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ANOTHER BREECH IN HIPPOCRATIC ETHICS: SHOULDN'T MEDICINE BE MORE THAN A BUSINESS?

BY GREGORY W. RUTECKI, MD, Fellow

Teaching about the "New Healthcare Paradigm" at the 2010 Summer Conference forced me to confront the "corporate transformation of medicine" in more detail than usual. In contrast to the "Hippocratic triangle," connecting God at the apex to doctor and patient at the lower angles, this specific transformation has become both insidious and under-appreciated. It has taken any semblance of a covenant model away from doctor-patient interactions and negatively transformed them into contracts—wherein supply forces demand, but only for those who can pay. Let us look at some recent trends suggesting medicine has devolved professionally into a business.

Did you know that feeding tube placement in elderly demented persons does not prolong life, decrease infections or aspiration, and probably offers no advantages over hand feeding? Then why are more feeding tubes placed in this population at for-profit rather than not for-profit hospitals?[1] *Consumer Reports* rated spinal surgery as number one on the list of overused treatments.[2] Did you know that the fastest growing demographic receiving lumbar spinal surgery is elderly persons with lumbar stenosis? There are three types of surgery for this population. The most complex surgery has increased 15-fold from 2000-2007, correlating with a higher rate of complications, deaths, and rehospitalizations.[3] The complex surgery costs $89,888, the simplest $23,724.[4] Yes, physician reimbursement increases similarly as well.[5] The editorialist was taken aback. Here are excerpts of what he said in response to the trends for spinal surgery, "Newer and more complex technologies are being used for patients with little specific indication … as currently configured, financial incentives… (are) a formidable economic and social problem."[6] Did you know that some physicians prescribe medicines based on marketing stimuli rather than scientific proof of efficacy and safety? Ezetimibe, a cholesterol-lowering drug, may be a case in point.[7] Costs for prescriptions increase, and if anything else, evidence-based treatment is compromised and pharmaceutical suppliers make profits. These are just a few examples, a veritable "tip of the iceberg" (percutaneous coronary dilatation for stable coronary disease is another). What about a more pervasive context for these behaviors?

For-profit hospitals are 3 to 11% more costly than not for-profits.[8] Not for-profits that convert to for-profit curtail the volume of uncompensated or charity care after conversion. During the 2001 recession, pharmaceutical companies increased profits (33%) while Fortune 500 companies experienced a decline (53%).[9] More than 80% of managed mental health firms are for-profit. As a group they limit care based on payment. Eighty-five percent of dialysis centers in the U.S. are for-profit. Their death rates are 30% higher with 26% less referrals for transplant.[10] Why are less people referred for transplant? If they undergo a successful transplant, they no longer require dialysis and that dialysis center loses reimbursement for their treatment. Again there are many more examples attesting to a pervasive corporate transformation (nursing homes fit the paradigm as well).

Is this merely a business discussion or does it have serious ethical ramifications as well? Appropriately, the evangelical healthcare community has stood their ground in the pro-life arenas of abortion, euthanasia, and stem cells. Where is their voice regarding the corporate transformation of their profession? No wonder unbelievers' criticism of conscience clauses includes "conscience without consequence."[11] Any mitigation in the corporate transformation will have a consequence for evangelical healthcare providers—it will be financial. But can our witness in the pro-life realm be authentic, if unlike the gospel, we do not penetrate every unjust practice associated with our profession? The individuals who alleged that Christian physicians exercising their pro-life conscience avoid consequences of their choices, also identified less enthusiasm from this group in providing charity care. Is this a just criticism?

Recently, I attended a welcome for incoming Christian medical students. A urologist was recounting his many overseas mission trips. At our charity hospital, there is not one community urologist who will see our uninsured patients. Although both a pro-life conscience and missionary zeal are laudable, there is more to being a healer than those two activities. In a historical survey of early Christian medical practice, Gary Ferngren observes, "With the exception of issues like abortion, exposure and assisted suicide, the medical ethics of Christian physicians are not likely to have been defined very differently than were those of their pagan colleagues, *except perhaps for a greater willingness to help the poor.*"[12] The progression of discipleship in Scripture went from Judaea (home base) to Samaria (close by) to the "ends of the earth." Charity for physicians should begin at home (depending upon which source there are approximately 50 million uninsured) and progress outward to the mission field. Local charity for physicians has been a historical constant, just as the missions' field has. There will be less time to see insured patients and a financial consequence as well.

The corporate transformation of our sacred profession is a serious threat to human dignity. The evangelical healthcare community has

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from the director's desk

BY PAIGE C. CUNNINGHAM, JD
EXECUTIVE DIRECTOR

"Why don't the Christians make a Christian argument?" the Jewish bioethicist demanded. "Why do they only make philosophical arguments? Are they ashamed of being Christian?"

This challenge was issued after a debate on abortion at Princeton. I listed with growing curiosity (and alarm) as I heard it recounted at a recent gathering during the annual meeting of the American Society of Bioethics and Humanities. I imagine that the Christian panelists established that the human embryo is a moral person entitled to human rights, and rightly condemned abortion as a violation of the dignity of the human person.

This is familiar territory for me. After all, I spent years as an attorney making just this sort of philosophical and legal argument in the public square. Theological concerns were marginalized to the church and Christian undergraduate audiences. This reflects the influence of John Rawls, the political philosopher who laid the groundwork for political discussions being held on supposedly 'neutral' or public terms.

Rawls' view is that in a liberal democracy, the popular consensus (consensus populi) should form the political basis of discussions and decisions. Public reason requires that arguments must be made in terms that are accessible to everyone. Now, carefully read this: Rawls wants us to offer reasons that we reasonably think that other equally reasonable people (religious or not) would find to be rational reasons. Religious motivation is not excluded, but religious reasoning is. A citizen whose "comprehensive doctrine" is religious must be able to defend their views with "public" arguments, that is, not based on religious reasons. Thus, we have a legitimate concern that this kind of demand excludes those whose "comprehensive doctrine" is religious. As a Christian, I cannot run two operating systems in tandem (and my computer does not do it very well, either), one for my "true" religious self, and the other for my "public" self. If my religious beliefs are genuinely comprehensive, that kind of compartmentalization is schizophrenic or disingenuous.

There is a "push-me/pull-me" dynamic afoot. Christians have been careful to use arguments in the public square that appeal on grounds other than a belief in the authority of the Bible. We believe these arguments to be valid, even if expressed in non-theological terms. Some would call this the use of natural law reasoning. This might mean, for example, using phrases such as "human dignity" and "respect for the human person," rather than "sanctity of human life" or "being made in the image of God." Yet, when we use those terms, we are often accused, as my friend Ben Mitchell experienced, of trying to "smuggle in" theistic assumptions. As if, in the info-voracious world of Google, any of us could hide our Christian connections, even if we wished to!

Could it be that something else is at work? On the one hand, by insisting upon secular reasons and "neutral" sources, the Rawlsian secularists have privileged themselves with the hegemonic position of deciding which viewpoints merit a public hearing. Religious perspectives are sequestered in the world of "private faith." On the other hand, it could be that a Christian moral perspective, in whatever form, makes them uneasy. The demand for neutrality may disguise a wish to silence reminders of a guilty conscience.

Regardless of the reasons, the challenge remains. Where do Christians stand in the public discourse on bioethics? Is it mandatory that our arguments be couched in philosophical terms which more closely resemble neutral, public reasons? Or, should we take the Jewish bioethicist's challenge to "make a Christian argument"? (Although she is outspoken about her beliefs, I suspect it costs her little, as her conclusions nicely mirror those of most secular bioethicists.)

Let me respond to her challenge in a different way. The problem is not that Christian philosophers are ashamed of being Christian. They are doing their job: philosophy. The gap is the noticeable paucity of Christian theologians joining the bioethics conversation, which is their job. While there is a richer body of Catholic moral theological reflection, the evangelical theological corpus is modest. This relative neglect, in comparison with other foci of theological studies, certainly affects what the evangelical church counts as significant. John Wyatt, Professor of Ethics & Perinatology at University College London, commented that "modern evangelical Christians tend to have a weak theology of creation and a weak theology of

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The Center for Bioethics & Human Dignity (CBHD) is a Christian bioethics research center of Trinity International University.

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BIOETHICS AT THE BOX OFFICE: 2009-2010 EDITION

COMPILED BY ALICE KONG, Summer Intern

CBHD often receives requests from educators and other individuals involved in engaging bioethics regarding popular resources (fiction, film, and television) that present materials relevant to bioethical discussions. In a two part series, we offer a recap of the past five years of relevant materials that have premiered on the silver screen. Readers are cautioned that the films represent a wide variety of genres and may not be appropriate for all audiences. Viewers are encouraged to read annotations/synopses available through such websites as www.movieweb.com or www.imdb.com.

CLINICAL ETHICS
My Sister's Keeper (Released 6/09, PG-13 for mature thematic content, some disturbing images, sensuality, language, and brief teen drinking)

CLONING
Moon (Released 7/10, R for language)

EMERGING TECHNOLOGY
Avatar (Released 12/09, PG-13 for intense epic battle sequences and warfare, sensuality, language and some smoking)

Gamer (Released 10/09, R for frenetic sequences of strong brutal violence throughout, sexual content, nudity, and language)

Inception (Released 7/10, PG-13 for sequences of violence and action throughout)

Repo Men (Released 3/10, R for strong bloody violence, grisly images, language, and some sexuality/nudity)

Surrogates (Released 10/09, PG-13 for intense sequences of violence, disturbing images, language, sexuality, and a drug-related scene)

Terminator Salvation (Released 5/10, PG-13 for language and intense sequences of sci-fi violence and action)

END-OF-LIFE
Happy Tears (Released 2/10, R for language, drug use, and some sexual content including brief nudity)

GENETIC ETHICS
Avatar (Released 12/09, PG-13 for intense epic battle sequences and warfare, sensuality, language and some smoking)

Extraordinary Measures (Released 1/10, PG for thematic material, language, and a mild suggestive moment)

My Sister's Keeper (Released 6/09, PG-13 for mature thematic content, some disturbing images, sensuality, language, and brief teen drinking)

Splice (Released 6/10, R for disturbing elements including strong sexuality, nudity, sci-fi violence and language)

HEALTHCARE
Side Effects (Released 4/09, R)

HUMAN ENHANCEMENT
Youth Knows No Pain (Released 4/09, NR documentary)

NEUROETHICS
Inception (Released 7/10, PG-13 for sequences of violence and action throughout)

ORGAN TRANSPLANTATION
Repo Men (Released 3/10, R for strong bloody violence, grisly images, language, and some sexuality/nudity)

REPRODUCTIVE ETHICS
Misconception (Released 1/10, NR)

My Sister's Keeper (Released 6/09, PG-13 for mature thematic content, some disturbing images, sensuality, language, and brief teen drinking)

The Back-Up Plan (Released 4/10, PG-13 for sexual content including references, some crude material and language)

The Kids Are All Right (Released 7/10, R for strong sexual content, nudity, language, and some teen drug and alcohol use)

The Switch (Released 8/10, PG-13 for mature thematic content, sexual material including dialogue, some nudity, drug use, and language)

RESEARCH ETHICS
Autopsy (Released 1/09, R for strong bloody violence, grisly images, language and drug content)

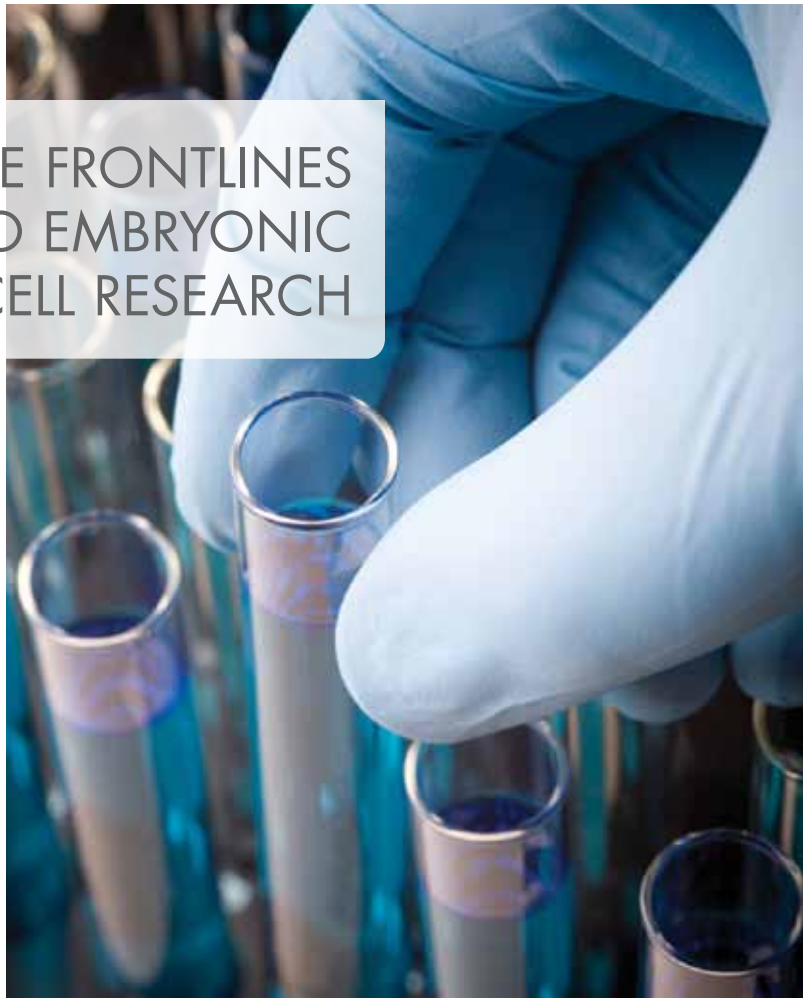
Extraordinary Measures (Released 1/10, PG for thematic material, language, and a mild suggestive moment)

Gamer (Released 10/09, R for frenetic sequences of strong brutal violence throughout, sexual content, nudity, and language)

Shutter Island (Released 2/10, R for disturbing violent content, language, and some nudity)

Splice (Released 6/10, R for disturbing elements including strong sexuality, nudity, sci-fi violence and language)

AN UPDATE ON THE FRONTLINES OF ALTERNATIVES TO EMBRYONIC STEM CELL RESEARCH



BY KIRSTEN RIGGAN, MA
Research Assistant

Embryonic stem cell research remains a controversial area of regenerative medicine, a field of medicine investigating means of repairing damaged or destroyed cells, tissues, and organs. While much hope and promise has been placed in the success of embryonic stem cell (ESC) research, only two clinical trials utilizing embryonic stem cells have been approved by the FDA. These initial trials will examine the safety of using these cells in humans. Even though ESC research receives much of the public attention directed towards regenerative medicine, other areas of research, including adult stem cell research and cell reprogramming are steadily progressing. Unlike ESC research, no significant ethical issues surround these two avenues of research. While not without their challenges, adult stem cells and cell reprogramming offer two ethical and promising alternatives to ESC research.

Adult Stem Cells

Adult stem cells are unspecialized cells that can be found in several organs and tissues in the human body including the liver, heart, skin, and brain. Due to the difficulty of isolating and harvesting stem cells safely and efficiently from these tissues, most adult stem cell research has focused on populations of stem cells that can be easily obtained including stem cells found in the peripheral blood, bone marrow, umbilical cord, amniotic fluid, and placenta. Stem cells taken from the bone marrow have been routinely used to treat leukemia, lymphomas, and blood disorders for more than 40 years. Bone marrow contains two populations of stem cells: hematopoetic stem cells (forms white and red blood cells) and mesenchymal stem cells (form bone, cartilage, fat, and other cells). So far, the majority of clinical treatments have utilized blood and bone marrow derived stem cells.[1] To date, over 70 diseases and conditions have been treated with adult stem cells.

Umbilical Cord Stem Cells

The umbilical cord appears to be a particularly advantageous source of adult stem cells, as it contains a rich and non-invasive source of stem cells that can be easily obtained. Like bone marrow, the umbilical cord contains two separate sources of stem cells, hematopoetic stem cells taken from the cord blood and mesenchymal stem cells isolated from the Wharton's jelly. Umbilical cord blood has been used in stem cell transplantations for approximately 20 years.[2] Cord blood stem cells have been used to treat approximately 80 diseases including both malignant and non-malignant diseases.[3] Mesenchymal stem cells isolated from the umbilical cord have been found to differentiate into cell types outside of their lineage including neurons and cardiac muscle increasing their clinical potential.

Stem cells isolated from the umbilical cord have certain clinical advantages over other adult stem cell populations including a reduced risk of viral contamination and lower risk of graft versus host disease. Additionally, partial human leukocyte antigen matches are well tolerated by transplant patients, a particular issue with bone marrow transplants.[4] One disadvantage to umbilical cord hematopoetic stem cells is the limited number of stem cells that are procured per cord blood unit. Ex vivo expansion techniques are being explored with some success. A recent study, for example, successfully expanded and transplanted cord blood stem cells in leukemia patients.[5] Mesenchymal stem cells isolated from the umbilical cord can be efficiently expanded ex vivo allowing enough stem cells to be generated for clinical applications.[6]

Cell Reprogramming

Cell reprogramming is the process of converting one cell type into another type. Two methods of cell reprogramming are currently being investigated by scientists, induced pluripotency and direct cell reprogramming. Both methods are still in the research stage of development and have not been tested as a treatment in humans. Further research is needed to determine if induced pluripotent stem cells or directly reprogrammed cells will be useful as clinical treatments.

Induced Pluripotent Stem Cells

Induced pluripotent stem (iPS) cells are fully differentiated cells that have been reprogrammed into cells that have embryonic stem cell-like properties, specifically pluripotency. This process is known as dedifferentiation. In 2007, two separate proof-of-principle studies were published demonstrating the ability of turning human somatic cells (adult cells found in the body other than egg and sperm germ cells) into pluripotent stem cells through the reprogramming of certain genes.[7] iPS cells could theoretically be created from skin cells

biopsied from patients and used to treat the patient without the threat of immune rejection. iPS cells have already been used to create a library of stem cells lines from skin cells taken from patients with a number of different diseases including Parkinson disease, type 1 diabetes, Duchenne muscular dystrophy, and Huntington Disease.[8] These cell lines may help scientists to better understand the pathology of these particular diseases as well as test new treatments. Additionally, in mouse models, iPS cells have been used to correct sickle cell anemia demonstrating their usefulness for stem cell therapy.[9]

Recently, adult mice have been generated from induced pluripotent stem cells.[10] This was an important step to demonstrate that iPS cells have complete pluripotency, meaning they can differentiate into all cell types in an organism. Without proper safeguards, however, this technique could theoretically be used to clone humans, although the complexity of the human species may prevent this. Scientists are investigating how well iPS cells differentiate into particular cell types, an important step to determine their clinical potential. The pluripotent nature of iPS cells makes these cells subject to similar issues of ESCs including problems with the development of tumors, which may ultimately prevent these cells from being useful as a cell replacement therapy.

Direct Cell Reprogramming

Direct cell reprogramming or direct conversion (also referred to as transdifferentiation) occurs when a differentiated cell is reprogrammed to a different cell type without first being reversed to a pluripotent state. Four examples have been demonstrated so far. In 2008, Douglas A. Melton's lab demonstrated this technique in mice by reprogramming pancreatic exocrine cells to insulin-secreting b-cells part of the endocrine portion of the pancreas.[11] In 2010, Marius Wernig's lab reprogrammed mouse fibroblast cells into neurons[12] and Deepak Srivastava's lab reprogrammed cardiac and dermal fibroblasts into cardiac muscle cells.[13] A recent study from Mickie Bhatia's lab became the first to demonstrate that this technique can be used in human cells, after reprogramming dermal fibroblasts into blood progenitor cells. These progenitor cells in turn produce functional cells from all three classes of blood cells (white blood cells, red blood cells, and platelets).[14] Clinical trials using directly converted blood cells could begin as early as 2012.

This technique appears to be more efficient than iPS cells. In experiments, up to 20% of cells were successfully reprogrammed. In contrast, iPS cell reprogramming has an efficiency of less than 0.1%. Directly reprogramming one cell type to another occurs in a shorter period of time, an additional advantage over iPS cells. In terms of clinical application, these cells may have a lower risk of tumor formation due to their lack of pluripotency and would also avoid issues of immune rejection since the cells could be taken from the patient directly or could potentially be reprogrammed in vivo. Unlike iPS cells, directly converted cells do not multiply easily in the lab, limiting their usefulness for applications that require large amounts of cells, such as drug screening. Further research is needed to determine if these cells will effectively work as a cell replacement therapy and if there are any issues with epigenetic modifications (changes which alter gene expression, but not the DNA sequence).[15] Like iPS cells, these directly converted cells may helpful in the screening of new medications and in the study of disease pathology.

1 Richard K. Burt, et al., "Clinical Applications of Blood-Derived and Marrow-Derived Stem Cells for Nonmalignant Diseases," *Journal of the American Medical Association* 299 (2008): 925-936.

2 See Kirsten Riggan, "Cord Blood Stem Cells: An Overview" available at http://www.cbhd.org/content/cord-blood-stem-cells-overview.

3 See, for example the list of diseases treated at the New York Blood Center National Cord Blood Program available at http://www.national-cordbloodprogram.org/qa/ (accessed December 8, 2010).

4 Christian Leeb, et al., "Promising New Sources for Pluripotent Stem Cells," *Stem Cell Review and Reports* 6 (2010): 20-22.

5 Colleen Delaney, et al., "Notch-Mediated Expansion of Human Cord Blood Progenitor Cells Capable of Rapid Myleoid Reconstitution," *Nature Medicine* 16 (2010): 232-236.

6 Leeb, 21.

7 Kazutoshi Takahashi, et al., "Induction of Pluripotent Stem Cells from Adult Human Fibroblasts by Defined Factors," *Cell* 131 (2007): 861-872 and Junying Yu, et al., "Induced Pluripotent Stem Cell Lines Derived from Human Somatic Cells," *Science* 318 (2007): 1917-1920.

8 In-Hyun Park, et al. "Disease-Specific Induced Pluripotent Stem Cells," *Cell* 134 (2008): 877-886.

9 J Hanna, M Wernig, S Markoulaki, "Treatment of Sickle Cell Anemia Mouse Model with iPS Cells Generated from Autologous Skin," *Science* 318 (2007): 1920-1923.

10 Xiao-yang Zhao, et al. "iPS Cells Produce Viable Mice Through Tetraploid Complementation" *Nature* 461 (2009): 86-90; Michael J. Boland, et al., "Adult Mice Generated from Induced Pluripotent Stem Cells," *Nature* 461 (2009): 91-94.

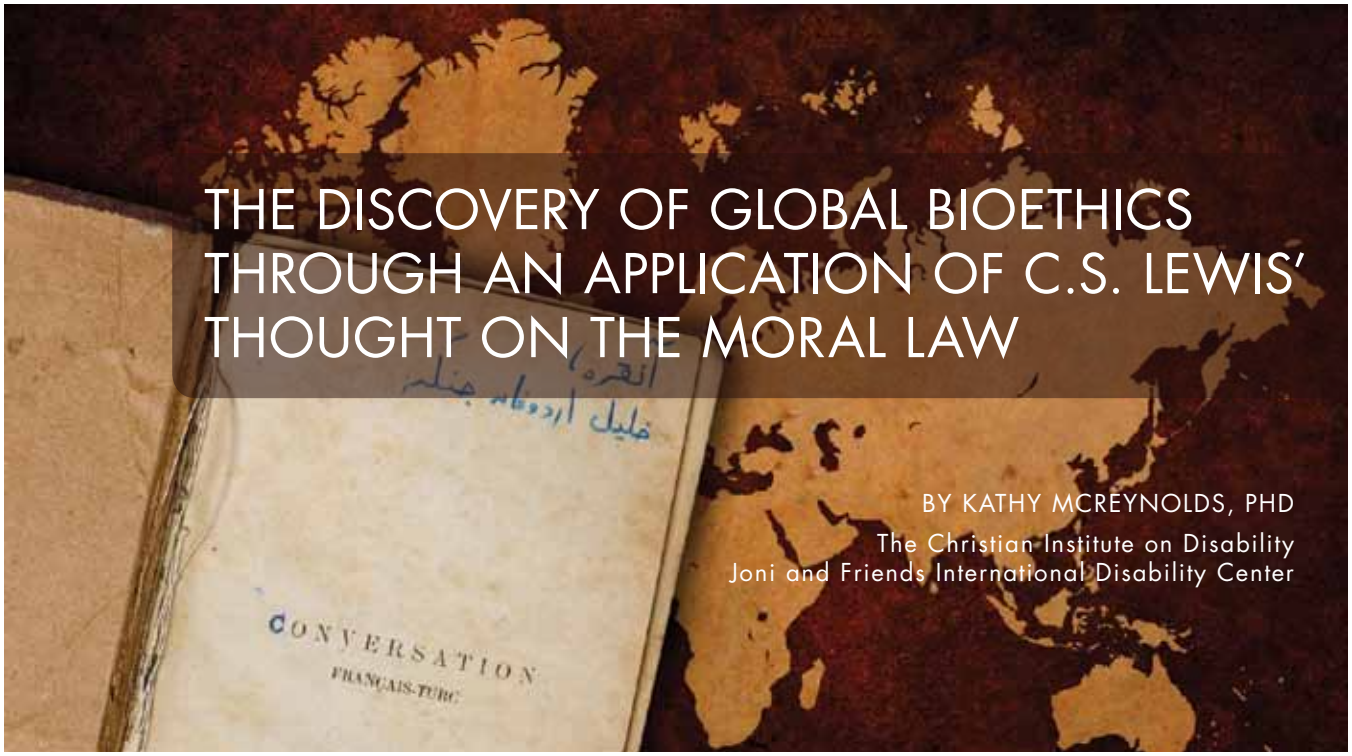
11 Qiao Zhou, et al., "In Vivo Reprogramming of Adult Pancreatic Exocrine Cells to b-Cells," *Nature* 455 (2008): 627-632.

12 Thomas Vierbuchen, et al., "Direct Conversion of Fibroblasts to Functional Neurons by Defined Factors," *Nature* 463 (2010): 1035-1041.

13 Masaki Ieda, et al., "Direct Reprogramming of Fibroblasts into Functional Cardiomyocytes by Defined Factors," *Cell* 142 (2010): 375-386.

14 Eva Szabo, et al., "Direct Conversion of Human Fibroblasts to Multilineage Blood Progenitors," *Nature* 468 (2010): 521-526.

15 Ewen Callaway, "Cellular 'Alchemy' Transforms Skin into Blood," *Nature News*, November 7, 2010, http://www.nature.com.ezproxy.tiu.edu/news/2010/101107/full/news.2010.588.html (accessed December 8, 2010).



THE DISCOVERY OF GLOBAL BIOETHICS THROUGH AN APPLICATION OF C.S. LEWIS' THOUGHT ON THE MORAL LAW

BY KATHY MCREYNOLDS, PHD
The Christian Institute on Disability
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Consider the following end-of-life case in Thailand:

> *A thirty-nine-year-old Thai construction worker, Gaew, falls at work hitting his head on the pavement. Unconscious, he is taken to the hospital in Bangkok where he is intubated and placed in the intensive care unit. His physician, Dr. Nok, feels that Gaew has very little chance of recovery and informs his brother, Lek, of his prognosis.*
>
> *Seeing his brother suffering, Lek makes the decision to remove his brother from the ventilator. Dr. Nok says that such an action is unethical and it cannot be done because their religion, Buddhism, forbids it. Not only is killing strictly prohibited, but various doctrines in the religion teach that the last part of the body to die is the breath.*
>
> *Gaew, like many Buddhists, has no advanced directive. In their culture the self changes from moment to moment and a person is not the same as they were ten days ago. It would be impossible for a person to know what they would want years later in a different state of consciousness.*
>
> *In order to not compromise their own karma, Dr. Nok and Lek prepare a strategy to circumvent their dilemma. Gaew's physician feels that it is Gaew's mental attachments that are preventing him from dying and if they can unknot his mind Gaew's spirit might be released. Lek tells the doctor that Gaew's wish was for Lek to ordain as a monk before dying. Even though they cannot know for certain what is troubling Gaew's mind in his new state of consciousness, they feel that this might be a key to release Gaew from his suffering.*
>
> *Lek and Dr. Nok decide that Lek should leave his brother to go ordain as a monk for several days, then return to Gaew. Though Gaew has very little brain activity, Dr. Nok feels that he may still be able to hear his brother's voice when he tells him of his ordination. This way, they can relieve Gaew's suffering while not damaging their own karma.*[1]

When it comes to solving ethical issues in medicine in a global context, some experts have argued that there is no such thing as "global bioethics." In the case above, two bioethicists, Scott Stonington and Pinit Ratanakul, argue that Western bioethics is insufficient to solve the problems that arise in the practice of conventional medicine in non-Western contexts. They point out that typical Western bioethical principles such as the ones proposed and popularized by Beauchamp and Childress (principles of autonomy, beneficence, non-maleficence, and justice) [2] fail to give any helpful ethical guidance in this situation. To their credit, Stonington and Ratanakul point out some of the weaknesses and inadequacies of some aspects of contemporary Western bioethics. They show that Western bioethics has been whittled down to principles most important to those who live in the West, that is, freedom and autonomy. Nevertheless, they do not give a proper justification of their own position.

Is All Bioethics Local?

Stonington and Ratanakul intend to show that end-of-life issues involving ventilators in Thailand demand that a case be made for local difference when it comes to bioethics. As far as they are concerned, if this case is persuasive, it nullifies any legitimate grounds for a global bioethics. "Thai" bioethics requires a focus on the concepts of interdependence and compassion. Thai bioethics takes into consideration the complexities involved in a shame-based culture. These issues which are important to the Thai population play a minimal role in medical decision-making in the West. Granted, this may well be the case.

Nevertheless, a question must be raised here: Does not "Thai" bioethics reflect an ethics which has also been whittled down to mere principles important to those in the East? In other words, how do these different emphases in medical decision-making expressed in the West and East respectively prove to undermine a case for global bioethics? Are not compassion, interdependence, freedom, and justice universally recognized as goods which everyone would want and get if they could? One would be hard-pressed to find anyone who would disagree on this point.

In order to address these questions, we may find helpful conceptual resources in the work of C.S. Lewis. Before we begin to analyze Lewis' arguments and their relevance to a case like this, a few more comments are in order. First, few bioethicists would ever argue against the reality of cultural diversity and the need for cultural sensitivity in medical settings. However, culture diversity and cultural sensitivity do not in themselves undermine the idea of a global bioethics. Second, the problem is that the arguments that some experts want to raise against global bioethics go much deeper than issues concerning cultural differences. Their underlying assumption seems to be that the new global medicine requires a new ethic altogether—an ethic that addresses not only cultural diversity and the new complex questions that arise in medicine because of new technologies, but also one that addresses the issue of "ethical diversity."

Now, it is one thing to acknowledge the reality of cultural diversity; it is quite another to claim that if there is cultural diversity, it follows that there is also ethical diversity. The argument that is being made, in other words, is that ethics is subjective and particular. Those, like Stonington and Ratanakul, who take ethical diversity to be *prima facie* true assert that is it necessary then to jettison "traditional" ethics altogether because of its irrelevance and inapplicability in modern situations. In order to develop a new ethic, so the argument goes, which takes into consideration cultural and ethical diversity and questions arising from technological complexities, we must start from scratch.

The Impossibility of Creating Diverse Ethics

Is that possible? Can we start from scratch, from a moral vacuum as it were, and create a whole new "diverse" ethical system to meet the needs of modern medical ethical issues? C.S. Lewis says it is simply not possible. He argues that we never start with a blank state; if we did, however, we would end with a blank slate. Those who claim that we need a new ethic can give no moral motive for entering into a new ethic unless that motive was borrowed from traditional morality, which, according to Lewis, is neither Christian nor non-Christian, neither Eastern nor Western, neither ancient nor modern, but general. The moral law, in other words, is objective, not subjective. Lewis does not give a religious argument in order to support his claims concerning the objective nature of morality; but one that is based on reason—that grand, classic, and robust understanding of reason.

Lewis associates the current problem with ethics and morality with the fragmentation of thought brought about by modernism. He makes the point that after studying the natural world, human beings began to study themselves. When they did this, it was "as if we took out our eyes in order to look at them." Reason then appeared to be nothing more than chemical or electrical events in the brain which itself is the by-product of a blind evolutionary process. In light of this, there is no good reason to think that human beings can know anything about ethics or morality or truth.

In the world of science the consequences of the contemporary disposition to undermine reason is minimized in that the scientist must assume the validity of his or her own reason, if for no other reason than to prove its subjectivity. This subtle dance with subjectivity can be dangerous for the scientist. There seems to be a move away from the use of words like *truth* and *reality* as defining terms of the scientist's overall objectives; instead, there is much talk about the objective being "practical results."

It is quite a different story when it comes to *practical reason*, where the full forces of the consequences of subjectivism are felt. Until modern times no influential thinker ever doubted that our judgments of good and evil were rational judgments or that what they discovered was something objective. It was taken for granted that in temptation, desire and passion were diametrically opposed not to a feeling, but to reason. Lewis shows that the contemporary view is quite different. Value judgments are not judgments at all. They are feelings forged in a community by forces in its environment and its traditions, and varying from one community to another. To say that something is "good," in other words, is to say that one has a preference for it, a preference that has been shaped by one's social environment.

It is important to hear Lewis in his own words as he expands on the consequences of this view:

> But if this is so, then we might have been conditioned to feel otherwise. "Perhaps," thinks the reformer or the educational expert, "it would be better if we were. Let us improve our morality." Out of this apparently innocent idea comes the disease that will certainly end our species . . . if it is not crushed; the fatal superstition that men can create values, that a community can choose its "ideology" as men choose their clothes. Everyone was indignant when they heard the Germans define justice as that which is to the interest of the Third Reich. But it is not always remembered that this indignation is perfectly groundless if we ourselves regard morality as a subjective sentiment to be altered at will. Unless there is some objective standard of good, overarching Germans, Japanese and ourselves alike whether any of us obey it or no, then of course the Germans are as competent to create their ideology as we are to create ours. If good and better are terms deriving their sole meaning from the ideology of each people, then of course ideologies themselves cannot be better or worse than one another. Unless the measuring rod is independent of the things measured, we can do no measuring. For the same reason it is useless to compare the moral ideas of one age with those of another: progress and decadence are like meaningless words.[3]

In his essay, "The Poison of Subjectivism," Lewis drives the point home that the whole attempt to get rid of traditional morality as something merely subjective and to substitute it with a new morality is wrong. This can be stated in two propositions:

1. The human mind has no more power of inventing a new value than of planting a new sun in the sky or a new primary colour in the spectrum.
2. Every attempt to do so consists in arbitrarily selecting some one maxim of traditional morality, isolating it from the rest, and erecting it into an *unum necessarium* [a supreme position which must be obeyed].[4]

The second proposition deserves a bit more attention. Lewis points out that traditional morality bids us to honor our parents and cherish our children. By isolating the second injunction alone, we set up a "futuristic" ethic, making concern for our children the sole criterion for ethical decision-making. Traditional morality tells us to love and care for our families more than we do strangers. Separating the first command from the second, we construct either a racist ethic or an aristocratic ethic where the claims of our relatives or our class are the sole criterion.

Consider the scientists who say that they must get rid of "taboo" traditional morality so that they can conduct their inquiries without interference because the potential health, comfort, prosperity, and security of posterity is their sole end. The scientists then demand involuntary euthanasia of all the aged and "unfit." But the duty to care for posterity on which the scientists base their whole ethical system was derived from the same source which commands that we honor the aged and commit no murder.

"If reverence for parents or care for strangers is merely subjective, open to human opinion, and a by-product of the forces of nature, then so is cherishing our children and love for our families."

These monolithic ethical systems are then used as grounds to attack the traditional morality which gives them validity in the first place! Starting from scratch, from the supposed ethical moral vacuum, we could not attain any of them. If reverence for parents or care for strangers is merely subjective, open to human opinion, and a by-product of the forces of nature, then so is cherishing our children and love for our families.

New moralities which bid us to consider the local nature of ethical concerns reflect a confusion of thought concerning what is really being said. Lewis suggests that we have two alternatives. Either the injunctions of traditional morality must be accepted as universally recognized principles of practical reason, or else there are no values at all. Values are merely the product of irrational emotions. It is completely meaningless, Lewis says, to dismiss traditional morality as subjective, irrelevant and outdated to attempt to reintroduce a value at some later stage in our philosophy. Any value we reintroduce can be countered in the same way. "Every argument used to support it will be an attempt to derive from premises in the indicative mood a conclusion in the imperative. And this is impossible."[5]

Modern culture does resist this line of reasoning by presenting two objections: [6]

1. Morality and ethics is different in different times and places—in fact, there is not one morality and ethics, but a thousand.
2. To admit that there is a transcendent objective morality is to stifle all progress and to become stagnant.

Lewis responds to these two primary objections with the following two points: [7]

1. Any current on-line or in-print *Encyclopedia of Religion and Ethics* will reveal the enormous harmony with regard to the practical reason of human beings. Far from finding vast conflicting views, we find exactly what we should expect if morality is indeed something objective; that is, a substantial agreement with considerable local differences of emphasis and perhaps no one code that includes everything.
3. Lewis takes issue with the word "stagnant." Stagnant implies that something has become stale or foul from standing too long. To infer that whatever stands long must be bad is to fall victim to a misconception. Lewis states that space does not stink because it has preserved three dimensions from the beginning. Two plus two has not become moldy because it still equals four. Love is not rejected because of its consistency; in fact, we desire that true love lasts forever! Lewis suggests that we get rid of the word "stagnant" with all its emotional baggage and substitute the word "permanent."

Does a permanent moral standard impede progress? On the contrary, except on the assumption of a changeless standard, progress is impossible. If the good is a fixed point, it is at least possible that we should get nearer and nearer to it; but if the terminal is as mobile as the train, how can the train progress towards it? Our ideas of the good may change, but they cannot become either better or worse unless there is an immutable standard by which we can measure them.

This last point may seem to contradict the argument that traditional morality is an objective standard which does not change. Lewis offers an answer that can only be understood by comparing a real moral advance with mere innovation. Moral philosophers from the Stoics to Confucius who say, "Do not do to others what you would not like them to do to you," succeeded by the Christian who says, "Do to others as you want done to you" reflect a real moral advance.

The Poverty of Subjective Ethics

The morality of Friedrich Nietzsche, which finds no rational grounds for value judgments at all, is a mere innovation. The refinement of the Golden Rule is an advance because those who recognize the validity of the Stoic's and Confucius' moral principle will be able to accept the Christian principle as a positive extension of the same principle. The Nietzschean ethic demands that we all start from scratch and become "value-creators," the very thing which is impossible to do. "It is the difference between a man who says to us: 'You like your vegetables moderately fresh; why not grow your own and have them perfectly fresh?' and a man who says, 'Throw away that loaf and try eating bricks and centipedes instead.'"[8]

Do these arguments for the objective and universal nature of morality and ethics mean that we will never face moral quandaries like the ones encountered in the case in Thailand? Not at all, says Lewis. It is the moral law that creates these questions in the first place, just as the rules of a particular game creates problems related to that game. The person who is not literate is free from grammatical problems. The person who does not know algebra is free from algebraic problems. A person who is sleeping is free from all problems (for the moment!). Lewis acknowledges that ethical conflicts will indeed arise and that some of these conflicts will be solved wrongly. What shall we make of this inevitability in light of the claims made here concerning the timeless applicability of traditional morality? Lewis sums it up best when he says the following:

> This possibility of error is simply the symptom that we are awake, not asleep, that we are men, not beasts or gods. If I were …recommending traditional ethics as a means to some end, I might be tempted to promise you the infallibility which I actually deny. But that, you see, is not my position. I send you back to your nurse and your father, to all the poets and sages and law givers, because, in a sense, I hold that you are already there whether you recognize it or not: that there is really no ethical alternative: that

> those who urge us to adopt new moralities are only offering us the mutilated . . . text of a book which we already possess in the original manuscript. They all wish us to depend on them instead of on that original, and then to deprive us of our full humanity. Their activity is in the long run directed against our freedom.[9]

Toward a Global Bioethics

Now that Lewis' view on the moral law has been discussed, it remains to examine exactly how his view can help us with regard to global bioethics in general and with regard to the end-of-life case concerning the 39-year-old Gaew, a Thai construction worker, in particular. First, Lewis demonstrates that principles such as compassion, duty, interdependence, freedom, and justice—all crucial to bioethics in general—do not require a new morality. All of them can be traced back to the objective moral law which has always been here. These principles cannot be reached by scratch or by way of a blank slate as it were; nor can they be attained in a "moral vacuum" because no such vacuum exists. As soon as the word "ought" is invoked, we are already operating within a moral landscape.

Second, with regard to Gaew's case in particular, it is first important to point out that it is not clear that he is suffering because he arrived at the hospital unconscious. There is no indication that he was in any pain. It is also not clear what is meant by "lack of brain activity." Does this mean that he is in a persistent vegetative state? Does it mean that he is presenting with signs of whole brain death? These issues need more clarity in order to determine whether or not it is morally permissible to withdraw the ventilator. Dr. Nok holds to the sanctity of life and her conscience forbids her to kill. This is not a uniquely Buddhist position, but can be traced back, as Lewis says, to traditional morality, and the universal disapprobation of unjustified killing. The ethical concern here is about whether or not withholding or withdrawing life-sustaining treatment can be considered "killing" a patient. There is much debate about this issue, and this debate reflects Lewis' stance that the moral law actually creates questions of casuistry. If we want light shed on these very heart-wrenching and complex end-of-life issues, we need to study, reflect, and gain wisdom. In other words, we must consult the tradition. We must realize that the wisdom we need for ethical dilemmas is *discovered*, not *created, which also implies that we must search for it.*

Finally, with respect to the notion that karma is a moral law which describes the consequences of certain behaviors in the afterlife, there is nothing in this assertion which necessarily undermines Lewis' argument for the objective moral law. The objective moral law, as far as Lewis is concerned, points to a Moral Lawgiver, who is transcendent overall. Lewis is a theist who argues that the moral law reveals something of God's nature, his holiness. The choices we make in this life, in other words, matter for all eternity. Though Buddhism is a non-theistic faith, it recognizes this law, if you will. Physicians who are also practicing Buddhists do have crises of conscience with regard to certain treatments. This fact, Lewis would say, demonstrates that a moral law is written on their hearts. This is one of his fundamental points.

Lewis goes further to say that this universal moral law points inescapably to the existence of God. The problem now is not so much an ethical one, but a religious one. And this is a problem that Lewis is happy to engage and has done so in many of his writings. The Buddhist and the theist do not see eye to eye on the question of God's existence. And they cannot both be right. This issue, too, calls for wisdom, study, and reflection in order to get at the truth. The theological question goes beyond the scope of this essay; but suffice it to say that Lewis has made a case for global bioethics through the application of the moral law. But the question of God is one that Lewis believes to be critical to every human being. A thorough search for an answer to this question is neither a trifling nor a needless occupation for us, but rather a necessary and important one.

1 This is a summary from a case study that appeared in Scott Stonington and Pinit Ratanakul, "Is There a Global Bioethics? End-of-Life in Thailand and the Case for Local Difference," *Public Library of Science Medicine* 3, no. 10 (October 2006): 1679-1682, http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030439.

2 Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. 6th ed. Oxford: Oxford University Press, 2008.

3 C.S. Lewis, "The Poison of Subjectivism" in *Christian Reflections,* ed. Walter Hooper (Grand Rapids: Eerdmans, 1967), 73.

4 Ibid., 75.

5 Ibid., 75-76.

6 Ibid., 76.

7 Ibid., 76-77.

8 Ibid., 77.

9 C.S. Lewis, "On Ethics," in *Christian Reflections,* ed. Walter Hooper (Grand Rapids: Eerdmans, 1967), 56.

Editor's Note: This essay is an expanded version of parallel paper that was presented at CBHD's 2009 Annual Conference, *Global Bioethics: Emerging Challenges Facing Human Dignity*. This essay serves as an example of broader reflection upon moral theology or theological ethics that can assist in developing a foundation for a more deeply rooted engagement of bioethical issues from a Judeo-Christian Hippocratic approach.

QUESTIONS?

Would you like to offer comments or responses to articles and commentaries that appear in Dignitas? As we strive to publish material that highlights cutting-edge bioethical reflection from a distinctly Christian perspective, we acknowledge that in many areas there are genuine disagreements about bioethical conclusions. To demonstrate that bioethics is a conversation, we invite you to send your thoughtful reflections to us at info@cbhd.org with a reference the original piece that appeared in Dignitas. Our hope is to inspire rigorous conversations between our readers and those who contribute material to this publication.

In the last issue of *Dignitas*, we were pleased to formally announce the creation of several new Communities of Influence. In this issue we take the opportunity to introduce you to the chairs and co-chairs of their respective communities. The Center is proud to acknowledge these outstanding individuals and thank them for their work and dedication in service.

ACADEMY OF FELLOWS

CHAIR: DÓNAL P. O'MATHÚNA, PHD

Dónal P. O'Mathúna, PhD, is Senior Lecturer in Ethics, Decision-Making & Evidence in the School of Nursing, Dublin City University (DCU), Ireland. He is also on the faculty of the Biomedical Diagnostics Institute and the Institute of Ethics at DCU. He is Chairperson of the DCU Research Ethics Committee and the ethicist on St. James's Hospital, Dublin ethics committee.

Dónal was born and raised in Ireland, and earned a BS in pharmacy from Trinity College, Dublin. He received his PhD in medicinal chemistry from The Ohio State University. After this, he pursued his interest in bioethics by obtaining an MA in Theology from Ashland Theological Seminary. Dónal's research interests include: ethical issues in nanotechnology; personhood in bioethics; critical thinking and moral reasoning in the teaching of bioethics; emotions and ethics, especially in relation to literature in teaching bioethics; the ethical and spiritual aspects of complementary and alternative therapies; and evidence-based reviews of complementary and alternative therapies.

Dónal has authored *Nanoethics: Big Ethical Issues with Small Technology* (Continuum, 2009). He has written, with Walt Larimore, MD, *Alternative Medicine: The Christian Handbook*, updated and expanded edition (Zondervan, 2007). He edited, with Bart Cusveller and Agneta Sutton, *Commitment and Responsibility in Nursing: A Faith-Based Approach* (Dordt, 2004). He is working on a book for CBHD on critical thinking in bioethics. He has published numerous articles and book chapters on bioethics and teaching bioethics (see www.BioethicsIreland.ie).

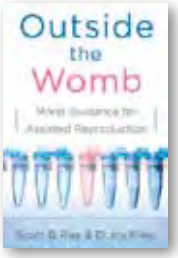
Dónal taught for several years at Mount Carmel College of Nursing in Columbus, Ohio until he returned to Ireland in 2003. He lives near Dublin with his wife and two sons, and his daughter attends college in Columbus, Ohio.

RECENT PUBLICATIONS FROM OUR FELLOWS:

The Center is pleased to highlight the individual contributions to scholarship of our fellows through the following recent publications:

Orr, Robert D. *Medical Ethics and the Faith Factor: A Handbook for Clergy and Health-Care Professionals*. Grand Rapids: Eerdmans, 2009.

Pellegrino, Edmund D. *The Philosophy of Medicine Reborn: A Pellegrino Reader*. Notre Dame, IN: University of Notre Dame Press, 2008.



Rae, Scott, and D. Joy Riley MD. *Outside the Womb: Moral Guidance for Assisted Reproduction*. Chicago: Moody Publishers, 2011.

Rae, Scott. *Moral Choices: An Introduction to Ethics*. 3rd ed. Grand Rapids: Zondervan, 2009.

Reynolds, John Mark, Roger Overton, and Matthew Eppinette. *The New Media Frontier: Blogging, Vlogging, and Podcasting for Christ*. Wheaton: Crossway, 2008.

Sugarman, Jeremy, and Daniel P. Sulmasy, eds. *Methods in Medical Ethics*. 2nd ed. Washington, D.C.: Georgetown University Press, 2010.

Shults, F. LeRon, and Brent Waters, eds. *Christology and Ethics*. Grand Rapids: Eerdmans, 2010.

Sutton, Agneta. *Christian Bioethics: A Guide for the Perplexed*. Great Britain: T & T Clark International, 2008.

Waters, Brent. *This Mortal Flesh: Incarnation and Bioethics*. Grand Rapids: Brazos Press, 2009.

Waters, Brent. *The Family in Christian Social and Political Thought*. New York: Oxford University Press, 2007.

HEALTHCAREETHICSCOUNCIL (HEC)

The Healthcare Ethics Council (HEC) is a community of healthcare professionals in affiliation with The Center for Bioethics & Human Dignity that recognizes and engages in dignified medical healthcare and professional education in the Judeo-Christian tradition.

Our Healthcare Ethics Council co-chairs are continuing to develop broad interest and participation in the HEC. If you are interested in participating, would like more information, or have recommendations for individuals we should invite, please contact us at info@cbhd.org.

CO-CHAIR: ROBERT D. ORR, MD, CM

Robert D. Orr, MD, CM, is a Senior Fellow with The Center for Bioethics & Human Dignity, and serves as Professor of Bioethics at The Graduate College of Union University,* Professor of Medical Ethics at Loma Linda University,* Professor of Bioethics at Trinity International University, and Professor of Family Medicine at the University of Vermont College of Medicine.* In addition, Dr. Orr chairs CBHD's Advisory Board.

Dr. Orr received his MD, CM from McGill University in 1966, did residency training in family medicine, and then engaged in the private practice of family medicine in Vermont for 18 years where he was named Vermont Family Doctor of the Year in 1989. A growing interest and involvement in medical ethics led him to pursue a post-doctoral fellowship at the Center for Clinical Medical Ethics at the University of Chicago (1989- 1990).

From 1990-2000 he was the Director of Clinical Ethics at Loma Linda University in southern California, and from 2000-2006 he was Director of Clinical Ethics at Fletcher Allen Health Care and the University of Vermont College of Medicine.* He was honored by the American Medical Association in 1999 when they gave him the Isaac Hays & John Bell Award for Leadership in Medical Ethics and Professionalism. In 2006 he was Scholar in Residence at the Kilns, the restored home of C.S. Lewis in Oxford, UK. In 2010, the Christian Medical and Dental Associations honored Dr. Orr by giving him the "Servant of Christ" Award.

He has authored, co-authored or edited six books, contributed 14 book chapters, and over 150 articles related to clinical ethics, the ethics consultation process, and issues in terminal care. He has given lectures on these topics regionally, nationally and internationally. He chaired the Council on Ethical Affairs for the California Medical Association, and was Vice President of the American Society for Bioethics and the Humanities. He has served on the Ethics Commission of the Christian Medical and Dental Associations and served as chairman of that commission from 1991-1994.

**For identification purposes only; does not imply institutional support.*

CO-CHAIR: FERDINAND D. YATES JR., MD, MA

Ferdinand D. (Nick) Yates, Jr., MD, MA, is Professor of Clinical Pediatrics, State University of New York at Buffalo. He is also the senior pediatrician and co-founder of Genesee-Transit Pediatrics, LLP. He earned Bachelor of Arts in Chemistry in 1974 and Doctor of Medicine in 1978 from The University of Virginia. He completed a residency in general pediatrics at Women and Children's Hospital in Buffalo, New York and subsequently entered private pediatric practice in 1981. Dr. Yates graduated cum laude with MA Bioethics from Trinity International University in 2004.

Dr. Yates is a Fellow of the American Academy of Pediatrics for which he has intermittently served on the Executive Committee for the Section on Bioethics. In addition he is a member of the Christian Medical & Dental Associations where he has been mostly involved with the Ethics Commission. He has also served on the Board of Directors for the American College of Pediatricians. In Buffalo, he has been a member of the ethics committees for both the Catholic Health System and for the Kaleida Health System.

As a medical ethicist, Dr. Yates offers bedside ethics consultations assisting in critical care decision-making at the bedside of adults and children. In addition, he is actively involved in the education of medical students and hospital resident staff. In the Buffalo community, Nick volunteers at Cornerstone Manor – a shelter for women and children – where he examines the children and educates parents as they reside at the shelter.

Nick and his wife Jackie worship at Randall Memorial Baptist Church, and they are blessed with two grown daughters.

CHURCHBIOETHICSNETWORK (CBN)

CO-CHAIR: SARAH FLASHING, MA

Sarah Flashing, MA, is a writer and speaker with a passion for teaching women how to discover truth. She has been in ministry to women in the church for several years, equipping them on a range of topics including women's ministry, apologetics and theology, and topics in bioethics. She is an avid blogger and her pieces can be read at The Center for Women of Faith in Culture, First Things/Evangel, and CT's Gifted for Leadership blog.

Sarah has been a guest on numerous radio programs including the John and Kathy Show and MBN's Prime Time America. She has testified before the Illinois State Legislature on embryonic stem cell research. Sarah is also an adjunct instructor of ethics at McHenry County College and speaks regularly at churches. Sarah and her husband, George, live in Harvard, Illinois with their 3 teenage boys and 3 cats.

CO-CHAIR: SUSAN M. HAACK, MD, MA, FACOG

Susan M. Haack, MD, MA (Bioethics), FACOG, is a board-certified obstetrician gynecologist . A native of Minnesota, she attended Western Michigan University and University of Texas, Austin, majoring in music, followed by medical school at UTMB-Galveston. She completed her residency in obstetrics-gynecology at Northwestern University-McGaw Medical Center in Chicago, and her MA in Bioethics from Trinity International University where she is currently pursuing a Master of Divinity.

Dr. Haack has spoken and written on issues pertaining to the beginning of life, end of life, professionalism and right of conscience. Additionally, she frequently reviews books for *Ethics & Medicine.* She and her husband, Dr. James Speichinger, practiced obstetrics and gynecology for 15 years in Pennsylvania before returning to Wisconsin where they currently practice consultative gynecology at Mile Bluff Medical Center in Mauston, Wisconsin, USA. Additionally, Dr. Haack is an Associate Fellow with The Center for Bioethics & Human Dignity.

CO-CHAIR: KEITH PLUMMER, PHD

Keith Plummer, PhD, is associate professor in the School of Bible and Ministry at Philadelphia Biblical University. He graduated from Brown University in Providence, Rhode Island and spent two years in the healthcare field. Dr. Plummer then attended Trinity Evangelical Divinity School, where he completed an MDiv and PhD in systematic theology from Trinity Evangelical Divinity School. His dissertation was entitled, "Canonically Competent to Counsel: An Analysis of the Use of the Bible in Biblical Counseling, Integration, and Christian Psychology with a Canonical Linguistic Proposal for Reclaiming Pastoral Counseling as a Theological Discipline." He also served for several years as the counseling/teaching pastor at Our Saviour Evangelical Free Church in Wheeling, Illinois, where he has taught classes on postmodernism, the Christian mind, introduction to critical thinking, biblical counseling, apologetics, worldview, Christian ethics, and systematic theology.

Dr. Plummer has written a number of book reviews and for several years maintained his blog entitled *The Christian Mind*, where he reflected on the interface between faith and culture with an emphasis on the cultivation of the intellectual life as a necessary aspect of Christian discipleship.

Keith and his wife, Ingrid, have been married for eighteen years and have two children: Candace and Brandon.

FROM THE DIRECTOR'S DESK, CONTINUED

eschatology and both of these are of foundational importance for bioethics."[1] The thin ranks of evangelical theologians reflecting bioethically needs a deeper bench. Kathy McReynold's essay in this issue of *Dignitas* is an example of doing this kind of moral theology.

CBHD will be unveiling a series of roundtable theological discussions on these and other questions. From these, we anticipate gleaning important theological insights in foundational bioethics concerns. The body of scholarly work will be expanded, and, we hope, more Christian theologians will accept the invitation to participate in conferences and unashamedly "make Christian arguments."

Paige Comstock Cunningham

1 "Interview with Professor John Wyatt." http://www.kingsdivinity.org/theological-articles/interview-with-professor-john-wyatt.

INTRODUCING OUR NEW CONSULTANT

Michelle Kirtley, PhD, is the new Consultant for Bioethics and Public Policy for CBHD. Prior to joining the Center's team, Michelle worked for six years on Capitol Hill for Congressman Dave Weldon, MD (R-FL) and Congressman John Fleming, MD (R-LA), serving as a science and health policy advisor. During her tenure with Congressman Weldon, she was responsible for overseeing the Congressman's legislative efforts in biotechnology policy, including legislation to ban human cloning, ban fetus farming, and limit the scope of human gene patents. During the healthcare reform debates of 2009-2010, Michelle advised Congressman Fleming on his legislative and communications strategy, drafting alternative healthcare reform proposals, speeches, opinion editorials, and constituent communications.

Michelle completed her doctorate in cell biology at the Massachusetts Institute of Technology (2004) and her undergraduate degree in molecular biology from Princeton University (1996). Michelle also serves as a Trustee for the Center for Public Justice, a Washington-based faith and public policy organization and has written numerous articles in bioethics policy, health policy and politics for their weekly newsletter *Capital Commentary*.

CBHD'S LATEST DC ACTIVITIES

BY MICHELLE KIRTLEY, PHD,
Consultant on Bioethics and Public Policy

On November 12, 2010, The Center for Bioethics & Human Dignity sponsored a briefing on Capitol Hill entitled "Post Election Analysis: What is on the Horizon for Bioethics?" Designed as an informational update for Capitol Hill staff and other Washington policy experts, the lunch briefing featured presentations by Richard Doerflinger, the associate director of the Secretariat of Pro-Life Activities at the United States Conference of Catholic Bishops, and Dr. David Prentice, Senior Fellow for Life Sciences at the Family Research Council. Mr. Doerflinger and Dr. Prentice both have a long history of being on the frontlines of bioethics policy in Washington, D.C.

From Mr. Doerflinger, attendees heard a detailed history of the federal government's involvement in embryonic stem cell research, dating from early in the Clinton administration, and an assessment of the legislative outlook for the various bills that would enshrine in law federal funding for embryonic stem cell research. Mr. Doerflinger also discussed the stem cell lawsuit that is currently moving through the courts. The plaintiffs in *Sherley v. Sebelius* allege that the Obama administration's executive order expanding federal funding for embryonic stem cell research violates federal law as stated in the Dickey-Wicker amendment. As Mr. Doerflinger pointed out, amendment author Senator Roger Wicker has testified in congressional hearings that the clear intent of the amendment was to prevent federal funding for any kind of embryo research, including embryonic stem cell research. A ruling in this lawsuit is expected early in 2011, although many expect it to be eventually appealed to the U.S. Supreme Court.

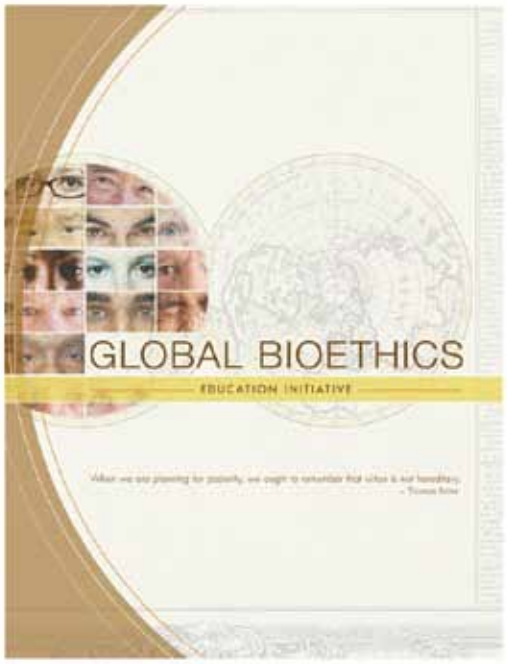
Dr. Prentice gave a scientific summary of a wide range of biotechnologies currently in development, including human cloning and synthetic biology. Many of these raise serious ethical concerns, yet remain unregulated at the federal level. In a political environment that has been dominated by concerns about the economy, Mr. Doerflinger and Dr. Prentice underscored the continued relevance of thoughtful, forward-looking bioethics policy.

For several of the Capitol Hill staff who attended, the event served as an introduction to CBHD. We hope to cultivate long-term relationships with these staff, the Members of Congress they represent, and other stakeholders on Capitol Hill so that the deep educational resources of CBHD will inform policy debates in Congress. This briefing is part of a series of events based in Washington, D.C. that will continue to educate policymakers on issues of bioethics and human dignity well in advance of their consideration in Congress.

GLOBAL BIOETHICS EDUCATION INITIATIVE

BY APRIL PONTO, Research Assistant

In 2009 The Center for Bioethics & Human Dignity launched the Global Bioethics Education Initiative (GBEI), a groundbreaking program dedicated to cultivating principled international bioethical thought. In keeping with the Center's vision of promoting global bioethical awareness, CBHD is investing in both rising and established international professionals and scholars who will further advance contextually sensitive Christian bioethical engagement globally. The Center's long-term vision for GBEI is to cultivate an international network of individuals and groups committed to Judeo-Christian Hippocratism.



Along with this, the Center desires to see the formation of worldwide, self-sustaining, bioethical organizations and committees to illuminate countries with little or no Christian bioethical presence. The Center desires to achieve this goal by investing in scholars committed to a Judeo-Christian worldview and the wealth of the Hippocratic tradition in order to promote an approach to bioethics that advocates the principled practice of medicine and a morally responsible use of technology.

The Center is pleased to work with Dr. Jameela George (2009 GBEI Scholar) who received a grant for her work in India. With the grant money she received from the Center she was able to mobilize a bioethics consultation in Chennai, India entitled "Christian Response to Ethical Issues in Healthcare Practice." As a direct result of her work, a growing number of physicians in her country are now sensitive to these issues and have joined together to create meaningful dialogue surrounding the bioethical issues in their country. In addition to this, Dr. George is in the early stages of pioneering a national center for bioethics. Her work has united both Catholics and Evangelicals in the country to work together to create this vital organization.

The Center's friendship with Dr. George has opened the door for Paige Cunningham to lead a team to teach a bioethics course for medical doctors in India this fall. The course is geared toward equipping men and women in medicine on pressing bioethical issues and addressing issues which are specific to India. Through this visit, the Center along with Dr. George, hope to establish contact and network with medical professionals in India to learn more ways the Center can engage other countries in the bioethics conversation.

Dr. Megan Best (2009 GBEI Scholar) has also received a grant from the Center for her work in Australia to study Christian perceptions of assisted reproductive technology. The Center has enabled Dr. Best to pursue this research with hopes of replicating this study in several additional countries, as well as eventually publishing the findings in a major peer-reviewed journal. Dr. Best is also working on a guidebook for Christians on issues in reproductive ethics based in part on studies during her time with the Center.

Through the Global Bioethics Education Initiative, the Center desires to develop relationships and networks of encouragement, support, and mutual learning. In keeping with this, Janne Nikkinen, DTh was named the 2010 GBEI Scholar. He visited from the University of Helsinki this summer to share and further develop his research especially in the fields of nanotechnology and healthcare rationing. Scholars at the Center were enriched by his participation and input, including a stimulating roundtable that he facilitated with Center staff on rationing. Dr. Nikkinen was grateful for the experience as well as the feedback he was able to receive from CBHD on his current research.

CBHD is currently accepting applications for 2012 from scholars interested in promoting bioethics in their local context. Scholars spend one month of concentrated research and strategic planning at the Center. During their stay, scholars will spend time collaborating with other scholars and fellows from the Center, and working on informing and presenting their ideas as well as fostering dialogue in various bioethical arenas. After their stay with the Center, scholars are invited to submit proposals to compete for the modest grants. To learn more about GBEI and the application process please visit the Center's website at http://cbhd.org/initiatives/global-bioethics-education-initiative.

The inauguration of GBEI has been made possible by a limited three year strategic gift. It would be a shame for GBEI to expire just as it is gaining momentum. *We need your help in making it possible to continue this dynamic initiative.* If you are interested in advancing Christian bioethics worldwide through the Global Bioethics Education Initiative, please consider making a gift to the Center specifically to fund this initiative by contacting Paige Cunningham at pcunningham@cbhd.org.

If you are or if you know of an international bioethics scholar who you believe would be a worthy candidate for this initiative, please contact Jennifer McVey at jmcvey@cbhd.org.

COLLABORATION AND ENCOUNTER II

BY COLLEEN MCCORMICK, CRNA, MA Bioethics

The approach of sectors within the medical community to nutrition and hydration in the care of patients at the end of life has undergone a massive shift over the course of the past decade. One might reasonably argue that few areas in healthcare practice have undergone more extensive modification than nutrition and hydration care decisions. The omission of nutrition and hydration as a part of the healthcare regimen has extended from those "in extremis" (wholly unable to maintain homeostasis, facing imminent death) to include those more accurately defined as profoundly injured or disabled, or in certain cases, because there is a suspicion on the part of the healthcare team of irreversible infirmity (terminal illness or condition).

The underpinnings of this transition in healthcare find their basis in philosophical changes within the medical community rather than any rigorously controlled scientific studies. A review of the literature on the topic reveals that the majority of the research relates to provider attitudes toward nutrition and hydration decisions.

This transition in approach to nutrition and hydration at the end-of-life is closely interwoven with the rise of hospice, palliative care, and hospitalist specializations. While these specializations have brought beneficial aspects to modern healthcare, each specialist group retains a subculture which has operated to shift the standard of care, at times to extremes. It is one thing for the omission of nutrition and hydration to accompany the end of life, and quite another to be the causative factor. It is one thing to omit care at the request of the patient/surrogate, quite another for the decision to be imposed by the healthcare provider.

With these issues in mind, the Second Annual Fall Foliage Dinner Discussion in Bioethics focused on questions of "Nutrition and Hydration at the End of Life." Held Friday, October 8, 2010 at the Radisson Hotel Ballroom in Manchester, New Hampshire, the conference is hosted annually by the Cabrini Institute.

Cabrini Institute, Inc. was founded in 2009 to promote ethical healthcare policy and practices, and to preserve faith-based healthcare. These goals are primarily met through ethics consultation and education. The Annual Fall Foliage Dinner Discussion forms an important aspect of the educational outreach objective.

This year the conference was, once again, co-sponsored by The Center for Bioethics & Human Dignity and the Tennessee Center for Bioethics and Culture. The cooperation and support of these two organizations has been essential to the success of this educational mission.

A powerhouse of Trinity Graduate School alumni converged to present various perspectives and field questions from an audience populated by a broad spectrum of individuals from across the country. Attendees included those personally facing or caring for others with chronic debilitating illnesses, an adjunct professor of philosophy and ethics from Franciscan University Steubenville, a leading local hospitalist and palliative care physician, and a variety of local medical practitioners, as well as a practitioner member of a New Hampshire state health committee, and a local television talk-show host.

Dr. Gregory Rutecki demonstrated, from a review of the medical literature, the impact of healthcare finances on decisions to feed and the means employed to deliver nutrition and hydration. Dr. D. Joy Riley offered a profound narrative, from a philosophical perspective, on what it means to eat and to be fed. Dr. Ryan Nash provided perspective from his experience as a palliative care physician. He made the case that "one size does not fit all" in decisions regarding nutrition and hydration, and stressed the importance of making decisions appropriate to the underlying diagnosis, not solely on philosophical grounds. Colleen McCormick presented a patient case study and used it as a starting point to define "end of life," and how it can be identified in light of the concepts of homeostasis and extremis. Ms. McCormick also unfolded for the audience the latest Ethical and Religious Directive of the United States Conference of Catholic Bishops, which speaks specifically to the moral choices involved in the decision-making process concerning nutrition and hydration in patient care.

This conference could not have taken place without a profound collaborative effort on the part of all the parties involved, and it is with sincere gratitude that I thank each one for the sacrificial investment made. A journal publication of the papers presented at the conference, and DVD copies of the conference presentation may be ordered through the Cabrini Institute website: http://www.cabriniinstitute.com.

SUMMER INTERNSHIPS OPPORTUNITIES:

The Center is pleased to offer a variety of volunteer and internship opportunities for undergraduate, graduate, and postgraduate level work throughout the academic year as well as the summer months. To learn more about how you or someone you know can apply for an internship with the Center, please visit our website at http://cbhd.org/about-cbhd/employment-opportunities. Applications for summer internships will be reviewed in the Spring. Please send all inquiries and documents regarding volunteer or internship opportunities with the Center to info@cbhd.org.

meet the staff

APRIL PONTO, Research Assistant

After graduating from The Ohio State University in Columbus, Ohio I was employed for five and a half years with an organization called OptionLine. OptionLine is a pro-life, in-bound pregnancy helpline for the United States and Canada. I worked as the Training and Human Resources Coordinator and hired employees, preparing them to answer phone calls, e-mails, and instant messages from men and women in pregnancy crisis.

While working there I became deeply interested in bioethical issues, practically beginning-of-life issues, and wanted to expand my knowledge. It was through my volunteer work with Oregon Right to Life that I became familiar with CBHD. I made the decision to leave my job and enroll full-time as a graduate student at Trinity Evangelical Divinity School because I knew the school could equip me with the tools I need to move forward in a career within the pro-life movement. My degree program is Master of Arts in Christian Thought with an emphasis in bioethics. I am excited to be a part of the Trinity community and to be employed at CBHD because they both approach bioethics with a Christ-centered perspective.

Upon graduation, my desire is to return to the pro-life movement with more knowledge, a broader background, and a more diverse work-experience. Though this is only my second semester as a full-time student at Trinity and at the Center, I am already being equipped for greater service and I look forward to learning more.

MAKILAH WITT, Event & Education Assistant

Originally from Northwest Ohio, I graduated from Wheaton College in 2010 where I majored in Philosophy and International Relations, and minored in Theology. The master's degree programs in Philosophy of Religion and Bioethics have been a wonderful catalyst for me to develop rigorous thinking grounded in faith and in critical engagement with the broken realities of this world.

I am grateful to be a part of the Event and Education team at CBHD. I am very passionate about fostering opportunities for dialogue and engagement in the philosophical and theological issues in bioethics. Knowledge is the first step to action, and it excites me to be a part of a center that is impacting the field of bioethics and public policy through offering a careful and faithful response to the profoundly complex issues of today.

During my time working at the Center, I have become increasingly interested in the role of the Church in developing the character of the Christian community to become agents of change in the world. This in my view is a call to discipleship and an opportunity to examine and challenge worldviews in order to expose and transform ways of thinking in both the Church and in the world. As a Christian and a scholar, I desire to stand in the gap between Athens and Jerusalem; the secular and the sacred, by engaging in a dialogue that brings clarity and cultivates faithfulness in response to the needs within our Church and world today.

ANOTHER BREECH, CONTINUED FROM PAGE ONE

to expand the horizons of its witness and respond explicitly. Dietrich Bonhoeffer observed that we are called "to stand with those who suffer" and "speak out for those who cannot speak."[13] A paradigm shift in medicine as merely business is a golden opportunity to tell unbelievers that Christian conscience welcomes consequences, even the negative ones.

1 Joan M. Teno, et al., "Hospital Characteristics Associated With Feeding Tube Placement in Nursing Home Residents With Advanced Cognitive Impairment," *The Journal of the American Medical Association* 303, no. 6 (February 10, 2010): 544-550.

2 "Ten Overused Tests and Treatments" *Consumer Reports* November 2007 http://www.consumerreports.org/health/doctors-hospitals/medical-ripoffs/10-overused-tests-and-treatments/medical-ripoffs-ten-over_1.htm (accessed February 21, 2011).

3 Richard A. Deyo, et al., "Trends, Major Medical Complications, and Charges Associated With Surgery for Lumbar Spinal Stenosis in Older Adults," *The Journal of the American Medical Association* 303, no. 13 (April 7, 2010): 1259; Eugene J. Carragee, "The Increasing Morbidity of Elective Spinal Stenosis Surgery," The Journal of the American Medical Association 303, no. 13 (April 7, 2010): 1309.

4 Deyo, et al., 1263.

5 Carragee, 1310.

6 Ibid.

7 Cynthia A. Jackevicius, Jack V. Tu, Joseph S. Ross, Dennis T. Ko, and Harlan M. Krumholz, "Use of Ezetimibe in the United States and Canada," *The New England Journal of Medicine* 358, no. 17 (April 24, 2008): 1820.

8 John P. Geyman, "The Corporate Transformation of Medicine and Its Impact on Costs and Access to Care," *Journal of the American Board of Family Medicine* 16, no. 5 (September 1, 2003): 444.

9 Ibid., 446.

10 Ibid, 449.

11 R. Alta Charo, "The Celestial Fire of Conscience – Refusing to Deliver Medical Care," *The New England Journal of Medicine* 352, no. 24 (June 16, 2005): 2471.

12 Gary B. Ferngren, *Medicine and Health Care in Early Christianity* (Baltimore: The Johns Hopkins University Press, 2009), 107.

13 Eric Metaxas, *Bonhoeffer: Pastor, Martyr, Prophet, Spy* (Nashville: Thomas Nelson, 2010), 128, 247.

VISITING SCHOLAR OPPORTUNITIES:

Visiting Scholar Opportunities: The Center is pleased to host scholars and professionals in any of the disciplines encompassed by bioethics who are on sabbatical or research leave from their respective employer. Visiting Scholars are provided research space and access to CBHD's study center resources. Availability for these opportunities is limited and are offered on a first-come basis. To inquire about these opportunities, please contact us at info@cbhd.org.

IN MEMORIAM: STANLEY BRISTOL

BY APRIL PONTO, Research Assistant

The Center for Bioethics & Human Dignity fondly pays tribute to Stanley Bristol, former board chairman, who passed away November 4, 2010 from complications of Parkinson's disease.

Stanley Bristol was a graduate of Wheaton College and Northern Illinois University. He received his doctorate in education administration and political science from Northwestern University. He began teaching in Wheaton at Washington School and became its principal; later he became superintendent of Schools in Kenilworth and Northern Suburban Special Education District. During this time, Stanley became active in special education and helped to lay the foundation work for the Northern Suburban Special Education District. He served a total of 23 school districts for 19 years.

In 1988 Stanley contacted Trinity International University about becoming an adjunct professor. Within one year he had been appointed as the head of the Education Department on Trinity's campus and also taught and supervised students in education. He retired from TIU in 2000.

While working at TIU, Stanley became involved in CBHD. He recognized the importance and significance of the young organization and began supporting the Center financially. Shortly after, Stanley transitioned into a member of the board and eventually his strong gifts in administration from his previous work as a superintendent elevated him to Chairman of the Center's Governing Board.

His remarkable enthusiasm coupled with his passion for education propelled the Center into new areas. Stanley was pivotal in developing regional conferences that became a key aspect of the Center's event activities for nearly a decade as well as giving attendees the opportunity to receive academic credit for their work and participation. Stanley's initiative and ingenuity has expanded awareness about bioethical issues and has opened doors to education and academic research.

It was his love of education that drove Stanley to devote his time to promote and develop the Center. He felt strongly that the expanding field of bioethics called for resources and information to be accessible to all people. Stanley clung to the importance of the special value and dignity of every human life and the dignity with which each person is endowed. This commitment flowed into all aspects of his life, from the way he interacted with his personal friends, to the way he helped those at the margins of society.

Stanley Bristol had an intuitive understanding of the importance of bioethics in our society. He viewed education as the medium for teaching medical professionals, legal professionals, clergy, laity, and all people about bioethics. While on the board he focused his attention on engaging all vocations, both Christian and secular, and shaped their thinking on current bioethical issues.

Stanley's wife, Vernelle, describes him as never shying away from any volunteer opportunity "He would never say no to taking the lead on something." He was a highly motivated individual whose contributions include: serving on the board of New Trier High School, former president and member of the board of the Irene Josselyn Clinic, member of the Family Services of Winnetka-Northfield, chair of the citizen's advisory board of Wilmette Rotary, chair of Pace regional bus system, and a member of the Stephen Ministry group at his church, Winnetka Covenant.

He is survived by his wife, Vernelle, sons - Mark (Dianne) Bristol, Kent Bristol, and daughter—Kelley (Timothy) Carlson. He is also survived by his brother, John (Beverly) Bristol, and five grandchildren: Tyler, Natalie, Peter, Andrew and Katie.

Dr. John Kilner who worked closely with Stanley at CBHD remembers Stan as "a visionary with a twinkle in his eye. He saw that education is the key to people recognizing the importance of understanding and engaging bioethical challenges. And he had a delightfully humorous way of encouraging people to participate in the educational process. He was a tremendous inspiration to me personally, and to so many others who worked with him. He is sorely missed."

Mrs. Bristol has asked that memorial gifts be given to their church, Winnetka Covenant, and/or to The Center for Bioethics & Human Dignity.

TOP BIOETHICS STORIES: JULY—DECEMBER 2010 EDITION

BY APRIL PONTO, Research Assistant

1. **"Defining the Boundaries of Genetic Testing: New Direct-to-Consumer Genetic Tests Raise Privacy Concerns"** by Michael Rugnetta, *Science Progress*, July 1, 2010.

> A recently released study by direct-to-consumer genetic testing company 23andMe reveals the privacy challenges ahead for public health policymakers as so-called genome-wide association studies, which look for specific genetic traits in huge genetic databases, enter the mainstream of scientific inquiry. (http://tinyurl.com/2exzq9n)

Concerns surfaced about the data generated from direct-to-consumer tests. Should private companies be able to garner income from these tests? Should the government seek to acquire this data for the sake of public health? Those most closely involved seek to define patient confidentiality in the face of this emerging technology.

2. **"Standards Issued for Electronic Health Records"** by Robert Pear, *The New York Times*, July 13, 2010.

> The federal government issued new rules Tuesday that will reward doctors and hospitals for the "meaningful use" of electronic health records, a top goal of President Obama. The rules significantly scale back proposed requirements that the health care industry had denounced as unrealistic. The Department of Health and Human Services said doctors and hospitals could receive as much as $27 billion over the next 10 years to buy equipment to computerize patients' medical records. (http://tinyurl.com/3yjgjut)

Many believe that electronic health records reduce cost and improve quality of care, while others feel that such records create privacy concerns for patients. The government is now giving monetary incentives to doctors and hospitals that choose to use this method for handling patients records.

3. **"The Promise and Dangers of Synthetic Biology: New Presidential Commission Prepares for Future Developments"** by Michael Rugnetta, *Science Progress*, July 20, 2010.

> The Presidential Commission for the Study of Bioethical Issues convened last week for its first meeting. The commission—created by executive order with the "goal of identifying and promoting policies and practices that ensure scientific research, healthcare delivery, and technological innovation are conducted in an ethically responsible manner"—was tasked by President Barack Obama to study first the implications of synthetic biology. (http://tinyurl.com/29h68fp)

The first Presidential Commission for the Study of Bioethical Issues convened as a result of the announcement of the successful creation of the first "synthetic" cell. The meeting and subsequent report focused on making scientific innovation "safe, responsible, and democratically accountable."

4. **"DNA Tests Give Bogus Results, U.S. Probe Finds"** by Associated Press, *Associated Press*, July 22, 2010.

> A U.S. government investigator told members of Congress on Thursday that personalized DNA tests claiming to predict certain inheritable diseases are misleading and offer little or no useful information. An undercover investigation by the Government Accountability Office found that four genetic testing companies delivered contradictory predictions based on the same person's DNA. Investigators also found that test results often contradicted patients' actual medical histories. (http://tinyurl.com/4goco5)

Personalized DNA tests may need additional scrutiny before consumers can depend upon their results. In the wake of these news stories the FDA began to probe the accuracy of these tests and is considering regulations.

5. **"Judge Stops Federal Funding of Embryonic Stem Cell Research"** by the CNN Wire Staff, *CNN News*, August 23, 2010.

> A U.S. district judge granted a preliminary injunction Monday to stop federal funding of embryonic stem cell research that he said destroys embryos, ruling it went against the will of Congress. (http://tinyurl.com/2ddfxyq)

In April of 2009 some restrictions for funding on embryonic stem cell research were relaxed. Now the debate continues as a U.S. district judge granted a preliminary injunction to withhold federal funding of embryonic stem cell research.

6. "**India, the Rent-a-Womb Capital of the World: The Country's Booming Market for Surrogacy"** by Amana Fontanella-Khan, *Slate*, August 23, 2010.

> Reproductive tourism in India is now a half-a-billion-dollar-a-year industry, with surrogacy services offered in 350 clinics across the country since it was legalized in 2002. The primary appeal of India is that it is cheap, hardly regulated, and relatively safe. Surrogacy can cost up to $100,000 in the United States, while many Indian clinics charge $22,000 or less. (http://tinyurl.com/48dzwbz)

Couples are turning with increasing frequency to outsourcing their pregnancies to India. While such actions give women of financial means the ability to avoid pregnancy complications, missed days of work, labor and delivery and more, others ponder the ethics of such reproductive choices.

7. **"5-day Pill Moves Emergency Contraception Back to Doctor's Office"** by Christine S. Moyer, *American Medical News*, August 30, 2010.

> On Aug. 13, the FDA approved ella for use in the U.S. The drug probably will be available by the end of the year. The progesterone agonist/antagonist prevents pregnancy when taken orally within 120 hours after a contraceptive failure or unprotected sex. Emergency contraceptives now on the market, including Plan B, are indicated for use up to 72 hours after sex. (http://tinyurl.com/3x7s3gt)

The FDA's approval of ella®, a 5-day emergency contraceptive that can have an abortifacient effect, adds to the abortion and right of conscience debate. Its predecessors, Plan B and Plan B One-Step, triggered the same controversy, but it was largely silenced when the medication was taken out the hands of the doctors and moved to over-the-counter status. Questions still remain regarding a physician's right to refuse the drug.

8. **"First Clinical Trial Involving Human Embryonic Stem Cells Gets Underway in Chicago"** by Karen Kaplan, *Los Angeles Times*, September 22, 2010.

> Enrollment has begun for the first clinical trial to test a therapy developed from human embryonic stem cells. The trial's primary aim is to assess the safety of Geron Corp.'s experimental oligodendrocyte progenitor cells, which have been in development for about a decade. They were derived from some of the earliest human embryonic stem cells ever created. (http://tinyurl.com/2dbjmbg)

A new study is commencing to determine the safety of Geron Corp's experimental oligodendrocyte progenitor cells in spinal cord injury patients. Proponents are welcoming this news citing the medical benefits of this research; others hesitate at the ethical issues involved with using human embryos for scientific experimentation.

9. **"US Apologizes for Infecting Guatemalans with STDs in the 1940s"** by the CNN Wire Staff, *CNN*, October 1, 2010.

> The United States apologized Friday for a 1946-1948 research study in which people in Guatemala were intentionally infected with sexually transmitted diseases. A statement by Secretary of State Hillary Clinton and Secretary of Health and Human Services Secretary Kathleen Sebelius called the action "reprehensible." (http://tinyurl.com/4tcogxj)

In the shadow of the Tuskegee syphilis experiment, new, unpublished records have been uncovered revealing that 64 years ago U.S. public health researchers deliberately infected over 1,600 Guatemalans with syphilis and other sexually transmitted diseases. The U.S. government has reached out to Guatemala offering deep apologies for the human rights violation.

10. **"'Father of Test Tube Baby' Wins Nobel Prize for Medicine"** by the CNN Wire Staff, *CNN*, October 4, 2010.

> The "father of the test tube baby," Robert G. Edwards, won the Nobel Prize for medicine on Monday, the awards committee announced. His contributions to developing in vitro fertilization (IVF) "represent a milestone in the development of modern medicine," the committee said. (http://tinyurl.com/63blrco)

Thirty-two years after the first child was created through in vitro fertilization, Robert G. Edwards receives the Nobel Prize for medicine. Though decades have passed since the first successful "test tube baby" the procedure still remains controversial with some deploring its use and others desiring to expand its use.

11. **"Arizona Budget Cuts Put Organ Transplants at Risk"** by Ted Robbins, *National Public Radio*, November 17, 2010.

> In Arizona, 98 low-income patients approved for organ transplants have been told they are no longer getting them because of state budget cuts. The patients receive medical coverage through the Arizona Health Care Cost Containment System (AHCCCS), the state's version of Medicaid. While it may be common for private insurance companies or government agencies to change eligibility requirements for medical procedures ahead of time, medical ethicists say authorizing a procedure and then reversing that decision is unheard of. (http://tinyurl.com/277fq6u)

In a rare move, the state of Arizona reneged on promises made to patients awaiting organ transplants. Individuals receiving medical coverage through the state who were previously approved for the procedure will no longer be eligible due to state budget cutbacks.

updates & activities

EDUCATION

CBHD hosted a special lecture by Janne Nikkinen, DTh, on September 7th, entitled "Rationing without Reason? Evaluating the Need for Healthcare Rationing." The lecture was held on the Deerfield campus of Trinity International University.

PARTNERSHIP

In November CBHD sponsored two lectures for the bioethics consultation group at the annual Evangelical Theological Society meetings in Atlanta. The lectures were: "Biotechnologies and Human Nature: What We Should Not Change in Who We are" by Dennis Hollinger, PhD, and "Recent Challenges to Fetal Personhood: A Critical Analysis" by Francis Beckwith, PhD. CBHD has agreed to sponsor two additional lectures for the 2011 ETS meeting in San Francisco.

MEDIA RESOURCES

CBHD.org on Twitter: @bioethicscenter

Bioethics.com on Twitter: @bioethicsdotcom

The Bioethics Podcast at thebioethicspodcast.com

Everyday Bioethics Audio Series at everydaybioethics.org

Facebook Cause at causes.com/cbhd

Linked-In Group at linkd.in/thecbhd

COMING SOON: WATCH FOR CBHD'S 2010 ANNUAL REPORT IN THE SPRING 2011 ISSUE OF *DIGNITAS*.

STAFF

PAIGE CUNNINGHAM, JD

- Represented CBHD at a variety of meetings in the Fall and early Winter including: a panel on synthetic biology by C-PET in August and the professional society meetings of ASBH in October and ETS in November.
- Delivered a lecture in November for the Science Seminar Lecture Series at Taylor University on "Human Animal Hybrids: What Are They and Should We Care?"
- Interviewed by Moody Radio in October on her audio series Everyday Bioethics.

KIRSTEN RIGGAN, MA

- Interviewed by Isthmus Journal in October on stem cell research.

MICHAEL SLEASMAN, PHD

- Delivered a lecture in September for the Science Seminar Lecture Series at Taylor University on "Thinking through Technology."
- Delivered two lectures in September at Lincoln Christian University. The first was a guest lecture on "Virtual Paradise?" to bioethics students. The second was a public lecture, entitled "Bioengagement: Stem Cells beyond the Hype."
- Interviewed by Focus on the Family in August on California Institute for Regenerative Medicine's stem cell curriculum.
- Interviewed by Northwestern Media Radio in July on human enhancement and the Center's conference Beyond Therapy.

ON THE CBHD BOOKSHELF

For those interested in knowing what books the Center staff have been reading.

ARTICLES OF NOTE:

Gregory Kaebnick, "Synthetic Biology, Analytic Ethics" *The Hastings Center Report* 40(4), July-August 2010, 49.

Ari Schulman, "Why Minds are Not Like Computers" *The New Atlantis* Winter 2009, 46-68.

Wesley Smith, "Defending the Hippocratic Oath: The Importance of Conscience in Health Care" *The Human Life Review* Winter/Spring 2009.

ON THE BOOK SHELF

Bavinck, Herman. *Reformed Dogmatics, Vol. 1: Prolegomena*. Edited by John Bolt. Translated by John Vriend. Baker Academic, 2003.

Bush, George W. *Decision Points*. New York: Crown Publishing, 2010.

Chapter 4 reveals insights into former President Bush's deliberations on developing a policy for his administration on embryonic stem cell research. Chapter 11 reflects on several of the global health initiatives of his administration, particularly those devoted to Africa.

Dixon, Thomas, Geoffrey Cantor, and Stephen Pumfrey, eds. *Science and Religion: New Historical Perspectives*. New York: Cambridge University Press, 2010.

Frame, John M. *The Doctrine of the Word of God*. Phillipsburg, New Jersey: P & R Publishing, 2010.

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M, Scott, and Elbrote. *Nature and Scripture in the Abrahamic Religions*. Edited by Jitse M. van der Meer and Scott Mandelbrote. Leiden: Brill, 2009.

Rauser, Randal. *Theology in Search of Foundations*. University Press, 2009.

Savulescu, Julian and Nick Bostrom, ed. Human Enhancement. New York: Oxford University Press, 2008.

Schloss, Jeffrey, and Michael Murray, eds. *The Believing Primate: Scientific, Philosophical, and Theological Reflections on the Origin of Religion*. Oxford: Oxford University Press, 2009.

Smedes, T.A. Chaos, *Complexity, and God: Divine Action and Scientism* (Studies in Philosophical Theology). Leuven, Belgium: Peeters Publishers, 2004.

Thobaben, James. *Health-Care Ethics: A Comprehensive Christian Resource*. Downers Grove, IL: InterVarsity Press, 2009.