

BIOETHICS: THE CHURCH AND THE FAMILY

SCOTT RAE*

Abstract: *This paper highlights several emerging trends in bioethics and explores how they affect both the church and the family. These include prenatal technology, infanticide, assisted suicide and eugenics, gene editing, and enhancement biotechnology. It then argues that the church has been under-educated in bioethics for some time, particularly in the areas of abortion, dealing with the end of life, and reproductive technologies, especially IVF.*

Key Words: *bioethics, abortion, infanticide, assisted suicide, gene editing, designer children, end of life, reproductive technologies, IVF.*

I am delighted to have the privilege of delivering this year's ETS presidential address, on the intersection of bioethics, the church, and the family. I should warn you in advance of the occupational hazards of stepping into this field, as I routinely caution my philosophy students who are desirous of taking up this field professionally. God, in his providential sense of humor, has seen fit to have my field "follow me home" for the past 30 years. As a result, these are not purely academic discussions divorced from the shoe leather of real life. At several times in the life of my family, I have had these discussions at the bedside of loved ones and around the kitchen table at home. For example, I never anticipated that my initial interest in the ethics of reproductive technologies, which began in the late 1980s, when IVF was only 10 years old and surrogacy was the stuff of TV miniseries, would come home with me. It was right about then that my wife and I began a roughly four-year, very painful journey with infertility. Ours had a happy ending, as we have 3 grown kids today, but it was only through what the non-theologically oriented would call pure luck, that I call the providential grace of God, that we discovered the root cause of the problem.

Phase II of my field following me home began in the early mid-90s with the first assisted suicide initiative on the ballot in California. I was asked to speak on the subject and participated in a handful of debates in health care settings, and carefully followed the court decisions on this throughout the 1990s, and have watched it closely to its passage into law just a few months ago in California. The debate over PAS generated a great deal of discussion about the broader issues around end-of-life care, most of it good and necessary discussion. It was around this time that this topic came home with me, as my wife and I began the first of three journeys through terminal illnesses with our parents. I vividly remember having the same discussions with my dad that I was encouraging my students to have with their

* Scott Rae is dean of faculty and professor of Christian ethics at Talbot School of Theology, Biola University, 13800 Biola Avenue, La Mirada, CA 90639. He delivered this presidential address at the 67th annual meeting of the ETS in Atlanta, GA on November 18, 2015.

parents about their wishes at the end of life, preparing advance directives, and the prospect of saying “enough” to medicine. When I went to see my father for the last time before he died, I remember remarking to my wife, “I hope I don’t have to give up my principled opposition to PAS based on what I might see.” As it turned out, he was in hospice care, which in my view is the closest human equivalent to having guardian angels taking care of you, and he was comfortable and surrounded by family when he went home to be with the Lord.

Phase III of these occupational hazards started around the year 2000, with the completion of the Human Genome Project, the mapping of human genetic code. With the avalanche of genetic information that became available at that time, many diagnostic tests came on the market. One of the first ones to be widely used was the BRCA 1, 2 tests for the genetic markers that dramatically increase the risk of breast (and ovarian) cancer. On my wife’s side of the family, virtually every woman (except for her sister) has had breast cancer, and several have died from it, including her mother. My wife’s oncologist told her that her family is the largest extended family he’s ever treated. So when the test for the breast cancer gene came on the market, I suggested that my wife not bother to be tested, and assume she’s positive for it—not some of my best advice to her! However, it took her three years to decide to have the test, and another three years to decide what to do about the positive result she got back. By the time she decided to do something about it, she had discovered a tumor, and the treatment for breast cancer was the same as the preventive treatment she had considered. The good news is that she’s fine today, but her ambivalence about being tested and about what to do with that information is widely shared across the culture today. It’s as though we’re not quite sure if we really want to know all the information that’s available to us about our genetics. I have great appreciation for the difficult decisions people are making based on genetic testing, both for adults and for their children. I’m not exactly sure what part of the field will next follow me home—which is why I’m considering taking up the prosperity gospel, in the hope that it follows me home!

I. TRENDS TO WATCH IN BIOETHICS

In the hope of preparing the church for challenges that are coming, I’d like to speculate into the future about what’s coming. In addition, it’s important to catch up and deal with that which is already in the mainstream of medical practice. So we’ll first look into the future, then address some areas of the present in which the church is undereducated.

1. *Technology and the status of the unborn.* I contend that technology, more than morality, philosophy, or theology, is the best hope for the unborn in the future. With ultrasound technology becoming more sophisticated (4D ultrasound has amazing clarity), and with its use in prenatal care becoming routine for most pregnancies, we should not be surprised that the general cultural attitudes toward the unborn are changing. Technology is making it more difficult for people to view the unborn as being “clumps of cells,” or somehow equivalent to pieces of tissue or organs. Though most people are still supportive of the law allowing for abortion in

the early stages of pregnancy, more are growing increasingly uncomfortable with full abortion on demand, and with abortion in the second and third trimesters of pregnancy. Perhaps more importantly, abortion rights advocates are increasingly conceding that the unborn child is indeed a person, yet still defending the right of the mother to end of the life of her full-person unborn child. Yet once the personhood of the fetus is conceded, one can make the argument that the unborn child actually has a claim on the mother's body for what he or she needs to survive and flourish. This would be analogous to a newborn having a similar claim on his or her parents, such that if they don't provide those things, an important right of the child is violated and the state would step in to place the child with someone who is able to provide those things.

Technology has undermined a common view in the culture that viability is the point at which the fetus "becomes" a person, and thus has rights and protectability. Yet viability today is much different than it was in 1973, when the Supreme Court essentially used viability to suggest that the state has a compelling interest in the protection of life in the third trimester, since in 1973, viability did not normally occur until the end of the second trimester. But today, in the NICU, babies are viable at as early as 23 weeks, a significant shift in what medical technology is able to accomplish (though to be clear, the premature newborn merely exchanges a full natural life support system for an equally full artificial one). And that is precisely what viability measures—the *state of medical technology*, which is constantly changing and varies from newborn to newborn; it is not any commentary on the ontological status of the unborn.

Further advances in technology may include the *artificial womb* in the next few years, which will clarify precisely what is meant by "abortion rights." Does the right to an abortion under the law mean the right to a dead child, or does it mean the right not to be pregnant? As of today, those two elements cannot be separated. But if and when the day comes that we have artificial wombs, they will be able to be kept separate. In addition, artificial wombs will do what ultrasound has done, only greater, in enabling people to see fetal development up close, further increasing the difficulty of dismissing the unborn child as simply part of the woman's body. Though these trends would be welcome news for the unborn, I'm not convinced that gestating children in artificial wombs would be good for their well-being, or for the mother's well-being, since they would be cut off from the relational element of a normal pregnancy that is critical for their healthy development.

A further technological innovation that promises to be helpful to the unborn affects our view of embryos. For many people in the culture, it is highly counterintuitive to think that embryos are persons, and many regard them as "clumps of cells," or equivalent to a "bag of marbles." This is the case even though science is clear that an embryo has an "inner directedness and connection to its environment" that is quite different from a disconnected set of cells. However, as former Valparaiso law professor Richard Stith points out, the science, which is also consistent with the Bible's teaching (though we don't have time to develop the biblical case here), is not enough to overcome this counterintuitive notion. He maintains that even though we can read a continuity of personal identity back in hindsight to

the embryo, what might the impact be if we could read that continuity *forward*? He points out that with a new technology that forensic scientists are using called “DNA phenotyping,” which supplements the work of sketch artists, could be applied to embryos. In its forensic setting, DNA left behind at a crime scene can be analyzed to produce DNA-based computer generated sketches of what the person of interest looks like. Stith argues for its application to the embryo in this way:

If adult DNA can lead to a sketch of that person’s face, *surely gestational DNA could be used to sketch the future face of an unborn child*, for the content of the DNA in our cells changes but little in our lifetimes. We are, perhaps, on the brink of a new advance in the pro-life consensus, one not unlike that brought about by the now widespread use of ultrasound technology.

2. *Academic justification for infanticide.* For some time, there have been supporters of infanticide in the bioethics community, such as Peter Singer and Michael Tooley in the US. These have largely been outliers among bioethics scholars, even though infanticide has been widely practiced in parts the world for some time. A recent cover story in the *Economist* entitled “Gendercide” estimated that since 1970, over 100 million baby girls have been aborted, abandoned, or otherwise been victims of infanticide. In the last two years, the journal *Bioethics* published a symposium on infanticide around a featured paper by two Australian philosophers, who have coined a new term for infanticide—the *after-birth abortion*. While they correctly recognize that birth constitutes only a change of location with no ontological significance for the status of the baby, they take the conclusion in the opposite direction, arguing for justifiable infanticide on the same grounds as legalized abortion. They argue that there is no morally relevant difference between a third-trimester fetus and a month-old newborn, and suggest that infanticide should be legal for the same reasons abortion is legal. Of course, in the symposium there were a variety of papers opposing their position, but what is new is the euphemism “after-birth abortion” for infanticide.

The good news is that in the US, infanticide is still illegal, though we did actually debate the Born Alive Rule in some state legislatures (that children born alive can’t be victims of infanticide). In addition, Dr. Kermit Gosnell was prosecuted successfully for several cases of infanticide that came out of his downtown Philadelphia abortion clinic, though they were only a fraction of the actual incidents of infanticide that occurred at his clinic. But there is growing academic support for the morality of infanticide, parallel with abortion.

3. *Connection between physician-assisted suicide and eugenics.* This trend comes very close to home, since my home state of California recently became the fifth US state to enact legalized physician-assisted suicide (PAS). Both PAS and euthanasia are legal in parts of Europe and this trend that connects PAS and eugenics is more prominent there than in other countries. Increasingly, advocates of PAS are linking the legalization of PAS with the demographic changes sweeping the developed countries, resulting in an unprecedented percentage of the population over the age of 65, with a shrinking younger segment of the population available to generate the resources to support the aging population. For example, British philosopher Kevin

Yuill points out the explicit connection being made between support for PAS and the numbers of elderly that will populate the western countries in the next several decades. Yuill describes himself as a typical European liberal on abortion, but opposes legalizing PAS due to its open eugenics agenda. British social commentator Brendan O'Neill, in the forward to Yuill's book points out that,

Time and again, thinkers and activists who claim only to support the exercise of individual autonomy at the end of life talk openly about the fact that letting people die will save society money and resources. Indeed, this has become one of the key implicit arguments for assisted suicide, since in Melanie Reid's words, it is 'ridiculous' that a society in crisis, a society filled with more old, demented people than have ever existed before, has failed to legalize the ending of sick people's lives (by PAS/euthanasia).¹

For example, British Baroness Mary Warnock, a very influential person in bioethics in Europe and well-known advocate for PAS, has insisted that the elderly should exercise their duty to die if they have become a burden to others or to the state. She states, "If you are demented, you are wasting the resources of the National Health Service."² In the US, this sentiment has been echoed by *New York Times* columnist David Brooks, who was drawing attention to economic conditions following the financial crisis in 2008–2010, when he said, "The fiscal crisis is about many things, but one of them is our inability to face death—our willingness to spend our nation into bankruptcy to extend life for a few more sickly months." O'Neill concludes, "Indeed today, to insist on the right to continue living despite the economic or environmental cost of one's life, despite the 'uselessness' of one's life in comparison with the lives of other, more able-bodied individuals—is surely regarded as immoral—after all, it sins against the new moralities of environmental awareness and generational responsibility."³ What a contrast to the Bible's commitment to the sanctity of life!

With the mention of the phrase "eugenics" one can easily recollect the Nazi euthanasia/eugenics program of the 1930s and 1940s. But the eugenic impulse did not originate there. It actually began in the salons of Europe and among the elites in the U.S., prior to the Nazis coming to power. To be clear, the Nazi program never had a beneficent purpose. It was always for eugenics, to create a master race rid of those it deemed deficient. It did slide down a slippery slope but started at the bottom of the slope and slid further. It is not a good example of the slide from beneficent to strictly eugenic purposes. But there were some points in common in the way we think about human beings—namely, the notion that some people were "useless eaters," a phrase being resurrected today, and the idea that someone could be a human being but not be a full person with rights to life and protectability, both of which are causes for alarm today in the way that the elderly are being viewed.

¹ Kevin Yuill, *Assisted Suicide: The Liberal, Humanist Case Against Legalization* (London: Palgrave Macmillan, 2013), xi.

² *Ibid.*

³ *Ibid.*, xv.

4. *Gene editing and designer children.* Through a new technology developed in the past year, gene editing is now being done. The process, known as Crispr-Cas9, is a new procedure that enables scientists to snip out defective genes and replace them with the corrected version, thus treating genetic disease right at the source. A protein called Cas9 functions as a genetic scalpel and repair enzymes enable researchers to seal the resulting gap with new genetic information, thus changing the underlying genetic code.⁴ This has exciting promise to deal with a variety of genetic abnormalities more efficiently than traditional gene therapy, which has failed to live up to its initial promise since its inception more than thirty years ago.

In an extension of this technology, Chinese researchers performed a similar kind of gene editing on human embryos, and researchers in the UK are currently seeking to engage in similar research.⁵ The embryos were non-viable, and the process had a fairly low success rate, and produced what are called “off target” mutations, in which the procedure affected other parts of the genome in ways scientists hadn’t anticipated. This raised concerns about the procedure’s safety in embryos, particularly since the genetic changes, both intended and unintended, would be inheritable by successive generations, making it a form of what has been long called “germ line therapy.” But it raises for the first time, the ability of science to do the kind of gene splicing and replacement that is necessary for producing “designer children.” Though the researchers insist that they have no intention of using the technology for genetic alteration of traits, the technology to perform gene splicing, though still in its infancy and not yet ready for public consumption, is here, waiting for someone to use it to do genetic alterations for non-disease traits. Some in the bioethics community actually believe that parents are morally obligated to engineer their children, to give them the best possible head start in life.

5. *Enhancement therapies.* Many different medical and biotechnologies have dual uses—to treat disease and clear medical and psychiatric conditions, *and* to enhance otherwise normal traits. For example, Human Growth Hormone (HGH), originally used as a treatment for dwarfism, is now routinely used for children who are at the lower end of the normal range for height. In addition, beta blockers, which have a variety of uses, namely to treat social anxiety disorders, are now being used by professions for whom steady hands and calm nerves are critical to performing their jobs, such as concert musicians and even surgeons. Further, Ritalin, the drug that treats ADHD, is often sold on the black market on college campuses for students who have no diagnosable ADHD, but who are looking for heightened concentration (known as “executive function”) and focus around final exam times. Other biotechnologies slow the effects of aging (on muscles and memory), flatten out the emotional lows of life’s difficulties (PTSD medications), treat depression and anxie-

⁴ Jonathan Rockoff, “Why Gene Editing Technology Has Scientists Excited,” *Wall Street Journal* (June 28, 2015), at http://www.wsj.com/article_email/why-gene-editing-technology-has-scientists-excited-1434985998-lMyQjAxMTA1MTE5NDUxMzQ5Wj.

⁵ David Cyranoski and Sarah Rearden, “Chinese Scientists Genetically Modify Human Embryos,” *Nature* (April 22, 2015), at <http://www.nature.com/news/chinese-scientists-genetically-modify-human-embryos-1.17378>.

ty without psychotherapy, and enhance mental acuity where there is no diagnosable illness (known as “steroids for the mind”). To be sure, many forms of mental illness have a brain chemistry component that has gone askew, and the medication works miracles in giving people their mental health back. But the concerns raised about these enhancement technologies are about medicalizing more of life, and as a result minimizing the moral component as medicine and biotechnology become more prominent, and as genetics is used to explain more and more behavioral issues. For example, shortly after the Genome Project was completed, *Time* came out with a cover story entitled, “Is Adultery Genetic?” The point of the issue was to treat infidelity as a disease, for which treatment, not repentance, was appropriate.

Further concerns are raised about accepting the limits of our humanity, as opposed to the work of the transhumanists in attempting to overcome our human nature. “Transhumanism is a class of philosophies of life that seek the continuation and acceleration of the evolution of intelligent life beyond its currently human form and human limitations by means of science and technology.”⁶ That is, it is the movement that seeks “the radical removal of the constraints of our bodies and brains and the reconfiguration of human existence according to technological opportunities.”⁷

What do we accept as life’s givens, and what of our limits can/should be altered/improved? Those are difficult questions, made more complicated by the fact that most people work very hard to overcome their limits and enhance their traits, with many things no one questions, such as exercise, music lessons, and Kaplan courses. Why should people not enlist the services of medicine and pharmacology to assist them in this? One reason to consider is the analogy with steroids, that using them cheapens legitimate achievement when they are used, even as a supplement to hard work. On the other hand, most people would likely have no objection if their neurosurgeon took a beta blocker to give him or her a bit steadier hand when operating on their brain.

A further difficulty in this area is making a careful distinction between treatment and enhancement, a topic that has long troubled bioethicists. Even when setting this distinction within a theological framework, as those conditions that are the result of the general entrance of sin being treatable and those that are not the result of sin, being enhancement, there is still ambiguity about where lines can be drawn. For example, there are some conditions for which treatment is considered acceptable, yet is difficult to insist that they are the result of the entrance of sin. Take male pattern baldness, for example. It’s not the norm but it’s hardly clear that it’s the result of the fall, yet we have no problem with treating it as best we can. Or take orthodontics as another example. The times that it fixes TMJ problems aside, most orthodontics is for cosmetic purposes, yet I don’t hear many people insisting

⁶ M. More and N. Vita-More, eds., *The Transhumanist Reader: Classical and Contemporary Essays on the Science, Technology, and Philosophy of the Human Future* (New York: Wiley-Blackwell Publishing, 2013), front matter.

⁷ Fabrice Jotterand, “At the Roots of Transhumanism: From the Enlightenment to a Post-Human Future,” *The Journal of Medicine and Philosophy* 35/6 (2010): 617.

that crooked teeth are the result of the entrance of sin. What this suggests is that though it might be clearer at the extremes, drawing lines consistently is very challenging and will continue to be in the years to come. Many people are skeptical that everything that goes beyond the therapeutic is therefore problematic for that reason. Since many of these are expensive, some in the bioethics community are rightly concerned that enhancement medicine and pharmacology will worsen the already existing disparities between the medical haves and have-nots.

II. BIOETHICS EDUCATION FOR THE CHURCH

Since many of us in ETS are involved in theological education for the next generation of church leaders/pastors, it's important to see how issues in bioethics come across the desk of local church leaders, and how they can educate their churches to deal with these issues. In my experience, churches are undereducated when it comes to bioethics, a neglect that is critical because these issues are not just academic ones, but touch people's lives in very tangible and deep ways.

Take *abortion*, for example. I suspect you could frequent many of the churches we attend or pastor for quite a long time without knowing that there is anything morally problematic about abortion. I routinely ask my seminary students when we cover this subject in class if their churches do anything to commemorate "Sanctity of Life Sunday." Most of my students have never heard of that particular Sunday, and usually only a small handful is aware of when it is (the third Sunday in January, closest to January 20, the date when the *Roe v. Wade* decision was handed down in 1973).

I understand the pastoral reluctance to delve into what is, for some women, a very painful subject, the discussion of which amounts to reopening old wounds. But it seems to me that the cost of neglecting that topic is high, if the men and women in our churches think that there's ambiguity from our pulpits on this. I also understand that in the cultural traditions in which some of our churches exist, unwanted pregnancies are a source of shame, and often handled quickly and quietly by abortion. I had a class discussion exercise on this subject that included a hypothetical young single woman with an unwanted pregnancy coming for counsel to the college pastor in her church. After several semesters of this, my students from some Asian ethnicities informed me that these conversations with the pastor would rarely, if ever, take place, because of the embarrassment involved in the unwelcome pregnancy. I found this tragic, because these women were cut off from the kinds of redemptive discussions that make our churches the ideal places for addressing issues like this that touch the core of people's lives.

Another area related to abortion in which I suspect our churches are undereducated has to do with abortion for genetic abnormality. Statistically, around 90% of pregnancies where Down's syndrome is diagnosed in utero, are ended by abortion. With the amount of genetic information available as a result of the Human Genome Project, there are hundreds of diseases and conditions for which we can test, either for the more direct genetic link, or for the genetic predisposition, which merely increases the risk of contracting the disease but does not guarantee it. As a

result, prospective parents are ending pregnancies for more genetic conditions, some of which only involve a heightened risk. I've heard anecdotally of pregnancies being ended for fixable conditions, such as cleft palate. The adult disability community is understandably concerned that the attitudes toward the disabled are changing, and not for the better—ironic, in a culture so committed to appreciating diversity.

It is widely assumed among the physicians, nurses and genetic counselors who care for these pregnancies, that if a couple receives bad news back from their genetic testing, they will end the pregnancy and try again for a genetically healthy child. It is not uncommon for couples to report feeling pressure, or the expectation that they will end the pregnancy under these conditions. At the least, the burden of justification shifts with genetic bad news. In a normal pregnancy, if someone wants to end it, we usually expect a good reason. But in a pregnancy with genetic problems, we expect a good reason *if the couple wants to keep the pregnancy*. My neighbors had a child with Down's syndrome as their third and final child, and they reported getting pressure from their physician to end the pregnancy. Most of the professionals who cared for them were shocked that they decided to continue the pregnancy. If this is what couples hear from the medical community (with exceptions to be sure), then where are they hearing the contrary view, in which all human beings are seen with intrinsic value and dignity regardless of their ability to function, a view consistent with the notion of human beings made in the image of God? If not in our churches, I suspect they are not hearing it at all. This is not to underestimate the challenges of caring for a child with genetic abnormalities. But it seems highly presumptuous to assume that unhappiness for the child and disability are somehow necessarily connected. I suspect that if we took a poll of genetically challenged kids and asked them if they think they would have been better off never having been born, they would think that an odd question. Of course, even if they are unhappy, that does not justify ending their lives on account of their disability.

A second area in which I believe our churches are undereducated is that of *assisted reproductive technology (ART)*. I realize that this is a vast and complicated area of study and that we can't resolve all the issues in the next few minutes. So we'll limit the discussion to the most often used ART, in vitro fertilization (IVF). We'll further limit it to a married couple utilizing the genetic materials of the husband and the wife, with no gamete donors or surrogates. This is the position that I believe the Bible teaches, but developing it is beyond our scope here.

In IVF, the standard of practice is for the woman to harvest as many eggs as possible in a single cycle. To do so, she is given powerful hormones that enable her to release as many eggs as possible, though with what is called "natural IVF," only one egg is harvested without these hormones. They are then surgically harvested, placed in a petri dish and combined with the husband's sperm, and hopefully, many of the eggs will be successfully fertilized. Normally, they all are not fertilized. The embryos that result are then implanted in the woman's uterus. Normally 2–3 are implanted, and if there are others remaining, they are frozen and stored for future use if needed (though in some parts of the world, government is mandating that the number of embryos implanted not be more than two, and in Australia, the law

allows only one to be implanted at any one time). If the first round of implants fails, then instead of starting over and re-harvesting eggs, the couple thaws out additional embryos and implants another 2–3 of them. However, if the couple achieves success, especially if they have multiple pregnancies, it is not uncommon for them to insist that their childbearing days are now over. In some cases, after giving birth to twins or triplets, the woman may not be able to carry additional children. In cases of success on the first try, the usual scenario is that couples have embryos left over that they either do not want to implant or cannot implant. Under our assumption that embryos are persons, they now have a very significant moral problem. Once reproductive medicine can freeze and thaw a woman's eggs successfully, this will no longer be an issue, since couples can thaw eggs and fertilize them a few at a time. But for now, that's a serious problem, and some argue that even freezing human embryos is itself morally problematic. They have difficult decisions to make about the disposition of these embryos—that is, *their children* who are in storage. They often are unaware that they might face this moral dilemma when they begin the IVF process, and if they have had children through IVF, they recognize the continuity between the embryos in the lab and the children they are holding.

This is essentially the story of good friends who had triplets through a version of IVF, known as GIFT (gamete intrafallopian transfer), which is not done that often today. They had triplets on the first try with five embryos remaining in storage, when the wife developed lupus, making future pregnancies a very bad idea. They then came to me and asked what their options were. The options are to implant the remaining embryos themselves, preferably not all five at one time, or if that's not possible, to put them up for adoption, through various *embryo adoption* programs (see the Snowflake program in California as an example), which they did, with all five of the remaining embryos. In addition, if they become pregnant with more than three, which sometimes does happen, their physician will likely advise them strongly to reduce the number of pregnancies to a safer number, known as *selective termination*. I have found that most Christian couples attempting IVF are ignorant of these moral dilemmas that they are likely to face in the normal process of IVF. In fact, I have found that most infertile couples are not that interested in the moral dimension of IVF, caring only about the cost and the success rate. It is not uncommon for infertile couples, whose pain is especially real and extremely deep, to be transformed by their desperation into uncritical utilitarians about ART in general, thinking that whatever will get them a baby is all that matters.

Other things to consider in this general area include egg donation (*egg selling* in reality), in which young women are paid to part with a harvest of their eggs in order to help an infertile couple who can't produce their own eggs to become pregnant. If you go to any state university college campus newspaper, you will likely find several advertisements for college-aged women to sell their eggs, on average receiving \$2500–\$3000 per harvest (to my knowledge these ads have not yet made their way into Christian college newspapers!). The safety of egg harvesting for these women is essentially a blind faith position, since the clinics do not follow up with the women who sell their eggs unless they have immediate complications, which

sometimes happens. There is simply no data to validate the infertility industry's claim that this is a safe procedure.

With sperm donation (sperm *selling* in reality), it's important to be aware that even though kids of sperm donor arrangements usually have a dad who raises them (though the number of SMCs—single mothers by choice—is increasing), they often have a deep and understandable longing to reconnect with their biodad, producing a reunion that is often disappointing for the child, since the sperm donor frequently has no interest in this reunion. This is because he commonly donated sperm as a younger man, many years ago, and often has his own family that takes up his time and energy. The thousands of kids in the Donor Sibling Registry still trying to reconnect with biodad is ample evidence that many sperm donors do not want such a connection. In some parts of the world, sperm donors are not granted anonymity, which predictably, is a strong deterrent to potential sperm donors, greatly reducing the number of willing donors. I would encourage single women who want a child either to adopt traditionally, or to pursue *embryo adoption*, which would give her the experience of pregnancy and childbirth.

A final area in which I would suggest our churches are undereducated is the *end of life*. This is an area of significant opportunity for deep pastoral ministry, both at the bedside and with the family. Though the most pressing issues may be medical, the questions which are of most interest to most patients are spiritual ones, such as, "What is my destiny?," "What is my legacy?," and "Am I right with the most important people in my life?" I am disappointed with the frequency I hear my seminary students indicate that they do not plan on doing hospital visits, for a variety of reasons, one of which is that the importance of it was not modeled by their pastoral mentors. Though we preach regularly about resurrection and eternity, I rarely hear any application of those biblical principles on death, dying, and eternity applied to how we should approach the end of life as patients and family members. In my 15+ years as a hospital ethics consultant, I have often wanted to ask believing families (but didn't) if they really believed what they said they believe about resurrection and eternity, because it sure didn't look like they did, based on how tenaciously they were holding on to earthly life for their loved one (who may not have wanted to have his or her homecoming delayed!).

First Corinthians 15 indicates that death is a *conquered* enemy, which suggests that it need not always be resisted, that under the right conditions (when treatment is futile or more burdensome than beneficial), it is acceptable to say "enough" to medicine and not delay one's homecoming any longer. I vividly remember wheeling my father-in-law out of the hospital for the last time following surgery for bladder cancer. He could only speak in a whisper and he motioned to me to lean down so he could whisper in my ear, and he said, "*Don't ever bring me here again.*" What he meant was that "I'm done with doctors, hospitals, treatments, tubes, and technologies that I don't want and that are making my life miserable." Though he could not articulate it this way, I think he meant to say that, "I will accept the rest of my days, however many, as gifts from the hand of God, but without medicine intervening." Saying "enough" to medicine is not necessarily violating the sanctity of life, since earthly life, theologically, is a *penultimate* good, not our highest good. Thus, it is not

required by belief in the sanctity of life to keep all people alive at all times and at all costs. Neither is it a lack of faith in a miracle-working God to turn off life support. I have often wanted to say to families (but didn't) who expressed this sentiment, that if we're waiting for a miracle, then let's go for broke and turn off everything! Of course, they are waiting for a medically-assisted miracle, without realizing that God doesn't need, and has never needed, medicine to work miracles. This is where our theology makes a tangible difference, as I try to explain to them that God is about to work a major miracle, healing your loved one of *all* his or her diseases, but most likely on the other side of eternity. The paradigm of resurrection and eternity is what should govern the way we approach the end of life. In our role as theological educators, we should be encouraging and equipping our students to walk with families and patients through the end of life, realizing that these are sacred moments that we have the opportunity to experience with them.

III. CONCLUSION

In view of the cultural erosion of respect for life, especially at the beginning and ending edges of life, let me encourage all of us to the following commitments:

(1) We must affirm the intrinsic value and dignity of all human beings regardless of their ability to function. We should be very careful about function-related views of personhood that lead to personhood being a degreed property, which cannot be the basis for *equal* rights. I would suggest the same caution with necessarily connecting the image of God to particular human functions, thus rendering the image of God a matter of degree, which in the Scripture, it is most certainly not.

(2) We must affirm the dignity of the ministry of health care, as we need to do with all the workplace (Col 3:23), and see the ministry of health care as a continuation of the healing ministry of Jesus.

(3) We must affirm a faith that engages these cultural issues and is not privatized. Christian faith has an inherent public dimension, particularly as it relates to the most vulnerable among us. In biblical times the orphan and widow were the examples that easily communicated this vulnerability. Today I would suggest that the most vulnerable among our human community are the unborn and the elderly.

(4) We must affirm the need for research in biblical studies and theology that engages these issues of culture—in medicine and bioethics, as well as business, the workplace, economics, and sexuality. If the Bible is to be understood as having something to say on these crucial issues, it's the people in this room who are the leaders for the church and the broader culture. I would like for our pastors to be viewed as having something of value to impart not only to patients in these areas, but to physicians and nurses, as well as throughout the arenas of service in the workplace. Pastors do not need to become bioethics experts, but need to be conversant enough at least to *identify* issues about which their faith needs to speak. We must affirm Bible teaching that helps educate the church that there are a number of bioethics issues that touch real life deeply, and to which Christian faith meaningfully speaks.