

# Brace for Impact! Challenges to Human Dignity

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**Overview:** Bioethics is dangerous stuff. At issue are worldview discussions that threaten to diminish all of us:

- What does it mean to be human?
- Is being human enough?
- Is human nature objective (fixed) or can we alter it?
- What makes humans valuable in the first place?
- Should ethics be driven by objective truths or a utilitarian calculus?

Specific questions:

- Beginning of Life: Which assisted technologies should be used?
- End of life: When is it okay to withhold treatment from a dying patient?
- Future life—Should we cure disease or enhance humans?

Crazy world of bioethics—No place for imperfection:

- Couple pays \$50,000 to egg donor with blue eyes, 5'10, SAT score of 1400.
- Lesbian couple: genetic mother, gestational mother, donor sperm
- Couple creates 10 embryos with donor eggs/sperm, then screens for defects
- Doctors become philosophers who decide which lives are worth living
- Transhumanist seek an evolutionary leap forward by altering the biological nature of human beings; they seek immortality by uploading “minds” to a computer
- The “new” dignity—not intrinsic value, but freedom to reinvent myself as I please

Competing Worldviews in Play—Everyone doing bioethics must grapple with worldview questions in five key areas. How one answers profoundly impacts bioethics and human value:

- Metaphysics: What is the nature of reality? What is ultimate reality?
- Epistemology: How can we know the world? What counts as knowledge?
- Anthropology: What is human nature? What makes humans valuable?
- Ethics/morality: What’s wrong with us? What’s right and wrong? What’s the fix?
- Cosmology: How did we get here? What happens after death? Where is history going and is it guided or unguided?

Neutrality is impossible. Everyone brings certain worldview assumptions to the table when doing bioethics. The two main contenders are:

- Philosophical Naturalism—Reality is strictly physical and consists of the material world alone. Only what we observe via the five senses counts as knowledge (a view known as scientism). Non-material things like souls, minds, morals, and human value are not real, but mere human constructs. Human dignity itself is a fiction and thus has no basis in reality, only religion. Indeed, in a universe that came from nothing and was caused by nothing, human beings are cosmic accidents, reduced to their genetic properties and functional characteristics. In a strictly material universe, autonomy and consent drive bioethics.
- Christian Theism—Ultimate reality is immaterial—namely, a personal God who created the material world. The material world actually exists and can be known, but it is not the only reality. Immaterial things like souls, morals, logic, and human nature exist. If non-material things exist, physicalism is false. On theism, humans have value because they bear the image of their Creator rather than some function they perform. They are not mere biological machines, but living substances with rational natures that endure through time and change. Morals are not fictions we socially construct; they exist objectively and are grounded in the character of a holy God.

Key question: Which worldview—philosophical naturalism or Christian Theism—does a better job accounting for human rights and the objective moral truths necessary to guide bioethics?

- Stephen Pinker—The concept of human dignity is “stupid” and lots of people disagree with it. When doing bioethics, we should abandon all worldview considerations in favor of consent and autonomy. However, Pinker assumes a worldview—naturalism—to debunk human dignity. And if disagreement means nobody is right, Pinker’s own view is false. After all, many people disagree with Pinker. Finally, Pinker confuses intrinsic dignity and attributed dignity. (More on the difference between the two later.)
- Naturalism is self-refuting. The claim that all reality is material cannot be verified empirically through the five senses. It is a philosophic, non-material claim. It also can’t say why anything has dignity and a right to life—fetuses or adults. Given we’re all cosmic accidents, there is nothing special about any of us.

**General Thesis for Conference:** Concern for quality of human life should not override the intrinsic value of human life.

## I. Human Dignity and Assisted Reproductive Technologies

A. The pain of infertility is real:

*A childless couple from church in their early 40s seeks your advice. They desperately want a child and their only hope is a controversial in vitro fertilization (IVF) procedure where, after receiving hormonal stimulation, the wife releases multiple eggs that are then fertilized in a test tube with her husband's sperm. The doctor will then place up to five resulting embryos in her uterus in hopes that at least one will implant. But here's the problem: She is not strong enough to handle a multiple pregnancy and if multiple embryos implant, her doctor insists she must "reduce" (abort) the extras or face serious health risks, including the loss of the implanted embryo she desperately wants. He insists "reducing" the surplus embryos is morally permissible because they can't yet function with self-awareness or feel pain. What advice should you give this couple? Are reproductive technologies like IVF intrinsically wrong or is there a way for couples to use them responsibly? What key principles should guide their decision?*

B. Can we do better than "too bad! Why don't you just adopt?"

C. Assisted reproductive technologies:

1. Intrauterine Insemination (IUI)—Sperm is artificially inserted into the uterus via a catheter--usually after the mother takes fertility drugs to increase the number of eggs released.
2. Gamete Intrafallopian Transfer (GIFT)—Sperm and egg are removed and placed in close proximity to each other in the fallopian tube. (Fertilization happens in woman's body.)
3. In Vitro Fertilization (IVF)—Sperm and egg are joined in test tube rather than woman's body. Resulting embryos are implanted or stored on ice.
4. Surrogacy—can be benevolent or commercial. Either way, there are two types:
  - (a) Genetic surrogacy—Surrogate provides the egg and the womb, then gives up parental rights when child is born.
  - (b) Gestational surrogacy—Surrogate provides the womb, but not the egg. Embryo(s) created using IVF are implanted in surrogate. Upon birth, gestational mother gives up all rights to the child.

D. **Thesis:** Assisted reproductive technologies (ARTs) are not wrong in principle, but as Scott Rae points out (*Moral Choices*), they must be evaluated within six biblical fence posts:

1. Status of the embryo--none should be destroyed or discarded. Any assisted technology that intentionally destroys human life is wrong for the same reason abortion is.

(a) Biblical case:

P1: All humans have value because they bear the image of God (Gen.1; James 3)

P2: Because humans bear the image of God, the shedding of innocent blood (intentional killing) is strictly forbidden (Ex.23:7; Prov.6:16-19; Mt.5:21).

P3: The unborn at any stage of development is a human being.

Therefore,

Conclusion: ARTs which intentionally kill human embryos are wrong.

(b) Given biblical teaching, genetic screening of embryos is wrong.

2. The gift of common grace—Is infertility an effect of the Fall of Man? If so, technology aimed at reversing that effect is not wrong per se, but must not violate biblical principles.

3. Procreation is to happen within marriage.

(a) The command to “be fruitful and multiply” is given to Adam and Eve within the context of one flesh marriage. Jesus and Paul reaffirm this principle.

(b) The “Baby M” case—the child had one father and two mothers. (Possible for a child to have two fathers and three mothers.)

(c) Surrogacy introduces a third party to the one-flesh union of husband and wife. Commercial surrogacy exploits poor women in third world countries.

(d) Maggie Gallagher: “Sex makes babies. Society needs babies. Babies deserve a mom and a dad.”

4. Adoption as a legitimate rescue mission:

(a) Biological lines matter.

(b) However, unlike surrogacy where a child is conceived for the express purpose of giving him up, adoption rescues a child who already exists.

5. Consider the risks—

(a) Multiples (IUI)

(b) Leftovers (IVF, GIFT)

(c) Worldview: Children are seen as commodities, products of parental desire.

6. Trust in God's sovereignty—

(a) We should not turn having a child into an idol.

(b) We do not have an unrestricted right to procreate.

(c) We should only use ARTs to extent we take personal responsibility for every child conceived.

(d) No screening for defects.

## II. Human Dignity and End of Life Care

A. Overview: Debates over Euthanasia and PAS are not about individual autonomy, personal choice, or dying with dignity, but a larger worldview premise—namely, that some lives are not worth living. That premise corrupts everything it touches:

1. It corrupts our philosophical anthropology, grounding human dignity in body-self dualism rather than intrinsic worth.
2. It corrupts our understanding of rights, confusing a desire to die with a right to die.
3. It corrupts end of life care, confusing a right to withhold treatment with a right to intentionally kill.
4. It corrupts our theological understanding of what it means to provide pastoral care to dying patients.

B. Case Study—You get the following email from a fellow church member:

*As you know, my husband Gregg is nearing the final stages of terminal cancer. He's refusing further aggressive treatment for the disease and is content to die. His physician tells us food and water—currently administered through a tube—may soon be an unnecessary burden and only increase his discomfort. At the same time, the doctor said that without increased doses of morphine, Gregg's pain will skyrocket as death approaches. Three questions: First, is it morally permissible to remove his food and water tube? Second, isn't increasing his morphine tantamount to hastening his death, perhaps a gentle form of euthanasia? At a minimum, it will render him*

*unconscious. Third, what principles should guide my decision? Gregg loves Christ and would want me to please God in all this.*

C. Define Terms:

1. *Euthanasia*—Doctor kills patient with lethal injection.
2. *Physician Assisted Suicide (PAS)*—Doctor gives the patient a lethal Rx the patient takes on his or her own

D. Case Against Euthanasia and PAS:

- P1: It is wrong to intentionally kill an innocent human being.  
P2: Euthanasia and PAS intentionally kill innocent human beings.  
Therefore,  
C: Euthanasia and PAS are wrong.

E. Culturally, the attempt to normalize assisted-suicide is driven by a **worldview premise** that some lives are not worth living. That premise captured the three gateways that determine culture:

1. **Medicine**—Dr. Harry Haiselden (1915)—baby Allan Bollinger case: Seeing intestinal and other abnormalities, Haiselden states the baby is fundamentally *not worth saving* and denies treatment.
2. **Law**—@Haiselden's inquest: The premise that “some lives are not worth living” is unchallenged. The inquest rebuked Haiselden (didn't prosecute him), but what they found objectionable was Haiselden refusing to treat a child *who would get better*.
3. **Theology**—Movie *The Black Stork* (1917)—Theme: God wills that children born with disabilities be allowed to die without treatment. Jesus wants that.

F. Post-WWII—Support for euthanasia tanks due to eugenics of Nazis. There's an intentional rhetorical shift away from eugenics to themes of autonomy and self-determination. But the premise that “some lives are not worth living” remains.

G. **Thesis:** Debates over Euthanasia and PAS are not about individual autonomy, personal choice, or dying with dignity, but a larger worldview premise that some lives are not worth living. That premise corrupts everything it touches.

**1. It corrupts our philosophical anthropology, grounding human dignity in body-self dualism rather than intrinsic worth.**

- (a) Philosophical anthropology answers the question, What makes humans valuable in the first place? No neutrality on that question.

(b) That PAS/euthanasia are NOT about autonomy or choice can be shown by asking just one question: "Who gets suicide prevention and who gets suicide assistance?" Or, "Who should we prevent from killing themselves?" Nearly always, the question will expose a failure to treat human being equally due to age or disability. Note the dialogue below:

Me: Should an 80-year-old depressed man get suicide prevention or suicide assistance?

Critic: It's his choice.

Me: Should we offer PAS to an 18-year-old who is chronically depressed?

Critic: No! That's different! He has his whole life in front of him.

**Note in this case**, the defender of PAS discriminates on the basis of *age*. He will provide suicide prevention to the youth but not the elderly. That is ageism. He will do the same with those struggling with disability:

Me: Should a healthy 35-year-old suffering from chronic depression get suicide prevention or suicide assistance?

Critic: Suicide prevention. He has a lot of life ahead of him. Treat his depression.

Me: What about a healthy 35-year-old who is depressed and paraplegic?

Critic: It should be his choice.

Me: So you don't think we should treat people equally?

Critic: What do you mean?

Me: Doesn't everyone deserve suicide prevention, especially those with disabilities? Why are you offering suicide prevention to people without disabilities but suicide assistance to those with disabilities? Isn't that a failure to treat them equally?

(c) Notice the critic just took a class of humans struggling with disabilities and relegated them to second class citizens! Instead of treating their despair, he offers them the choice to be killed, something he won't do with non-disabled people. Put simply, he assumes some lives are not worth living! He just offered the opposite solution to two people in the exact same situation (being depressed) because one of them was disabled! (Alleyne & Van Maren, *A Guide to Discussing Assisted Suicide*)

(d) Body-self dualism /personhood theory (BSD, PT) is behind the critic's response. According to BSD/PT, the *real* you is not your body, which is merely blind matter in motion, but conscious desires, capacity to reason/have relationships. Lose them, you are no longer "person" with rights.

(e) Schiavo Case—Our side accepted the personhood premise: We argued, "She might get better" when she had no duty to get better.

(f) PT grounded in BSD is seriously flawed and dangerous:

- It's absurd—You end up saying, “My body existed before I did” or “I was mere matter until my conscious self showed up.” If the real you is conscious desires, you've never been hugged by your mother since you can't hug desires!
- It doesn't argue for why a given function is value-giving in the first place. And who decides? Once personhood is divorced from the human body, human value subjective. Those in power decide who lives/dies. Might makes right.
- It distorts “*dignity*”—confusing *intrinsic* dignity with *attributed* dignity. Intrinsic dignity is yours in virtue of your humanity. Attributed dignity is yours because of age or accomplishment. To cite Kaczor, the beach bum and the university professor are equal in their intrinsic dignity, but not their attributed dignity. The university professor has flourished according to his nature. The beach bum has not, which is why we consider his life wasted. The right to life is based on our intrinsic dignity, not our attributed dignity.
- It can't account for equality—If equality is based on something we don't share equally, those with more of it have greater value than those with less.
- It justifies involuntary euthanasia—if only those with cognitive function above a certain threshold count as “actual persons,” those who fall short can have their rights over-ridden by actual persons. Killing them is only wrong on consequential grounds.
- Logic of involuntary euthanasia: 1) Establish euthanasia as a “benefit” to patient. 2) Argue those who cannot request that benefit due to cognitive impairment deserve equal right to that benefit. 3) Appoint a bioethicist to suggest that benefit for patient. Walah! You get involuntary euthanasia. This is not a slippery slope! Involuntary euthanasia is happening right now in the Netherlands and Belgium (and soon, Canada).
- It justifies involuntary organ donation—If cognitive function grounds your right to life, those who fail the test can have their rights over-ridden by those who are actual persons. This has already been proposed by Jeff McMahan and Carol Kahn.

- It empowers doctors to make *philosophical* value judgments they are not qualified to make. “Bioethics” transforms medicine from “do no harm” to medical discrimination against the weak. It turns doctors into killers.
- Futile Care Theory—Docs can refuse *desired* medical care based on their subjective opinions of the patient's quality of life. Agnetta Sutton—Doctors are qualified to say a *treatment* is futile; they are not qualified to say a *patient* is.

**2. The premise that “some lives are not worth living” corrupts our understanding of “rights” and abandons patients in their hour of need.**

(a) The “desire” to die is not the same as having a “right” to die. In the Schiavo case, pro-lifers failed to challenge the premise that it’s okay to kill people who wish to die. The right to life is “inalienable”—you can’t waive it!

(b) Mary Anne Glendon in *Rights Talk*—People like to pluck rights out of thin air.

(c) Rights entail obligations from surrounding community—Docs, etc., are obliged to facilitate the exercise of your right to die. “Rights” go way beyond the individual. What the “right to die” really means is that you not only have a right to attempt suicide, but a right to force others to help you succeed.

(d) Where does right to die come from? Classical Liberalism doesn’t provide it:

- Locke—Self-ownership does not mean you can treat your body like property (for example, you can't sell yourself into slavery) because your right to life is inalienable. My body is mine only in the limited sense that it's not yours! My body is mine to use, not mine to dispose of!
- Kant—Being “autonomous” does not mean “do as you please,” but freedom to do as you ought as a rational being. It means pursuing what is truly good for you!

(e) Appeals to “autonomy” can’t ground a right to die:

- Autonomy is reasonably limited—Selling oneself into chattel slavery is immoral. And it’s wrong for docs to intentionally mutilate a healthy body, even if a patient requests it.

- No limiting principle—If autonomy is sufficient to ground right to die, you can't limit it to dying people. Everyone deserves that right, healthy or sick.
- Infringes on autonomy of others—Even if autonomy justifies your right to die, it does not justify someone else killing you or forcing someone else to kill you via PAS/euthanasia.

(f) Autonomy or abandonment?

- Question for critics: *When do we quit on someone facing psychological suffering?*
- “Despair” = suffering without meaning. The loss of a will to live is a symptom of some other unmet need.

(g) The desire to die is highly unstable and can change!

- Elizabeth Bouvia (1980)—she was quadriplegic, divorced, forced out of grad school, suffered a miscarriage, was bankrupt, and her brother died—all in one year. Yet it was simply assumed she wanted to die due to her disability. Her emotional trauma was completely ignored! Despite winning the right to remove feeding tube, she began eating and lived. Friends came to her aid. What she needed was not cold autonomy, but for others to show they valued her life more than she did. She needed time to recover her emotional equilibrium.
- Thomas Passmore—A mentally ill man has a 666 hallucination, cuts hand off w/ a table saw, and a judge refuses to intervene and order medical staff to reattach his hand. The judge refuse to save Passmore from himself in the name of “autonomy.” Was this autonomy or abandonment of a mentally ill man, a colossal failure to care for him? Arthur Caplan: *“A nation that has created a healthcare system in which doctors, nurses, and administrators are not sure whether it is the right thing to do to sew a mentally ill man's severed hand back onto his arm is a society gone over the edge regarding autonomy.”*
- Estimates: 95% of those who commit suicide have diagnosable psychiatric illness—the majority suffering from depression that can be clinically treated. AND YET, only 5 of 178 Oregon patients who died of PAS in 2014 were referred for psychiatric help! ONLY 5! PAS under the guise of "autonomy" is the state abdicating its duty to protect innocent life.

**3. The premise that “some lives are not worth living” corrupts end-of-life care, confusing a right to withhold treatment with a right to intentionally kill.**

(a) Foundational principle #1: *Always care, never harm!* While we must never aim at death, it does not follow death must always be resisted. (Death is a conquered foe for the Christian!)

(b) Foundational principle #2: *Withholding treatment that no longer benefits the patient medically is not immoral provided we do not aim at death.* Rejecting treatment that is burdensome is not a rejection of life. However, as Agnetta Sutton points out, a truly medical decision to withdraw treatment is based on principle that the treatment is valueless (futile), not that the patient is so. True, death comes, but it's the result of underlying pathology, not my direct action.

(c) Morphine—We need to draw distinction between euthanasia and effective pain relief for dying patients. A physician administering morphine may *foresee* a hastening of death, but he must not *intend* it. That said, it's okay for terminally ill patients to sleep before they die, thus relieving their pain. It is not okay to intentionally kill them.

(d) When PAS is on the table, the doctor-patient relationship is corrupted. Cost-benefit analysis drives medical decisions, leaving patients to think they have a “duty to die” so as not to be a burden.

(e) Gilbert Meilaender: Instead of asking “*is the patient’s life a benefit to him?*” we should inquire, “*What, if anything, can we do that will benefit the life he has?*” Our task is not to judge the worth of this person's life relative to other possible or actual lives. Our task is to care for the life he has as best we can.

**4. The premise that “some lives are not worth living” corrupts our pastoral care to dying patients.**

(a) Biblical case against Euthanasia/PAS:

P1: All humans have value because they bear God's image.

P2: Because humans bear the image of God, the shedding of innocent blood (intentional killing) is strictly forbidden.

P3: Euthanasia and PAS shed innocent blood.

Therefore,

C: Euthanasia and PAS are wrong.

(b) “Martyr” justification for PAS—“Bible affirms martyrs, therefore, PAS is okay.” This justification is problematic. Martyrs don’t *aim* at their own death. They *foresee* it and accept it for sake of being faithful to a greater good (fidelity to God, moral principles, etc.) For example, Jesus doesn’t aim at death. In fact, three times He prays, “take this cup from me.” He does not run from the soldiers, but doesn’t rush out to meet them either. Judas, however, does aim at his own death.

(c) Our pastoral duty: Not assisting people with suicide, but providing care. We should help them end well:

- affirm the intrinsic value of the person
- talk eternal matters
- Help them bring closure with family and loved ones
- Treat their despair. Help them rest in Jesus
- Help them communicate essential messages—I love you. Thank you. Forgive me. I forgive you.

(d) Help them plan medical directives well in advance of need! Melinda Penner of Stand To Reason wrote down her wishes 12 years ago—long before a tragic brain injury left her semi-comatose:

*If I am permanently disabled but not certified terminal, I wish all care provided to sustain my life and alleviate my physical discomfort. I do not wish my life to be terminated due to permanent physical disablement. I personally do not consider nutrition and hydration to be medical treatment, but basic sustenance which every living organism requires to live. I do not wish nutrition and hydration to be withheld or withdrawn to facilitate or accelerate my death. I wish my life and death to be a testimony of the intrinsic value of all human beings which God has given us by virtue of our creation in His image, and of my absolute faith and trust in my salvation through my Lord and Savior Jesus Christ. I have absolute confidence that I will be with God in Heaven upon my death and anticipate that time joyfully. Therefore, my life should not be artificially prolonged. However, neither is my life to be artificially shortened based on a functional or instrumental view of life.*

(e) Help church members anticipate secular objections, pre-need:

- Argument from “autonomy”—Christians are not masters of their own fate. They belong to God (1 Cor. 6:19-20). They are to honor God with their bodies, not destroy them. The timing of one’s death belongs to God alone (Heb. 9:27). Meanwhile, the appeal to autonomy is flawed in other ways. First, a desire to die is not the same as a right to die. In

her book *Rights Talk*, Harvard law scholar Mary Ann Glendon writes that Americans mistakenly tend to express personal desires in the language of personal rights. And they do so within the context of extreme individualism. But rights claims, unlike desire claims, go way beyond the individual. They unavoidably draw obligations from the surrounding community. Doctors must prescribe lethal doses to secure the right to die. Legislative bodies must craft laws to enshrine that right. The criminal justice system must enforce it. Second autonomy is not absolute. You cannot sell yourself to chattel slavery. A doctor should not mutilate your healthy body, even if you desire him to do so. You cannot use your body for prostitution or illegal drugs. Third, if the right to die is grounded in autonomy, you can't limit that right to dying people. Anyone—sick or well, old or young—must be able to exercise it and government must compel others to help them exercise it. Yet most proponents of assisted-suicide want to limit the right to die to terminal patients. Fourth, the coupling of autonomy with the right to die undermines the autonomy of the elderly, sick, and dying—who may feel the need to justify their existence. The right to die becomes a duty to die—as true in the Netherlands. Fifth, the right to die also undermines the autonomy of physicians who are forced to participate in assisted-suicides or quit. Sixth, are we promoting autonomy or abandonment? A depressed patient suffering from a debilitating injury or illness may express an initial desire to die, but later change her mind. As Wesley J. Smith points out, what she most needs in her moment of profound emotional crisis is not “cold autonomy,” but “intervention and sufficient time” to recover her equilibrium. Her most urgent need is not “choice,” but for others to show her that they value her life more than she herself does.

- Argument against “religion”—Any challenge to autonomy is dismissed by secularists as “religious.” This is a dismissal rather than rejoinder. As Beckwith points out, arguments are true or false, valid or invalid. Calling an argument “religious” is a category error like asking, “How tall is the number five?” Moreover, the claim that my ultimate good in life is to be independent is itself a deeply metaphysical commitment every bit as religious as a Christian view of the human person. The Christian worldview states my ultimate purpose is to serve my Creator. I am not my own; I belong to Christ, who purchased me with His own blood. The secular- autonomy view says I am master of my own fate and my ultimate good is to be independent. Notice that both views are doing metaphysics—that is, advancing a philosophical anthropology about the nature of human persons and

how they ought to order their lives. One view is no more religious than the other.

- Argument from “mercy”—We don’t have to kill people to control their pain. Even if we heavily sedate them so they “sleep” before they die, the intent is not killing, only controlling their suffering.
- Argument from utility—Utilitarianism is flawed. First, some acts are wrong in themselves, such as torturing toddlers for fun or framing innocent people for crimes they didn’t commit. Second, it’s an incomplete theory: Utilitarianism can’t define “good” without borrowing from other, deontological systems. Third, utilitarianism fails to give guidance on decision making. That is, it can’t calculate the greatest good. Finally, who decides what is useful/good? Might makes right in this system.

Summary:

1. Withholding treatment that no longer benefits a patient is not immoral. Intentionally killing him is. Euthanasia and physician assisted suicide intentionally kill innocent human beings. Therefore, euthanasia and physician assisted suicide are wrong.
2. Allowing natural death to run its course in terminally ill patients does not violate the sanctity of human life. However, we must never forget that dying patients—like all humans—bear God’s image. Thus, we are never to intentionally kill them via euthanasia or doctor-assisted suicide.
3. While doctors are indeed qualified to determine if a treatment is futile, they are no more qualified than anyone else to determine that an individual life is futile. Instead of asking, “Is the patient’s life a benefit to him?” the physician should inquire “What, if anything, can we do that will benefit the life that he has?”
4. Regarding morphine, instead of intentionally killing the patient with a heavy overdose, the physician provides a carefully calibrated increase in morphine aimed at controlling pain.

### III. Human Dignity, Human Nature, and the Quest for Enhanced Living

A. Biotechnology asks: Is our purpose to restore the body or enhance it? Is it okay to alter human nature so we can transcend our natural limits? What does perfection look like?

B. **Starting point:** What does it mean to be human? Do humans have natures they ought to fulfill or are they free to reinvent themselves any way they please? The culture wants to answer the enhancement question before answering the foundational one. How can you say what human perfection looks like if you don’t know what a human is?

C. As noted earlier, the use of medical technology to treat disease is part of God's general revelation to alleviate the effects of sin's entrance to the world. Biotechnology used to repair the effects of the fall clearly within biblical limits.

D. Enhancing existing traits is not reversing or repairing the effects of the Fall. It's something more. Here is where it gets fuzzy: Where is the line between repair and enhancement? Are all enhancement therapies wrong? What about:

1. Orthodontics (braces) / baldness treatments
2. Cosmetic surgery
3. Anabolic steroids to enhance muscle growth in athletes
4. Beta blockers to calm performance anxiety
5. Medications like Adderall, Ritalin, etc., have clinical uses, but can be used to enhance.

E. The worldview underlying enhancements is body/self dualism (BSD):

1. As noted earlier, BSD says the real "you" is not your body, but your conscious self, feelings, desires, and experiences. The body is a mere construction project we invent to suit personal preferences. Thus, bodily autonomy is absolute.
2. Biblical anthropology rejects BSD. Your body matters. You are not a ghost in the machine, but a dynamic union of body and soul. The body has intrinsic purposes.
3. How culture is duped into accepting radical change (Michael Kruger):
  - (a) Step 1: Tout the moral virtues of the proposed behavior
  - (b) Step 2: Insist God has bigger things to worry about
  - (c) Step 3: Show how good results come from the behavior
  - (d) Step 4: Portray those against the behavior as mean, unloving
  - (e) step 5: Insist Jesus is on your side

(Example: Ted Peters and Gaymon Bennett on ESCR)

F. Biblical concerns with enhancements:

1. The imago Dei: What is our motive/intent for using enhancement therapies? That is, in using them we run dangerously close to buying a premise hostile to a biblical understanding of the imago Dei. Namely, we wrongly assume our value is grounded in our performance (or traits) not our common human nature which bears the image of our Maker. Immoral motivations include beliefs that certain bodily traits (skin color, hair, eye color, etc.) are inferior and should be changed. Accepting that premise is a slam against God's wisdom. Attitudinally, it assumes God erred including such diverse traits in the human race. Practically, it results in

discrimination against those we judge inferior because they possess undesirable traits.

2. The distinction of species: Are we honoring biblical parameters found in the creation account? Cross-species mixing is wrong. Scripture is clear God created living things according to their kinds (Gen. 1). The clear distinction between species is called “good.”

3. Access: Are we creating a widening gap between have and have nots? Will families face pressure to enhance or be left behind? Will failure to use enhancement therapies be seen as child neglect? The fate of families who refuse to enhance is unknown.

4. Justice: What is our obligation to future generations? Is it right to alter the genetic structure of future generations without their consent, especially when the long-term effects of enhancement are unknown? Enhancements have tradeoffs: an enhancement of one trait impacts other traits.

5. Authority: Who decides which traits are desirable? How many of them must you have to count? And why those traits and not something else? Which worldview determines acceptable traits? Genetic enhancements force a parental concept of “perfection” on children and future generations.

6. Contentment: Does our use of enhancement technologies undermine the givenness of life? Will it undermine incentive to put forth a good effort?

Conclusion: Genetic therapies that cure disease are morally permissible, but therapies used to enhance the genetic endowment of the person raise troubling questions. Traits like eye color, height, and gender are God-given and His sovereignty in these matters should not be usurped. The notion of designer offspring undermines the unconditional acceptance of children as gifts. Regarding enhancements in general, Christians should skeptically view technologies aimed at re-writing the created order. It is one thing to restore (or repair) human function. It is quite another to alter the natural limits of human nature. As Kevin Vanhoozer points out, the quest for cognitive enhancement is as old as Adam and Eve. It’s a denial of the created order and represents salvation through medical technology. For the Christian, transformation does not come through biochemistry, but through growing up in Christ (Ephesians 4:15). The gospel, in particular, is about conforming our minds to Christ, not enhancing them with a substitute bio-chem savior. Enhancing one’s cognitive limits implies a wrongful heart towards the Creator’s design. The larger biblical narrative is the story of God redeeming the world from the Fall and how He is renewing, not enhancing, all things. For the Christian, the ultimate reality is a resurrected body, not chemical transformation. In short, using technology to repair broken bodies is a gift from God. Using it to transcend our God-given limits is sin. (Vanhoozer cited in Kilner, *Why the Church Needs Bioethics*, pp. 105-124; see also Mitchell, pp. 110-136)

### Suggested Reading:

1. Gilbert Meilaender, *Bioethics: A Primer for Christians* (Grand Rapids: Eerdmans, 2005).
2. Scott Rae, *Moral Choices: An Introduction to Ethics* (Grand Rapids: Zondervan, 2018).
3. Wesley J. Smith, *Culture of Death: The Age of Do Harm Medicine* (San Francisco; Encounter, 2016).
4. Leon Kass, *Life, Liberty, and the Defense of Dignity* (San Francisco: Encounter, 2002).
5. Nancy Pearcey, *Love Thy Body* (Grand Rapids: Baker, 2018).
6. Christopher Kaczor, *A Defense of Dignity* (Notre Dame: University of Notre Dame Press, 2013).
7. John Kilner, et al, *Why the Church Needs Bioethics* (Grand Rapids: Zondervan, 2011).
9. Ira Byock, MD, *The Best Care Possible* (New York: Penguin, 2013).
10. Agneta Sutton, *Christian Bioethics: A Guide for the Perplexed* (London: T&T Clark, 2008).
11. Blaise Alleyne & Jonathan Van Maren, *A Guide to Discussing Assisted Suicide* (Life Cycle Books, 2017)
12. Ben Mitchell, et al, *Biotechnology and the Human Good* (Washington, DC: Georgetown Univ. Press, 2007)
13. Francis J. Beckwith, "The Case Against Abortion," *Ignatius Insight*, December 21, 2008.  
[http://www.ignatiusinsight.com/features2007/print2007/beckwith\\_defendlife\\_dec07.html](http://www.ignatiusinsight.com/features2007/print2007/beckwith_defendlife_dec07.html)
14. Roberta Green Ahmanson, "The New Dignity: Gnostic, Elitist, Self-Destructive Will-to-Power," *Public Discourse*, November 25, 2015.

### Video Resources:

#### Case for Life Bioethics Conference:

<https://www.youtube.com/playlist?list=PLdcS3W3NMJk8exbtu1zlotH6l20KM1oUN>

#### Biola University "Ethics at the Edges of Life" w/ Scott Rae and Scott Klusendorf

<https://www.youtube.com/playlist?list=PLE4C867C1C1F81AC9>