Human Enhancement*. (Praeger, 2015).

Messer, Neil. *Flourishing: Health: Disease, and Bioethics in Theological Perspective*. (Eerdmans, 2013).

**MacKellar, Calum, and Christopher Bechtel, eds. *The Ethics of the New Eugenics*. (Berghahn, 2014).

**Mitchell, C. Ben, *Ethics and Moral Reasoning: A Student's Guide*. (Crossway, 2013).

***Mitchell, C. Ben, and D. Joy Riley, *Christian Bioethics: A Guide for Pastors, Health Care Professionals, and Families*. (B&H Academic, 2014).

Moo, Jonathan, and Robert White. *Let Creation Rejoice: Biblical Hope and Ecological Crisis*. (IVP Academic, 2014).

**Rae, Scott. *Introducing Christian Ethics: A Short Guide to Making Moral Choices*. (Zondervan, 2016).

COMING SOON: ZIKA UPDATE