

moral contradiction (euphemistically labeled a paradox by some Kierkegaardians), various interpreters have written about Isaac as the archetypal martyr, the beloved son who freely submits to his father's and Yahweh's murderous intent. The apostle Paul and the author of the Epistle to the Hebrews viewed the crucifixion of the beloved Son of God as a willing sacrifice essential to bringing about forgiveness. When the doctrine of vicarious atonement portrayed god as persecuting his only begotten son because of humanity's sin, it raised questions about the character of the god demanding the violence. The doctrine portrays him as taking part with the group in killing the victim. René Girard and others advance the thesis that the whole process of creating moral approval for cruelty and liquidation gave birth to a conviction that the victims, far from being genuine human beings, were the poisonous agents of contagion and pollution. Much of the Bible appears deeply involved in notions of ritual impurity.

**Unending Violence.** By the first century CE, the idea of everlasting torment had become a part of some branches of Judaism and emerging Christianity. The Greek word *Gehenna* referred to the garbage area outside Jerusalem and became a symbol of the place where the unclean or the unbelievers would be cast. Since unbelievers were seen as unholy and impure, many believers felt that holiness required unbelievers to suffer perpetual torment in the eternal garbage pit where the worm would not die and the fire would never be extinguished. Various attempts to spiritualize the fire have been motivated by the desire not to reduce the amount of human torment, but to escape the conclusion that the torment springs from God's perpetual acts of unprecedented, relentless violence against his creatures.

Historically, the word *Gehenna* derived from the Hebrew *ge-hinnom*, the valley of Hinnom, where various kings of Judah engaged in human sacrifice by fire (2 Chron. 28:3, 33:6; Jer. 7:31). The prophet Jeremiah denounced it as foreign to the mind of Yahweh. King Josiah regarded the practice as wicked and ended it. Ironically, many Jewish and Christian believers of the first century embraced the idea of human sacrifice by fire. According to various Old Testament passages (Gen. 8:21; Exod. 29:19–25; Lev. 8:21, 23:13; Num. 15:10, 28, 22–24), the god Yahweh apparently required certain select animals to be cooked over open flame. The pleasing aroma ascending to heaven would bring him great satisfaction. Some portions of the New Testament portray the crucifixion of Jesus as a satisfying sacrifice to god: "Christ gave himself up for us, a fragrant offering and sacrifice to God" (Eph. 5:2).

The idea of human sacrifice by fire persists in some branches of Christianity. *Gehenna's* inmates become a perpetual sacrifice to the god's presumed holiness. By never allowing the inmates to lose consciousness, this god established human sacrifice in perpetuity. Ironically, if taken to its logical conclusion, the doctrine of ever-

lasting *Gehenna* would render the sacrifice of Jesus to have been slight when compared with the sacrifice made endlessly by any one of the unbelievers. Some Christians who reject the doctrine of everlasting torment interpret the flames of *Gehenna* to be the burning enmity and hostility within the hearts of some of their fellow believers.

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JOE EDWARD BARNHART

**BIOETHICS AND UNBELIEF.** On the face of it, bioethics without belief is mostly bioethics, for much of contemporary thinking about bioethics has been developed without the explicit and obvious derivations of principles from religious assumptions. The leading bioethics text of the twentieth century, Tom Beauchamp and James Childress's *Principles of Biomedical Ethics*, was written with the idea that whatever religiously derived principles the one (Childress) might offer, the other (Beauchamp) could demonstrate from nonreligious beginnings.

That work, now part of the core of bioethics literature, follows various professional organizations and federal commissions in endorsing a set of four principles from

which various rules and guidelines are derived for more specific situations. They are the principle of nonmaleficence, the principle of beneficence, the principle of autonomy, and the principle of justice.

The principle of nonmaleficence enjoins healthcare practitioners to avoid being the causes of harm to patients and others. It is the oldest and primary principle of the medical ethics found in the writings of Hippocrates, a Greek physician born in 460 BCE, which dominated the practice of medicine in subsequent centuries. Though contemporary bioethics has preserved this ancient principle, because of the growing power of medical intervention and the cultural drift away from unitary conceptions of human good and harm, nonmaleficence as a principle has been placed on equal footing with the principle of autonomy.

The principle of autonomy recognizes the importance of the values and wishes of patients in determining the direction and extent of medical interventions. The principle is clear enough for the competent patient with full capacity to understand the consequences of a choice among the alternatives offered by medicine (including the possibility of no action). This principle is the basis for the requirement, in both medicine and research, of *informed consent*, generally interpreted as a requirement to present to the patient or subject the proposed treatment or research protocol, the alternatives that fall under standard practices of the profession for the malady or injury in question, and the potential consequences of each alternative and their likelihood of occurring. Patients may then, with assistance, compute the expected value of each alternative and its probable consequences weighted by their own personal values. Healthcare professionals, given the patients' choices, may then elect to comply or to leave the therapeutic relationship (under certain conditions), thereby preserving their own autonomy. In the research context, potential subjects must be provided with explanations of the research protocol and its attendant risks given in language appropriate for the individual's level of education and must be provided with the opportunity to exit the protocol at his or her choosing.

But the capacities of many patients are severely diminished—by dementia; by psychoses and neuroses; by infancy or youthfulness; or by coma, persistent vegetative states, and other neurological disorders. For such patients, concurrent informing and consultation is usually not possible; various alternative strategies have been devised that seek to make an approximation of the patient-centered decision process. Advance directives given formally to caregivers or through written documents, or informally to friends and relatives, are typically sought. Where they cannot be found, substituted judgments based on what is known of the patient's values and beliefs are often sought. Where those are unknown or insufficient, various rational-person standards, either culturally explicit or culturally neutral, are

employed. The ethics committees of hospitals and other institutions devote much time to grappling with these difficult decisions, which are often complicated by the emotions, interests, and values of family members, friends, and healthcare providers. Sometimes this spills over into the public arena accompanied by the posturings of politicians and special interest groups. The now-infamous Terri Schiavo case illustrates how explosive these decisions can become.

The principle of beneficence provides both the general motivation to provide medical services to patients, and for seeking to advance medical practice through basic and applied research. Beneficence is understood as implying both a duty to remove and to prevent natural harms, and—more controversially—a duty to provide positive enhancements to ordinary lives. Beneficence as harm prevention prompts widespread vaccination and inoculation programs; beneficence as harm removal prompts research into development of new surgical techniques, artificial organs, prosthetic devices, and even of fields such as genomics and proteomics in order better to understand and adjust treatment to the individual's responses to potential therapies. Beneficence as enhancement prompts research that aims to improve the individual's naturally occurring qualities, including selection of characteristics in potential offspring, the use of surgery and other treatments to augment appearance through implants and various injections, and even off-label uses of steroids and other drugs and techniques to enhance performance of athletes. This third, most controversial type of application of the principle of beneficence arises out of what has been called the technological imperative, the position that what is technologically possible ought to be tried. It further reflects the pressure of a society that funds medical research and education in order to serve more than just its health needs as traditionally conceived.

Finally, the principle of justice seeks to remind practitioners—as well as the social and economic constructs that cover the costs of their services—that fundamental respect for human dignity requires that at least basic medical services be available to all, regardless of any patient's ability to pay for them. Further, the principle of justice requires that the burdens of research be borne by the full range of individuals who have the potential to benefit from its results, and not by elements of a society that, because of particular vulnerabilities, present tempting populations for exploitation. This principle is thought by some to imply a moral requirement for universal health insurance; minimally, it implies an obligation on the part of hospitals and providers to provide treatment in emergency situations without regard to the patient's ability to pay.

Bioethicists generally agree on these principles, although some caution against applying them too rigidly. They may cite the enormous variability in human circumstances, social structures, and belief systems as rea-

sons why reasoning based on principle is often inadequate to the problems of bioethics. Others insist that the goal of bioethics ought not to be to articulate principles and rules underlying bioethics, but rather to articulate the qualities of character, or virtues, required of good physicians and other healthcare professionals. But the greatest disagreements within bioethics are rooted in the background metaphysical presuppositions and beliefs held by the practitioners of bioethics.

**Religious Approaches.** Religious traditions locate the warrant for the principles of justice, beneficence, non-maleficence, and autonomy in natural rights: that is, rights of humans arising from their natures as creatures of a supreme being who is often characterized in terms of analogies with human roles. Thus, the supreme being is characterized as a lawgiver, a father to human children, and an all-knowing, omnipotent, perfectly good being. Many traditions teach that this being is engaged in a struggle with a powerful but malevolent lesser being; human disease and suffering are often laid at the door of this diabolical one. So on the religious view, the warrant for bioethical principles lies in the nature of humans as creatures of a supreme being, beings who possess free will and who reside in a world characterized by the evil machinations of a would-be tyrant; in such a world, the mandates of medicine lie in that profession's efforts to ameliorate suffering and restore health as the natural and optimal state of a creature in a theocratic struggle between good and evil. Even without the postulation of satanic forces, traditional religious bioethics recognizes the tension between what humans may will or wish and what is acceptable to their creator. The *rapprochement* between religious and secular ethics has often turned on the question of what it is that makes the supreme being's wishes good (see ETHICS AND UNBELIEF). If that being wills something *because* it is good, then there must exist a standard for good that preexists and is independent of the divine will, some standard which is potentially as discoverable by reason as it is through revelation.

**Nonreligious Approaches.** Various nonreligious traditions provide a range of options for grounding bioethics. Utilitarians generally accept the primacy of pleasure or happiness for humans as a universally shared, primary motive, and see the pursuit of scientific knowledge and technology as serving the maximization of happiness and the minimization of suffering through a common duty of all humans. That common duty to produce the greatest balance of benefit over disbenefit for all those affected by your actions is itself explained in various ways: through a theory of natural moral sentiments; through an analysis of the logic of the nature of each human as a rational, purposive agent; or through a sober agreement to constrain self-promotion in recognition of the dangers of such a policy gone rampant.

Hence, there is no general ethical theory of unbelief, unitary in its core assumptions, that can provide a single positive account of the principles of bioethics. Part of the

genius of Beauchamp and Childress's work lies in the effort to settle on a common ethics of healthcare *despite* the diverse origins of its principles in various religious and nonreligious traditions. In a pluralistic society, such an achievement is an admirable lesson in mutual respect and cooperative accommodation.

**When Religion Matters.** Nonetheless, there are two major arenas of bioethics in which the presence or absence of religious presuppositions seems to make a major difference in conclusions regarding how medicine ought to comport itself, and regarding what is to be regarded as morally permissible in options offered to patients. One is the arena of conception, with its attendant issues of abortion and fetal stem cells. The other is the arena of death and dying. That is, at beginning and ending points of human life, we find that prior religious metaphysical assumptions typically result in the advocacy of markedly different outcomes from those advocated by persons whose values are not grounded in religiously dictated beliefs.

The metaphysical presuppositions of religiously guided bioethics are typically associated with the concept of the presence of a *soul*, a hypothesized entity held both to explain the orderly development of the unique qualities of the human being through gestation and maturation and to tie the mandates of religious commands to eventual consequences of reward or punishment. A common position is that the individual's immortal soul is present within the body from the "point" or "moment" of fertilization until the "moment" of death. From this premise, together with the assumption that fundamental human rights are bestowed on every being with a soul, it follows that the right to life is present from the very earliest point of human development. Hence, any action that destroys the resultant embryo, whether in an act of abortion or in pursuit of stem cells for research or medical treatment, is a violation of the individual human being's right to life.

Associated rights to being conceived in a natural way—that is, between married parents who experience the unitive and procreative aspects of sexual intercourse—are found in the religious and metaphysical presuppositions underlying much of religious bioethics, a view conspicuously espoused by the then-cardinal Josef Ratzinger, now Pope Benedict XVI. From these doctrines arise the standard prohibitions against contraceptive-preventive measures insofar as these are conceived as thwartings of divine purposes.

**Dilemmas of Twinning and Cloning.** Those holding such a religious view must make various ad hoc arrangements to handle such issues as twinning and cloning. If future persons are endowed with souls at the earliest moment of conception, how are cases in which later bifurcation will occur held to be accommodated? On the most "conservative" view, a fertilized ovum that is destined later to become twins has two souls infused into it at fertilization, as recently argued by Rose Koch. A fer-

tilized human ovum not so destined cannot be made into twins; the fact that fertilized ova of other species are capable of such artificial cleavage into twins is not evidence of such possibilities for humans, as it is the infusion of the soul (presumably, solely an endowment of humans) that completes the individuation of the human embryo into a given person.

Somewhat surprisingly, this view implies predictions that make it, at least in the version as described, capable of being tested—although the ethics of attempting any such test poses deep difficulties for the religious viewpoint. First, given that a particular embryo not destined for twinning has already been endowed with but a single soul, it should not be possible to subject that embryo to an artificial process of twinning—that is, to render it mechanically into two or more undifferentiated bundles of totipotent cells each of which can then proceed through normal gestation and development. For the role of the unique soul is to produce a unique individual; even in the case of natural identical twins, the view is that they are preordained to emerge by some supernatural power that foresees, if not determines, the twinning; in such cases two souls are associated from the start. Given other assumptions about the independence of human action, a deliberate, artificial twinning should be physically unable to produce two viable offspring. Conversely, if such an artificial twinning were successfully to occur, that would constitute evidence that a single, indivisible soul had not been associated with the embryo from its earliest stages.

Second, given that two embryos each have an individual soul implanted within from the earliest stages of development, it should not be possible for those embryos to fuse and produce a single individual. Ad hoc adjustments are, of course, possible even here; one might hold that in the case of natural fusion, the fused individual was preordained and one of the embryos lacked the requisite soul, or perhaps lost it in the process of fusion. But the possibility of artificial fusion, given the standard assumptions about human authority for human actions, would imply that this ad hoc adjustment could not be extended to artificial fusion. That is, given two embryos each with a soul, it ought not to be possible for them to be deliberately fused into a single ball of totipotent cells that can then become implanted and develop into a single human being, albeit with some untypical characteristics: perhaps both male and female external sex organs, perhaps two distinct blood types, and perhaps with different cells in the same organ or tissues showing XX and XY chromosomes. That such chimeric humans occur naturally is beyond dispute.

Finally, the possibility of cloning an individual human from the somatic cells of another human, thereby bypassing the process of fertilization altogether, places yet another burden on the proponent of traditional religious ontology. Should the cloning of human cells eventuate in an embryo, the question of when a soul is

infused becomes even more tenuous. The soul associated with the individual from whom the skin cell was taken presumably remains with that individual; also, nothing occurs that is like the union of previously disparate genetic material which is traditionally held to constitute the creation of the receptacle for the soul. Again, an ad hoc adjustment in the account is necessary, and again human agency challenges the theocentric account of the creation of unique individuals.

The view that humans are possessed of a divinely given soul characterizes the differences between religious bioethics and the bioethics of unbelief as well. Traditionalists reject the idea that your life is your property, with the consequence that, under conditions of extreme suffering and despair, ending it actively—with or without the assistance of a physician—is morally impermissible. This prohibition stands with the notion that, as creatures of a supreme being, we live at his pleasure in accordance with his plans, and that we therefore lack the authority—outside of self-defense justifications—to end our lives. In its most extreme forms, religious bioethics even prohibits killing a fetus to save the life of the mother where the threat to the mother's life is innocent of malevolent intent. Only where normal medical treatment, such as the necessary removal of a cancerous uterus, foresees but does not intend the death of the fetus is a medical act resulting in death permissible. On the traditional view intentional suicide and active euthanasia are always impermissible; under some conditions, withholding burdensome treatment that prolongs dying but does not hold significant promise of cure or return to meaningful activity is permissible even if death is thereby hastened, as is treatment of suffering where such treatments may have, as a foreseeable but unintended consequence, the hastening of death.

**Implications of Unbelief for the Value of Human Life.** Divorced from the trappings of religious metaphysics, mere human biological life—where the human person has either not developed or is no longer functional—comes to have at best only utility value. Tempting though it is to attach great significance to the potential for the emergence of personhood, that significance is typically tempered by considerations of probability or likelihood of successful emergence, by costs to those charged with its development, and by the prognosis for the potential human person's burdens and capacities. The utility value of the earliest states of human existence and the final stages lies with their potential as sources of organs and tissues for transplantation and research. Absent a person in whom there is a socially principled recognition of rights, it makes no sense to speak of a right to life that overrules other interests.

Among nonbelievers, there still remain substantial divisions over what is permissible in these arenas of medical decision. Some secularists have seized upon the potential of abuse in legalized physician-assisted suicide, holding that the dangers of creeping justifications

and social pressures endanger the interests of the elderly and the handicapped. Organizations such as Not Dead Yet have opposed liberalized laws, such as that in Oregon, which permit physician-assisted suicide under defined conditions as an open door to unscrupulous nursing home operators and weary family members eager to unshoulder their burdens. Often these protests lose sight of the far wider burdens to patients of an inescapable status quo, and the medical community has been slow to respond to calls for better management of patient suffering.

Nonetheless, unbelievers generally claim a right to determine, for themselves, the time and manner of their deaths. Articulate individuals such as those depicted in the film and play *Whose Life Is It Anyway?* have advanced a powerful challenge to traditional attitudes toward unwanted life, advancing the thesis that the autonomous individual with capacity should have the choice between ending life while still with capacity, having life ended after capacity is lost but while organic life is still ongoing, and allowing the process of dying to run its natural course with or without artificial extension. Physicians such as Timothy Quill and Jack Kevorkian have responded to the requests of their patients for greater control over the end of life in a variety of ways. While, due to various complexities in the physician-patient relationship, the results have not led to federal courts recognizing a general right to assisted suicide, the effect has been to return legislation on these issues to the states, allowing for the effective emergence, state by state, of policies and practices reflecting the will of the majority of voters.

Regulation, not prohibition, has emerged as the key to avoiding a slide from the abuses of prolonged dying into abuses of hastened dying. The Oregon Death with Dignity law, now in place for nine years, has seen a gentle increase in the use of physician-prescribed lethal medication by patients with terminal diagnoses. So far in Oregon, only patients with decision-making capacity have been allowed to receive such terminating measures. In Holland and other European countries that have also permitted physician-assisted death, somewhat looser standards have seen the practices extended to formerly competent patients who have elected termination to be initiated after losing competence; in some cases euthanasia has been practiced on the assurances of family members that such is consistent with patient wishes, even if not formally recorded.

These and similar considerations have led ethicist Peter Singer recently to predict that, in the next thirty-five years, the traditional view of the sanctity of human life from conception will collapse and be replaced by a concept of personhood that will assume the primary role in questions of ending human life. Mere membership in the species *Homo sapiens* will not be the ground of rights, but rather possession of the qualities of personhood that make in the intact person for autonomy and the

possession of morally significant interests. Singer writes: "We will understand that even if the life of a human organism begins at conception, the life of a person—that is, at a minimum, a being with some level of self-awareness—does not begin so early. And we will respect the right of autonomous, competent people to choose when to live and when to die."

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RICHARD T. HULL

**BIRTH CONTROL AND UNBELIEF.** Though various methods of birth control have been tried throughout history, those methods were not usually mentioned in medical literature. Rather, they were more or less secret information, passed from midwives to their patients or even from woman to woman. Such knowledge was often thought to depend upon witchcraft, and some women were scapegoated for possessing alleged knowledge of ways to prevent pregnancy or induce abortion. In Western culture, this became particularly the case after Pope Innocent VIII, in a bull, or policy statement, issued December 5, 1494, stated it had been called to his attention that members of both sexes were using incantations, charms, and conjurations to "suffocate, extinguish, and cause to perish the births of women" or to "impede the conjugal actions of men and women." Such alleged practices came to be associated with witchcraft, and witches came to be viewed as the causes or sources of impotence, infertility, abortion, and preventing pregnancy. In the case of birth control, the witches were said to have secret recipes for emmenagogic medicines—recipes believed to stimulate the menstrual flow and bring about miscarriages—or, in stronger words, abortions. Some seventeenth- and eight-