

BIOETHICS: THE TWILIGHT OF CHRISTIAN HIPPOCRATISM

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Sir Edward Creasy's *Fifteen Decisive Battles of the World*ⁱ may seem to reduce human history to the military engagements that, since Marathon, have marked the high- and low-water marks of imperial power. Yet there was nothing antecedently inevitable about the victory of Miltiades over Datis, and part of the virtue of this sort of history writing is the lesson it teaches that a well-fought engagement can really make a difference. When our grandchildren come to write their intellectual and social histories there can be little doubt as to the decisive significance of current discussion of bioethics in determining the shape of post-Christian Western society, and it is a thousand pities that the contemporary evangelical movement shows so general a disinterest in serious engagement in this discipline.ⁱⁱ Widespread recent recruitment of evangelicals to the pro-life cause has had no parallel in the vigorous academic field of inquiry that in the past two decades has taken the leading edge of bioethical thinking far beyond the horizons of the abortion debate. And vigorous it has proved to be. The burgeoning of bioethics as an academic/professional discipline is a recognized phenomenon in the academic world, plainly measurable in publishing, academic appointments, international conferences, and the establishment worldwide of scores of "centers" and other institutional expressions of commitment to this new field. Perhaps the best of all barometers is the appearance of new journals, and here progress has been spectacular, with a constant stream of fresh announcements.ⁱⁱⁱ Evangelical participation in the mainstream bioethics community has been modest, with a modesty unbecoming those who have such a stake in the outcome of the community's thinking.^{iv}

Evangelical investment in bioethics institutions has been almost nil.^v

Explanations are generally elusive, though not entirely so. One factor has been the widespread evangelical unease with philosophy, the lingua franca of the bioethics world. Another lies in the forgivable but ultimately disastrous desire of evangelicals for simplicity at all costs. The pro-life movement offers a necessarily simplistic account of the crisis in contemporary medical-scientific values by fastening exclusively on the status of the fetus as its sole public policy concern (though the question of euthanasia has started to awaken an adjunct interest, if no more). The pro-life movement can hardly be faulted for its political savvy (a single-issue focus is almost required for effectiveness), though a deeper awareness of the public policy issues that will confront evangelicals ten or twenty years down the road would have given a three-dimensional quality to campaigning concerns, as well as helping to prepare the constituency for the next campaign and the next-but-one. Pro-life organizations — evangelical and other — have shown scant interest in sponsoring the kinds of research that would help develop their own thinking beyond the demands of the immediate political agenda.

A further factor, affecting the evangelical constituency more broadly — and perhaps especially its existing educational and other institutions — is the uncertainty and, at points, deep disagreement that have marked its response to key questions such as abortion.^{vi} There has been some development here, since evangelical opinion was much more divided and uncertain twenty years ago on that issue than it is today. But as euthanasia and the various dimensions of our new capacity for genetic manipulation rise up the political-moral agenda, further division and uncertainty within the community appear inevitable. Indeed, our failure to develop institutions within and among which these questions could be addressed is

storing up all manner of difficulty in articulating an evangelical position on issues that have yet to be posed. This is not least among the reasons why such institutional development is now urgent.

But the intention of this essay is no more to explain the parsimony of the evangelical imagination than to lambaste it. There is limited though growing evidence that the situation is at least beginning to right itself, with a handful of evangelicals participating in bioethical debates and interpreting bioethics to the evangelical community. What is particularly urgent, if this development is to be sustained, is the need for appropriate institutions to be established so that a self-sustaining evangelical mind can develop, sketching broad perspectives for its community, defining options on particular controverted questions, and giving effective voice to evangelical concerns in the twin arenas within which the crucial discussions are in progress: public policy debate, and behind public policy debate — and sinisterly and depressingly determinative of it — debate within the international bioethics community.

Yet what of bioethics itself? Its phenomenal growth has been widely observed. As the supremely interdisciplinary discipline, it stands at the confluence of the biomedical sciences, law, philosophy, theology, and, of course, ethics itself as analyst and would-be arbiter of the contested terrain in which most "bioethicists" — who have themselves set out from one of the traditional disciplines — have established for themselves a multidisciplinary bridgehead in the land of values, science, and medical practice. This, of course, is not some arcane country, but the place where a new understanding of what it means to be human is being fashioned and tested. So the Christian stake could hardly be higher.

How then should we understand the establishment and rapid growth of this most interdisciplinary of disciplines? There are

two coincident factors that together begin to offer an explanation. The first factor is the "revolution" in medical technology. This is actually not one but a cluster of developments — developments in drug therapy, surgery, the technology of life-support systems, and parallel developments such as the general appropriation of information technology. These developments have combined to lengthen the reach of medical science, and they have also combined to add increasingly expensive items to the menu of clinical options. Expectations have been raised and often met, fueling an inflation of demand. Consequent crises in resourcing have been one result. Attempts at resolution have, of course, taken different forms within different health-care systems, but resultant rationing in such procedures as renal dialysis and neonatal special care has been universal — whatever its method — and has given public focus to ethical conflicts. At other times it is the availability of new biological techniques — supremely, *in vitro* fertilization — that has raised new issues. In other cases, different issues are prominent: abortion, of course, continues for the public and politician alike to be the most significant bioethical issue of our day, and though it is safer and more widely available than ever before, it is nothing new. The next big storm is brewing over euthanasia. Though this question is intersected by special concerns over the use of technology — which enables many patients, whether accident victims or terminally ill, to survive when previously they would have died — the practice, like that of abortion, is as old as human society.

The prominence of these life issues in contemporary bioethical discussion gives the lie to the widespread assumption that the bioethics boom is simply the fruit of revolutionary progress in the development of medical technology and the hard questions it has forced upon us. The second level of explanation is more fundamental, and it lies in the breakup of the ethical consensus in Western society. The

medical culture to which we have fallen heir dates back before Christ to the Hippocratic physicians of ancient Greece, though it was early recognized by Christians as congruent with their own special values and came to exercise a mesmeric influence down many centuries of health care in Judeo-Christian (and also, though distinctly, in Islamic) society.^{vii} Central to that medical culture has been the sanctity of life. (Proscriptions of both abortion and suicide-euthanasia lie side by side in the Hippocratic Oath with principles such as confidentiality and the germ of the idea of what we now call a profession.)^{viii} Medical values have not been isolated from those of society at large, though the relationship is complex and medicine has maintained — or has been expected to maintain — the highest values held in general esteem.^{ix} The Hippocratic profession was from the start a moral calling, and its most characteristic feature was its inseparable blending of its distinct moral values and medical technique, strikingly illustrated by the prohibition in the oath from teaching medical skills to any persons who have not already first committed themselves to the Hippocratic values.

Part of the special importance of current developments in medical values lies in the role of medicine as an index of wider social change in the double move both away from Hippocratic-Judeo-Christian values and, at the same time, away from *any* consensus values. For it is not that some new religion has usurped the old; the post-Christian society is developing as a kind of anti-society in which consensus values — the substructure of every other society, past and present — have been displaced by a value anarchy that seeks its validation and strives for social cohesion through models of autonomy alone, as if pluralism were a unifying "ism" like any other. Just as medicine once served as standard-bearer of all that was best in the old society, so it is coming to exemplify the new in its ambiguity and growing incoherence.

CHRISTIAN HIPPOCRATISM

The Western medical tradition owes its origins and its character to a striking fusion of pagan and (Judeo-)Christian notions. The enduring association of Hippocrates of Cos and the practice of medicine in the Christian/post-Christian West offers telling evidence of the welcome that the church extended to this product of pagan antiquity. There is some evidence of Christian attempts to bowdlerize the pagan oath^x (an approach adopted with much success within Islam, where also Hippocratism was welcomed and became the standard of medical values).^{xi} But it was the original, overtly pagan form of the oath that was adopted into and remained the standard of Christian medicine.

There is much uncertainty as to the origins of the oath and its historical connection with Hippocrates himself. He was the most famous of all the physicians of antiquity, and his name is associated with a considerable library of writings on ethical, clinical, dietary, and other medically related issues, conventionally referred to — with unintended humor — as the Hippocratic *corpus*. Scholarly opinion locates some of this material after his time, and there seems good reason to believe that, however formal or informal it may have been, there was a Hippocratic "school" associated with the name and memory of Hippocrates of Cos that sought to perpetuate and develop his thinking.^{xii}

More than one historical reconstruction has been offered,^{xiii} but the most influential (it was actually cited by the court in *Roe v. Wade* in a curious attempt to relativize the significance of the Hippocratic tradition) remains that of Ludwig Edelstein, a distinguished historian of medicine who in 1943 published a monograph on the oath in which he sought a location for its values and its understanding of medicine within the religious and philosophical schools of Greek antiquity. Edelstein searched the religious-philosophical options of the period for one in which the declared values of the oath would find a home. He found it in the school of the

Pythagoreans, about whom not much is known, though we do know that they held some distinct opinions on some of the highly controversial issues on which the oath displays a distinctive view (especially abortion and what Edelstein calls suicide-euthanasia, both of which were commonly approved in the Greece of antiquity but forbidden in the oath).

Edelstein's Pythagorean identification of the early Hippocratics may or may not be correct. But the significance of his work has been to reprimatinate Hippocratic medical values as those of a reforming minority. This is important for two reasons. First, before his monograph there was a tendency for writers to laud the values of the oath as self-evidently true, a collection of statements of the obvious.^{xiv} Second, we have inherited Hippocratic medicine as consensus medicine, for so it has been for many centuries during which few have dissented from its understanding of human dignity and the role and calling of the physician. Edelstein's work reminds us of the highly controversial character of human values, of which the dissonant ethical voices of Greek antiquity offer us a paradigm; and it reminds us of the calling of the first Hippocratics and the challenge they faced as they sought to commend and practice their very distinctive values in a society that marched to a different drum. In other words, Edelstein's thesis reprimatinates Hippocratism as a dissident medical creed, and the oath as (to use his term) a "manifesto" for the human medical values it advocates. Since the wheel of medical values is set to turn full circle as we emerge into a post-Hippocratic medical culture, this rediscovery is timely.

The readiness with which Christians embraced Hippocratic medicine, and even its plainly pagan oath, underlines its fundamental congruence with a Christian agenda for medical values. That is perhaps most evident in the stress that the oath places on the sanctity of human life. The explicit prohibition on medical killing (whether in abortion or in

medically assisted suicide) and the patient-first emphasis (Hippocratic philanthropism) outline a non-manipulative, servant role for medicine and energetically distinguish between medicine as healing and medicine as anything else. The old pre-Hippocratic medicine — like the post-Hippocratism emerging today — did not make these distinctions. Moreover, the context of these distinct ethical commitments was theistic, even if its theism was pagan. The key to the significance of theism for the oath lies in the fact that it was an *oath*. How far we have moved from a medical culture in which the transcendent ethics of Christian Hippocratism set the context for clinical practice is sadly evident in the fact that of the many influential modern restatements of (more or less) Hippocratic medical values, starting with the definitive Declaration of Geneva of 1948, which sought — on behalf of the World Medical Association — to reinstate the Hippocratic basis of international clinical practice after the sorry story of Nazi medicine, not one is actually cast in the form of an oath; and no one seems to have noticed. For the first Christians, this pagan medical ideology, which sought to limit the physician's role to that of healer and which did so explicitly *coram Deo*, was immensely attractive. What is more, by its nature the oath declares medicine to be, first and foremost, a matter of moral commitment.^{xv} This is made explicit in its own prohibition on the passing on of medical skills to those who have not first accepted its values. The understanding of medicine that is gaining currency today — as essentially a set of skills that may or may not be acquired alongside this or that code of values — is anathema to the oath, which joined together technique and value, the "life" and the "art" of the Hippocratic practitioner, in an indissoluble union that has characterized not simply the idea of medicine but, at its best, the idea of a profession. Thus Hippocratism was adopted into the church, *mutatis mutandis*, as the basis for the Christian practice of medicine. And it is

for these same reasons that the Christian stake in Hippocratism is today so great.

It has been common for evangelicals to dismiss the significance of bioethics as simply an intra-professional discussion, important no doubt for physicians, but not more important for the rest of us than ethical discussions within the many other professional communities. But this dismissal arises out of a naive understanding of the significance of medicine. The subject matter of contemporary bioethics is only incidentally related to the professional responsibilities of the physician. That is part of the reason why *bioethics* or *biomedical ethics* is generally used in place of *medical ethics* as the generic term for the discipline (in North America, at least). Bioethics treats of fundamental human values; generally these values involve a medical or medical-scientific component, but at several removes from the "old" medical ethics, which majored in medical etiquette — addressing such questions as whether or not it is proper for a physician to form a liaison with a patient, for example. Not that these areas are unrelated; the Hippocratic Oath addressed them both (and its doctrine of medical confidentiality, for example, remains fundamental and unchallenged). But the farther the center of controversy moves from professional etiquette, the greater is its impact on public policy discussion and matters that affect us all at the most profound level. So abortion and euthanasia are, of course, issues with vital medical dimensions, but none would deny that they are chiefly moral and social questions and that, at the level of principle, they are not for the medical professions to resolve.

This is, indeed, one reason why the discipline of bioethics has developed, and why it has developed alongside and not as a department of medicine. But that leads us to recognize the universality of the questions that are being raised under this head. Rather curiously, part of the reason for and part of the result of the underdeveloped state of bioethical discussion

within the evangelical community lies in the conservative character of evangelical medicine in this respect. The medical mainstream has been more open, and has been open for a longer period of time, to non-medical participation in bioethical discussion than has evangelical medicine. In the light of evangelicals' overt religious and moral commitments, this is surprising, and its explanation is probably to be sought in sensitivity in areas like abortion over which evangelical opinion has itself been divided (especially twenty or more years ago, when bioethics was in its infancy and the structure of much later discussion was being decided).

The subject matter of bioethics is humankind; man, male and female, made in the image of God. That is the starting point of Christian reflection, and that is also the point at which contemporary secular bioethical discussion makes contrary assumptions about the nature of the being who is the subject of argument. Human being is made in the *imago Dei*, and while the content to be given to this fundamental biblical concept is the subject of continuing discussion,^{xvi} it is bearing the divine image and likeness that marks off human being from all other kinds of created being and declares human life to be "sacred" or to possess "sanctity." The use of these religious terms to indicate the inviolability of human life (whether in general, or more specifically as technical terms in bioethical discussion) is no accident, and it reflects precisely the Christian theological tradition. The import of Genesis 1:26 — "Let us make man in our image" — is spelled out in 9:6. The capital sentence awaits those who take human life, since is it made in the image of God; human life, that is, is sacred and inviolable because of its intimate connection with God himself, who is its Creator.

Yet men and women are mortal, condemned to death by sin, the effects of which are universal; and it is in this dialectic of sanctity and mortality that the calling of the physician and, indeed, the task of the bioethicist lie. For the believer there is

an irreducible ambivalence in his or her attitude to death, the last enemy whose gloomy portal is also the gate of life. Yet for the unbeliever, too, there is ambivalence, and it is the ambivalence of the unbeliever that has dominated and continues to dominate bioethical discussion of issues on the boundaries of life. The unbeliever has no resurrection hope and for that reason may strive to hold on to what remains of life at all costs, since it is all there is. But if there is no resurrection hope, there is also no resurrection judgment, no accountability, no notion that life is God's to give and God's to take away, no confidence in divine providence and comfort. So the unbeliever may move from fear of death to fear of dying — or fear of continuing alive in conditions of distress — and may opt for that control over dying that has always been available in suicide and its medical surrogates.

What is more, unbelievers may take to themselves power over the dying of others, with that same lack of accountability to resurrection judgment and with exclusive concern for comfort in the here and now (whether their own or that of the "other"), whether the "other" is an unborn child or a demented and costly parent, and whether the means is the abortionist's instrument or the withdrawal of the food and drink that sustain the chronic and incompetent sick. Much of contemporary secular bioethics may be understood as a life-and-death struggle between the desire to hold on to life because it is all there is and the increasingly stronger desire to take control of death to make life easier. In some cases the easier life and the eased death are predicated of the same person, and thus it may be the patient who seeks and who takes hold of the keys. But more and more, the life made easier and the death that makes it so are distinct, the keys of death seized not by a patient in anguish (for very, very few now need die like that) but by a relative or a physician or an insurer or an administrator, whose life will be easier (emotionally, financially...) because that other life is over.

That is, of course, the typical pattern with abortion (there are some few indicators that could be claimed to suggest that the child herself would be happier dead, but they are few), and that pattern is increasingly becoming the dominant pattern for euthanasia. Life is cheap because death is cheap, and the medical decision-making process become the theater of a power-play in which the race is to the strong, and patients' rights — vaunted as the justification for breaking the mold of rigid Hippocratic values — have become a Trojan horse for the entry of extraneous interests into decisions concerning the life and death of the patient. It has never been plainer that Hippocrates was the patient's friend.

ISSUES IN DEBATE

The list of topics addressed in current bioethical discussion grows every month as technology advances and ethical options open wider. Cryopreservation, fetal brain tissue implants, the immense array of genetic possibilities — clearly this is not a single-issue debate, and for that reason there are questions on which a Christian response will not yet have come to a clear focus. But at the heart of the contemporary scene lies the abandonment of the Christian-Hippocratic conviction of the sanctity of human life. Many of the particular questions being explored around the margins of technological possibility and ethical acceptability are options only because of that denial of the central tenet of our medical culture. So our focus must continue to lie here, in the sanctity-of-life doctrine that imparts such dignity to the individual and that stamps the calling of the physician with such an ideal of disinterested service — without both of which our medical tradition lies in tatters.

BEGINNING-OF-LIFE ISSUES

We have already noted the major, if somewhat belated,

evangelical engagement in the pro-life movement. This has not always reflected unanimity among evangelicals on at least some of the abortion options, but it does reflect a mainstream evangelical commitment on one side of the debate rather than the other. In the United States, as in other countries, evangelical medical opinion has been the most divided, both with respect to abortion itself and when confronted with related questions such as that of deleterious research on the human embryo. That does not augur well for the coming round of debate on euthanasia, for which — as with abortion twenty years ago — evangelical opinion is thoroughly ill-prepared, and which is also destined to move rapidly beyond intellectual reflection into the marketplace of public policy and legal change. Indeed, we may well see a rerun of the abortion awakening, in which the intellectual struggle *followed* political-legal decisions and an evangelical mind was achieved altogether too late. We have already noted that among the most striking features of the contemporary debate on life issues is its lack of novelty: the religious-philosophical discussion and the medical practice both go back through classical society into primitive times, and indeed both abortion and euthanasia are practiced today by primitive peoples as well as in technological societies. While these questions may have taken on fresh perspective, in themselves they are unconnected with the new technological and other resources of contemporary medicine. Indeed, it is worth remarking that the Hippocratic repudiation of these practices was in the context of a primitive medical culture; the clinical and other resources available in modern Western society for the care of unwanted children, the handicapped, and the chronic and terminally sick are incomparably greater. Yet it is now that the turnaround in the ethical consensus has taken place.

The abortion argument began as an argument about when life begins, and that is a question on which Christians have a

highly distinctive answer. For there is a series of biblical indicators that together come to a particularly — indeed, even a surprisingly — sharp focus in answer to our question. In fact, the debate has moved on, and it is now much more the debate that some of us have feared it would become: a debate about when life, which has very plainly already begun, may legitimately be taken. This is a more logical though also a more sinister debate, in which the continuity of fetal and born human life has ceased to tell against abortion and has begun to tell in favor of euthanasia. The self-evident and substantially Hippocratic assumptions of a generation ago have given place to radical questioning. In the pro-life syllogism (human life is sacred, fetal life is human life, therefore...), the focus has shifted from the minor to the major premise.

Broadly, Christians have taken two kinds of approaches to the determination of a biblical position, both alike recognizing the uniform character of Christian opposition to abortion on all but extreme therapeutic grounds from the earliest days of the church (our first evidence is in the *Didache*).^{xvii} One approach has noted that there is no explicit reference to abortion in Old or New Testament as something to be commended or condemned, though in a famously difficult passage (Exod. 21:22-25) we find casuistic discussion of the penalty due for causing a miscarriage. More than one interpretation of the text is possible,^{xviii} but even on the conventional reading its relevance to the procuring of abortion is very remote; for it outlines a case in which two men are brawling, heedless of the fact that a pregnant woman is nearby, and as a result of reckless but accidental injury to her she miscarries. The result is a fine for those responsible. It is hard to see how they are responsible for anything other than brawling recklessly near a pregnant woman. They are certainly not responsible for procuring an abortion. And, as we need to be reminded, the limited range of criminal

sanctions possible in Old Testament society meant that a fine could be an appropriate penalty for a relatively serious offense. The suggestion of some interpreters that if the fetus were fully human the death penalty would have been appropriate is extraordinary.^{xix}

A very different approach seeks guidance not first of all in the matter of abortion, looking for legislation and arguing from silence, but with respect to the nature of unborn human life.^{xx} There are several different lines of argument in this approach. First we have the significance of the creation of humankind in the *imago Dei*, as we have already noted. The context of this statement lies in the taxonomy of the created order that is found in Genesis 1. (Whatever else this chapter says, it does set out such a taxonomy.) The implication is plain: wherever humankind is found, wherever this species that we call *Homo sapiens* is met, there is one who bears the divine image. The image is co-terminous with the biological constitution of humankind. This is in truth a very striking statement, for not only does it bear momentous implications for the dignity of both women and men, but it also declares in principle the equal dignity and value of every human life — irrespective of color or creed, moral worth or depravity, age or sickness, mental impairment or genius: all who share in the genetic constitution of the human race bear that inestimable dignity that is bestowed by God in their creation in his image.

A second line of argument picks up the manner in which, within the Old Testament especially, the process of generation is addressed. Abraham begat Isaac. The point at which one generation was succeeded by the next was (surprise, surprise!) the point of generation, the point of begetting. In light of what has been said about the taxonomy in Genesis 1 — and in light of what I shall say next about the incarnation — this argument has particular force. So, from the very beginnings of human biological existence, that being is by definition a new member of *Homo sapiens*, who, in common with all

mammalian species begets and reproduces himself and herself — the product of human conception is no *tertium quid* but the next generation of the species.

A third line of argument addresses the incarnation of Jesus Christ. In support of the full humanity of the fetus much use has been made of biblical references to unborn human life, especially in Job, in some of the prophets, and in certain of the psalms. These texts are by no means irrelevant, but they pale beside the narrative of the birth of Jesus Christ. For the point of incarnation is plainly put at the point of his virginal and supernatural conception. There is no separation made between his biological beginnings as Mary's conceptus and the mysterious overshadowing of the Holy Spirit. In the case of Jesus we have an open-and-shut case for the highest possible view of the earliest stage of fetal life. Incarnation took place in embryo. This raises many questions, though in terms of orthodox theology it is straightforward. Jesus' humanity is patterned after our humanity, sin only apart; so the character of his own unborn human life is also the pattern of ours. If we find it hard to imagine a zygote possessing the dignity of one who bears the image of God, we have only to cast our minds to the miracle of the incarnation. The problem lies, not in the unimaginable genetic complexity and completeness of the zygote, but in the altogether limited imaginative faculty that we are able to bring to bear on the subject.

The coupling of these suggestive biblical-theological arguments with the striking fact of Christian opposition to abortion from the earliest days of the church, and until very recently in an unbroken tradition, leads us to an enthusiastic endorsement of the Hippocratic refusal to participate in abortion that was, until lately, the orthodoxy of the Western medical tradition. And if the debate moves on to the possibility of using human embryos for deleterious research, the grounding of our argument against abortion in the decisive

character of conception-fertilization already gives us our answer. If human life is sacred right from its biological beginnings, then we stand face-to-face with that which bears the ineffable image of its — her, his — Maker.

END-OF-LIFE ISSUES

No more than a generation ago, euthanasia — however it was dressed up — was regarded as at best the preserve of cranks and at worst as subversive, with ideological overtones of fascism. This issue is now at the very heart of the public policy debate on health care and human values. Although it has not yet been made the subject of a political-legal revolution that compares with *Roe v. Wade* and the abortion legislation that marked a similar path in most industrialized and many other countries during the 1960^s and 1970^s, there is widespread public support for voluntary euthanasia in most Western countries. That support depends critically on fears and misunderstandings, but it has offered cover for a succession of legal and political moves toward a positive euthanasia policy in many countries. These moves have opened increasingly liberal approaches to case law in marginal situations and have prepared public opinion for more general legal change. The high-water mark of these developments in the United States is the so-called Patient Self-Determination Act of 1991, which obliges hospitals and other institutions receiving federal funding to inquire of patients on admission whether they have a "living will"; in Europe it is the *de facto* legalization of voluntary euthanasia in Holland, where statute has still to catch up with a permissive public policy in which prosecuting authorities and courts have conspired with the major medical bodies to give doctors a license to kill their patients.^{xxi} As we have already noted in more general terms, from the standpoint of history the most curious feature of this movement away from the

sanctity-of-life doctrine is the degree to which the resources needed to sustain those who are handicapped or chronically or terminally ill have so dramatically increased just at the moment when opinion is shifting round to favor killing. An excellent example of a fundamentally different approach is hospice care, a recent development in geriatric and palliative medicine that has sought "death with dignity" in supportive community care of the dying, joining expertise in drug therapy and pain control with associated medical and nursing skills.^{xxii} Yet euthanasia is cheap, and the central place that cost containment holds in current discussions has given a major fillip to the euthanasia trend, as the Patient Self-Determination Act shows. With the ethical framework of which the sanctity of life was a key element now in flux, the desire to limit costs will place increasing pressure on end-of-life choices and may well be the deciding factor in legislative moves toward voluntary euthanasia. And if the key pressures at the level of legislation will be financial, it seems clear that the Chinese walls that alone separate the "voluntary" and the "involuntary" will not long survive (any more than this distinction has proved reliable in the sub-legal and informal euthanasia context of the Netherlands).^{xxiii}

It is important to note some of the distinctions and connections that characterize this discussion before we return to biblical-theological comment. The overt justification for the modern euthanasia movement is that of patient self-determination; patient autonomy is to replace Hippocratic paternalism, as it is perceived, giving patients the right to "medically assisted suicide" or "aid in dying," as its proponents variously term it. In fact, what they seek is a curious amalgam of suicide and homicide; the decision, they say, should lie with the patient, and if the patient requests death the attending physician should be obliged to comply and bring it about. This is not actually assisted suicide but homicide with consent, homicide at the victim's request; it

actually partakes of the moral problematic of both suicide and homicide. And its rooting in the patient's act of free decision, on which whatever defense is offered must wholly rest, is deluged in difficulty. For what kind of free choice on this most fundamental of human questions is someone who is by definition a patient able to make? Who can assess the pressures on one who is, say, chronically sick, who is trying to double-guess her relatives to decide whether they would really prefer her dead, who is juggling financial uncertainties and perhaps knows that her children's hope of a legacy entirely depends on her dying sooner rather than later? These are typical of many questions that can be raised about the simple coherence of the euthanasia project, aside from ethical critique.

There is then the question of the alleged distinction between this voluntary, patient-autonomy euthanasia and involuntary killing, which of course most euthanasia advocates seek to disown. Aside from the psychological difficulty of envisaging free choices for and against euthanasia in a family, in a hospital, indeed in a society that formally endorses this as an option, there is a basic logical difficulty. What is to be the ground on which the physician is obliged to bring about death? There are two possible answers: either the simple expressed desire of a person who seeks death, perhaps qualified by its repetition on successive occasions or before successive physicians, or an expressed desire coupled with a certain medical condition. If the latter, the question arises how those who satisfy the medical criteria but do not express a wish to die will ultimately be treated, especially when they are incompetent. The pressure to move from voluntary to "non-voluntary" (in the case of the incompetent) and ultimately to a full involuntary euthanasia policy will be unstoppable. (For example, there might be federal withdrawal of Medicaid and Medicare, insurance exclusions, and so forth if a "voluntary" decision for euthanasia is not made.) On the

other hand, if no medical criteria are set down, the policy is simply a charter for suicide: the jilted teen and the postnatal depressive will have nothing to bar their way. The basic problem, of course, lies in the assumption that it can be good to will one's own death and that any community that accepts that proposition as part of its understanding of the rights of the individual can flourish. There is no third way: the acceptance in principle of medical killing will resolve itself either in the encouragement of arbitrary decisions for suicide or in the creation of classes of persons for whom the choice to die is regarded as reasonable; and if the latter, then those in that class who do not choose to die will be marginalized at best, and at worst will be killed for their unreason and their claim on community resources. It is a truly frightening prospect.

Over against this option for death the Christian sets Job's dictum. "The LORD gave and the LORD has taken away: may the name of the LORD be praised" (1:21). Job refuses the urgings of his wife "to curse God and die" (2:9). He lays hold on the providential purposes of the good God who has given him life, and he trusts him for aid as it becomes harder to live and as death looms bitter-sweet on the horizon of his pilgrimage.

This is not to say that there are no hard choices to be faced. One reason why our failure to develop an evangelical bioethics is so serious lies squarely here: we have yet to form a community within which appropriate biblical-theological responses to real, hard questions can be formulated. Yet the beginnings of that culture lie in the old medicine of Christian Hippocratism and in the application of its principles to new situations. In accordance with those principles, futile treatment has never been good treatment. The well-advanced dying process is the place for palliation, not invasive and distressing procedures initiated to please relatives or on the advice of the hospital attorney or to pursue some tacit

experimental purpose. How we define futility in a sanctity-of-life context may be radically different from a quality-of-life evaluation, but Christian Hippocratism has always recognized that there is a time to die.

KEY QUESTIONS FOR AN EVANGELICAL BIOETHICS

The agenda is as long as the road is untraveled, yet several key questions stand out that require address from a biblical-theological perspective. First and most broadly, we need to develop a biblical theology of medicine. The field of medicine offers a prime example of the theological-hermeneutical challenges that confront evangelicals today, since the practice of medicine and the questions raised in the discussion of medical values are of prime importance to the church. Yet where Scripture touches on this subject, it does so almost entirely indirectly.

If life is sacred because God has made us in his own image, and if death is nonetheless universal in fallen human experience, what is the place of medicine? The hope of humankind is the hope of the resurrection of the body, and that bodily resurrection — in its imaging yet transcending human experience before the mortal consequences of the fall — gives rich significance to those anticipations of the resurrection of the body that we find in the New Testament, supremely in the healing miracles of Jesus. It is common to see "natural" medical healing as quite other than the healing of a miracle; yet both alike stay the progress of mortality and thereby offer broken and anticipatory witness to the eschatological abolition of death. A biblical theology of medicine will be eschatologically oriented.^{xxiv}

Second, we must address the question of health-care provision at the extremes of human existence: the anencephalic baby, for example, or the patient in a persistent vegetative state. The pressure is on (and it has been felt by

some evangelicals already) to adopt essentially quality-of-life criteria in these cases that would be vigorously repudiated if they were applied more generally. If we move in just a little from the margins, we stumble over the curious medicalization of the giving of food and drink (symbolized in the use of the labels "nutrition" and "hydration" for these elemental human requirements), a major step — unwittingly or not — in the generation of opportunities for medical killing and a potent threat to the sanctity-of-life position. It is hard to exaggerate the importance of such bellwether questions as the evangelical mind crystallizes in the flux of current discussion.

Finally, the fundamental technological development of our time lies in the field of human genetics. The unlocking of ever great proportions of the genetic code has begun to realize an ultimately enormous range of manipulative possibilities affecting the very nature of the human species. The harvesting of these developments will begin in earnest just as the values of post-Hippocratism have established themselves in mainstream medicine. The generation of appropriate Christian responses will require the resources of a major intellectual community, but such a community in this field has scarcely begun to develop.

THE PROBLEM OF CONSENSUS

Despite the fundamental significance of the sanctity of life for the assumptions that govern bioethical discussion, and despite the central place that beginning-of-life and end-of-life issues hold on the public stage today, there is yet another kind of issue that we must address — that of consensus in medicine. We have already noted that the scene has been set for the incipient breakup of the Christian-Hippocratic consensus. Many particular substantive questions are on the agenda, not because society's mind has all of a sudden

changed, but because the prevailing consensus — and with it, the *idea* of a consensus — has begun to crack. Abortion began to be defended, irrespective of the merits of traditional arguments pro and con, as a concomitant of the right of privacy or the rights of women. Euthanasia is on the agenda as an exercise in self-deliverance, the final act of patient autonomy. Curiously enough, academic bioethics has concerned itself less and less with these and other similar substantive ethical questions, and increasingly with questions of procedure. Of course, these questions are not unrelated. Procedural questions may well also, in themselves, be of ethical interest. But the weight that is now placed on the establishment of procedures that will allow individuals of diverse ethical convictions to determine their treatment regime is a declaration of despair. Its implication is that there will be no new consensus and that the only area in which we can seek agreement with one another is in the determination of the procedures of disagreement. This can be illustrated no better than in the title of the milestone congressional legislation of 1991 to which we have already referred: the Patient *Self-Determination* Act. Whatever the cost-containment concerns that may lie behind this and similar legislation elsewhere, the question we must keep asking is this: Why do we need procedures laid down in federal law that assume that we no longer share a community of values in terminal care? Is there no longer a medical *community*, representative of the broader community, infused with the values of centuries of humane clinical experience, whose judgment that wider community can trust? There are many partial answers; but at root we recognize, on the one hand, the undeniable and general fragmentation of community values, though we also recognize, on the other hand, that it is in the interest of a (morally) liberal minority on the leading edge of that fragmentation to give the impression that things have gone farther and faster than they actually have. This in turn is

deeply influencing the move to pluralism. The societies of Europe and North America are actually more cohesive — in fact, much more "societies" — than many of their glib interpreters suggest; and that is particularly true in the field of bioethics, where the purveying of half-truths about the significance and state of incipient pluralism is proving catalytic and has actually helped to give birth to the discipline.

So should I have a living will? The answer to this question lies buried in the complexity of Christian-Hippocratic tactics in an age in which Hippocratism is proving to be "biologically tenacious" (a chilling phrase that some bioethicists have applied to patients who refuse to die when they "should"), and yet an age in which, equally certainly, a post-Hippocratic medical culture is in the making. Originally a clever ploy in the armory of euthanasia advocates, this coyly named advanced directive permits the patient to decide ahead of time the principles according to which treatment decisions should be made should the patient become incompetent, so that these decisions are not left in the hands of relatives, physicians, hospital administrators, or — ultimately — the courts. Perhaps our response should be that drawing up a living will offers Christians a wonderful opportunity to ensure Christian-Hippocratic canons of medical care right to the last. Yet, aside from many practical problems that the use of the living will poses, every time someone draws one up another nail is knocked in the coffin of consensus. That may not be an argument against using the living will in the United States, where one evidence of the weakness of the consensus is the degree of involvement of the judiciary in clinical management decisions; but it is an important argument against their general introduction in some other jurisdictions (e.g., in the United Kingdom) where there is still a substantial consensus in medical values and considerable confidence in physicians as interpreters of the best in the humane medical tradition.

This raises the question of tactics. Part of the naiveté of

sections of the pro-life movement has lain in the assumption that, with the striking down of *Roe v. Wade* or equivalent watersheds in other parts of the world, all would somehow be well. Liberal abortion is a symptom of the diseased character of contemporary medical ethics; it is not the disease in itself. Political advocacy on those bioethical issues that break surface in public policy discussion is vital, but it must be part of a grand strategy by which political and other initiatives must be judged — everything down to my own initiative or lack of it in exercising patient "self-determination" and drawing up an advance directive.

The key lies in an awareness of the state of fragmentation of the consensus, on the one hand, and a rediscovery of the origins and logic of Hippocratism on the other. Nothing must be done that makes it easier for the bioethics community to point the finger and cry "pluralism"; we must seek to shore up and draw attention to the elements of consensus, which are, incidentally, far more in evidence in our society and in the health-care professions than among bioethicists themselves. And yet we must also begin to look ahead to the day when the prophecies have come true and we enter an age of truly post-Hippocratic medicine. As we focus on this developing situation, we seek to apply our general principles of Christian community and witness. We must be dissident, and we must be prophetic; we must maintain our own distinctive community while never entirely dissociating ourselves and our community from the wider community of which we remain indissolubly a part. And that is where the rediscovery of Hippocratic origins has a special and challenging relevance. For if the first Hippocratics were dissidents and prophets, protesting the inhumanity of the medical culture of their day and leading the way to a better one, there are footsteps in which we can follow.

NOTES

i. Edward Creasy, *The Fifteen Decisive Battles of the World* (1851), various re-issues.

ii. There are notable exceptions, including Carl F. H. Henry himself and, especially, Harold O. J. Brown. Recent writers include Allen Verhey and John Frame.

iii. There is a new announcement every few months, though evangelicals have yet to launch a technical journal.

iv. Very few evangelicals are to be found at the international conferences that have become determinative of the development of the bioethics community. It is of course true that evangelicals who are interested in these questions tend to be associated with evangelical schools, which in turn may be less interested in funding such participation — which raises the institutional question afresh.

v. Modest exceptions are the Lindeboom Instituut at Ede in the Netherlands and the fledgling Centre for Bioethics and Public Policy in London. Trinity Evangelical Divinity School is in process of launching an M.A. track in bioethics.

vi. For example, members of the (British) Christian Medical Fellowship offered two conflicting responses to their government's advisory body on embryo research issues.

vii. This thesis is further sketched in my book *The New Medicine: Life and Death After Hippocrates* (Westchester, Ill.: Crossway, 1992).

viii. The Hippocratic Oath reads as follows (translation by W. H. S. Jones in his book *The Doctor's Oath* [Cambridge Univ. Press, 1924], with minor alterations and added headings):

THE COVENANT

I swear by Apollo Physician, by Asclepius, by Hygeia, by Panacea, and by all the gods and goddesses, making them witnesses, that I will carry out, according to my ability and judgment, this oath and indenture:

DUTIES TO TEACHER

To regard my teacher in this art as equal to my parents; to make him partner in my livelihood, and when he is in need of money to share mine with him; to consider his offspring equal to my brothers; to teach them this art, if they require to learn it, without fee or indenture; and to impart precept, oral instruction, and all the other learning, to my sons, to the sons of my teacher, and to pupils who have signed the indenture and sworn obedience to the physicians' Law, but to none other.

DUTIES TO PATIENTS

I will use treatment to help the sick according to my ability and judgment, but will never use it to injure or wrong them.

I will not give poison to anyone though asked to do so, nor will I suggest such a plan. Similarly I will not give a pessary to a woman to cause abortion. But in purity and in holiness I will guard my life and my art.

I will not use the knife either on sufferers from stone, but will give place to such as are craftsmen therein.

Into whatsoever house I enter, I will do so to help the sick, keeping myself free from all intentional wrong-doing and harm, especially from fornication with woman or man, bond or free.

Whatsoever in the course of practice I see or hear (or even outside my practice in social intercourse) that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets.

THE SANCTION

Now if I keep this oath and break it not, may I enjoy honour, in my life and art, among men for all time; but if I transgress and forswear myself, may the opposite befall me.

ix. The relation of medicine and society is most helpfully discussed in Eliot Freidson, *Profession of Medicine: A Study in the Sociology of Applied Knowledge* (New York: Harper & Row, 1970).

x. See Jones, *The Doctor's Oath*, pp. 23ff.

xi. See M. Ullmann, *Islamic Medicine* (Edinburgh: Univ. of Edinburgh Press, 1978).

xii. Little is known with any certainty about Hippocrates of Cos (460-377 B.C. are the years most often suggested for his life; he died old, some say a centenarian). Jones summarizes what we do know

in *The Doctor's Oath*, with the authority of the editor of the Loeb edition of the *corpus*.

xiii. For references see the most recent scholarly study in English of the Hippocratic tradition (though its chief interest does not lie in Hippocratic *ethics*). Owsei Temkin, *Hippocrates in a World of Pagans and Christians* (Baltimore: Johns Hopkins Univ. Press, 1991), p.21 n.16.

xiv. Jones, *The Doctor's Oath*, offers a good example.

xv. For a contemporary echo, see especially the work of Stanley Hauerwas — e.g., his book *Suffering Presence* (Notre Dame: Univ. of Notre Dame Press, 1986).

xvi. Helpfully and most recently summarized by Gerald Bray in *Tyndale Bulletin* 42/2 (1991) 195-225.

xvii. The *Didache* is a very early statement of post-apostolic Christian practice, dated to the first half of the second century or before.

xviii. The New International Version reads: "If men who are fighting hit a pregnant woman and she gives birth prematurely but there is no serious injury, the offender must be fined.... But if there is serious injury, you are to take life for life..." (Exod. 21:22-23).

xix. In his influential book *Abortion: The Personal Dilemma* (Exeter: Paternoster, 1972), R. F. R. Gardner introduces this text as the "one clear reference to abortion in the Old Testament" and comments: "it would seem fairly obvious that in any case the text implies a difference in the eyes of the law between the fetus and a person" (p. 119).

xx. This line of argument is laid out at more length in my contribution to *Abortion in Debate* (Church of Scotland Board of Social Responsibility; Edinburgh: Quorum Press, 1987), pp. 1-19.

xxi. See Richard Fenigsen, "A Case against Dutch Euthanasia," in *Hastings Center Report*, Special Supplement (Jan./Feb. 1989); reprinted in *Ethics and Medicine* 6/1 (1990) 11-18.

xxii. See Cicely Saunders, "Euthanasia: The Hospice Alternative" in *Death Without Dignity: Euthanasia in Perspective*, ed. Nigel M. de S. Cameron (Edinburgh: Rutherford House, 1990).

xxiii. See Richard Fenigsen, "The Report of the Dutch Governmental Committee on Euthanasia," *Issues in Law and Medicine* 7/3 (1991) 339-44.

xxiv. I have developed this theme somewhat in an appendix to *The New Medicine*, cited above in n.7, and in a forthcoming issue of *Christian Scholar's Review*.