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Loma Linda University Center for Christian Bioethics

LOMA LINDA UNIVERSITY CENTER FOR CHRISTIAN BIOETHICS

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Provonsha on Religion and Bioethics

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Jack Provonsha was not a prophet, but often he spoke prophetically. Twenty years ago, in an article titled "Religion and the Bioethical Enterprise," he described the prospects of bioethics thus: "Bioethics as an infant progeny of ethics has already largely taken over the house as infants are prone to do. Bioethicists are multiplying and new bioethics centers are appearing almost monthly. There is no question that these issues are fascinating."[1]

Today the infant is an adult and by its rapid international outreach has made the global village a little smaller. No matter what country or continent you visit, the march of a universal medicine and technology crosses all national borders and makes bioethics an international phenomenon. Conferences are being held in all corners of the world with philosophers, theologians, social workers, lawyers, and physicians grappling with such universal problems as the status of the embryo, stem cell research, cloning, euthanasia, etc. Thus, the latest development in the field of bioethics can be described as follows: while the problems of bioethics encountered are universally the same, solutions to those problems differ markedly from culture to culture. Good and bad, right and wrong, have different meanings for different people. The universalization of bioethics has shown the fragility of our monolithic, God-given notions of "basic human values." Muslims in Sudan consider it disingenuous for practitioners of male circumcision to call clitorectomy evil. Suicide is sinful for Americans, but not for Japanese. Thus religion, in tandem with economics and politics, exerts enormous power in shaping bioethics in various countries. Bioethics speaks in several tongues, yet those who have grown up in America are mostly monolingual. Given the nature of their infrastructure, it is high time that bioethicists in this country become culturally bilingual if they are to take part intelligently in what has mushroomed into a bioethical internet.

In the body of this paper I will try to make the case for the inclusion of religion at the table around which the bioethical conversation takes place, but first it is necessary to address some objections to this move.

First, a brief historical sketch. Two hundred years ago America's founding fathers made a constitutional separation of church and state. A person's religion was deemed his own private affair, and played no part in public life, no matter how big and powerful the religion. From the birth of the nation, secularization was the hallmark of American society, and notwithstanding efforts to introduce prayer into public schools, or erect the Ten Commandments in state courthouses, the wall of separation has survived to this time.

This means that when the discipline of bioethics was born some 40 years ago, it was developed as a secular discipline. Ironically,

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its early leaders were Christian theologians, such as Joseph Fletcher and Paul Ramsey, but as members of a secular society they abjured sectarianism. According to Daniel Callahan, co-founder of the Hastings Center, bioethics only gained public acceptance when its ties with religion were severed. Acting in a diverse cultural situation, it adopted a different kind of moral language—a language of rights that seeks moral consensus. Philosophers were preferred to theologians as proper specialists in the field, unless the theologian agreed to leave his faith at the door. In the public arena, faith was seen as divisive and subjective, while philosophy and reason were respected for their objectivity and impartiality.

Among the reasons for the exclusion of religion from bioethics is the criticism that religions are rooted in antiquity and therefore cannot supply guidelines for contemporary problems. Jack Provonsha tackles this objection by first conceding that:

> Given the fact that so many of our bioethical questions were spawned by the technology of the late 20th century, one should probably not expect very many helpful answers from religious traditions formalized long before anyone dreamed about genetic engineering, xenografts, *in vitro* fertilization, embryo transfer, and fetal surgery. The Old Testament knows of surrogate parenting, but what of total life support, TPN, hemodialysis, pacemakers, ventilators, and when to start or stop them? What of health care equity and cost-benefit effectiveness?[2]
>
> Institutionalized religion also has lost much of its traditional effectiveness as the repository and vehicle of moral values transmission. In disturbing ways each generation has tended to become now oriented, isolated from both the past and future. On these terms religion and bioethics might seem to have very little to do with each other.[3]

However, Jack follows his concession with the observation that:

> In the Western world, Judeo-Christian presuppositions do mightily inform such questions. The very existence of the biomedical science that poses the questions derives from the Judeo-Christian premises. It is no accident that science flourished in that portion of the world most influenced by biblical monotheism. The "oneness" of reality and the sense of order that…monotheism implies, gave to science its philosophic foundations, including its optimistic affirmation of the world. The Creator had said, "It is very good."[4]
>
> That affirmation also conditioned man's attitude toward fellow creatures. Humane treatment of animals, for example, even while granting priority to man…is the logical development of a positive view of nature. Animal experimentation will always be a matter of serious ethical concern in such a conceptual setting.[5]

A second reason for the exclusion of religion from bioethics is that it is divisive. This becomes apparent in a common practice of journalists intentionally to concentrate on the moral dimensions of medical stories, rather than on their religious side. The rationale is that moral positions can be argued on their merits from both sides, whereas religious positions are merely the settled judgments of faith. This preference is illustrated well in the Karen Anne Quinlan case where the religious angles were not touched upon—that Karen was a Roman Catholic and that her parents sought advice from the church and from major Catholic ethicists.

It must be admitted that some denominations prefer to defend institutions and creeds, and appear fearful to pursue the truth; but these are exceptions to the rule. Most theological ethicists are not barricaded behind dogmas, even though they do draw upon and are responsible to traditions and communities.

Further, the so-called divisive character deserves fair comparison. Are the arguments of Platonists and Aristotelians, idealists and pragmatists, situationists and absolutists any less divisive than among Buddhists and Christians? Also, when the press covers conventions of anthropologists, sociologists, psychologists, and philosophical ethicists do they ever get the feeling that they are in battle zones of born-again Christians? We now turn to the main body of the paper which attempts to show the relevance of religion to bioethics.

First, religious traditions represent the collective wisdom generated by several thousand years of deep thinking on moral issues. They speak to our common humanity and address values that are unaffected by the march of time. They have developed universal ethical principles, such as the Golden Rule, or Do No Harm, found in all religions, which can be expeditiously adapted to the latest medical situation. Dr. Willard Gaylin, co-founder of the Hastings Center, observes: "The genetic age will transform medicine, but the questions we pose are the eternal questions of justice, human rights, suffering and freedom…. While the metaphors of medicine are creative and captivating, the questions are for all of us to ponder."[6]

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"Provonsha on Religion and Bioethics" continued…

Second, religions contribute to bioethics by teaching through their writings and exemplifying through their saints what it means to be human, and this, in the words of Jack Provonsha, "is what the bioethical enterprise is ultimately all about." He explains: "A conception of person as possessing the self-conscious capacity to control one's own behavior, to make choices, to determine one's destiny, to love, to interact socially, to be responsible, to be competent—qualities that distinguish human existence as more than merely being alive—derive from a biblical, Judeo-Christian way of looking at man."[7]

Third, the elements of motivation and sustainability are essential for any movement. Provonsha claims that through their affirmation of the transcendent dimension of human life, religions contribute these elements to the bioethics enterprise, which serves as a necessary corrective to merely secular interests. He acknowledges that struggling with bioethical issues can indeed be stimulating and fascinating, but in the face of the long haul "the capacity for maintaining that interest through the perplexing years ahead is more likely to characterize those whose commitment includes faith. So much about the answers to these questions is related to one's ultimate purposes as over against this-worldly professional goals."[8]

"...bioethics only gained public acceptance when its ties with religion were severed."

Fourth, the importance of religions for the bioethical enterprise comes out of their common origin in the human experience. People in all parts of the world and in every age face three fundamental problems: (1) how to maintain good health; (2) how to cure illnesses; and (3) how to delay death and reduce its attendant suffering. All three problems are of equal ethical concern to religion as to medicine. Religion and medicine are inescapably brought into dialogue when confronted with beginning-of-life issues such as procreation, genetics, abortion, contraception, fertilization, and birth. Religion and medicine are equally bonded when we face end-of-life issues: soul, sanctity of life, quality of life, aging, autonomy, dignity, caring, suffering, pain, and dying.

Fifth, we are witnessing a shift in the definition of the nation that is of far-reaching consequences. With almost no fanfare, the United States is experiencing its most dramatic religious transformation in this century. What has been a nation steeped in the Judeo-Christian tradition is fast becoming the most religiously diverse country in the world. More religions are being practiced in the United States than any place else. At least 200 denominations coexist in the country, and the numbers are growing. The impact promises to be as far-reaching as the rise of the Roman Catholic Church in the mid-1800s. Brought about by immigration, geographic mobility, intermarriage, and a growing disenchantment with older religious institutions, the shift is redefining the nation.

The United States is now home to nearly 5.5 million Muslims, just below the 5.9 million Jews; 1.4 million New religionists; 1.3 million Hindus; and 0.6 million Buddhists, among others. According to Huston Smith, the East and West are being flung at one another, hurled with the force of atoms, the speed of jets, the restlessness of minds impatient to learn ways that differ from their own.

Eastern religions can contribute to bioethics on several levels that complement or correct Western religious approaches. We mention a few:

- Eastern religious thinking is holistic. It views the person as an integrated whole and not just an aggregate of several body parts that are the domain of specialists.
- Eastern religions see the person as grounded in nature: a microcosm within the macrocosm. Diet, climate, soil, season, time, and place are all factors with which to reckon.
- Health and healing are regarded as acts of nature. In medico-moral terms, the natural is the good.
- Health is identified as a positive state, not just the absence of disease.
- Health is multi-dimensional: physical, mental, social, and spiritual. The person is apprehended as an individual, having a unique constitutional type, and as the bearer of an unmatched set of propensities and life experiences.
- Eastern religions give prominence to the notion of balance. They promote moderation in matters of sex and abstinence, food and drink, work and play, sleeping and waking, faith and common sense.
- Eastern religions view medicine as essentially preventive and promotive, elevating caring above curing.
- Longevity is not measured in number of days, but quality of time.

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- Death is an inevitable part of the natural process and is therefore not an evil to be fought at all costs. Death is the opposite of birth, not of life.
- Health is more than what the doctor does; it is a total lifestyle that carries on from cradle to the grave.
- Health is not the ultimate good but the penultimate good.
- Maintaining good health is a moral obligation, because only through a sound body and sound mind can one realize the divine within.

Finally, it is not our purpose to elevate one religious system over the other in its ability to contribute to the bioethics enterprise. The fact is that both Asian and Western approaches to bioethics possess unique strengths and stand to benefit by their cross-fertilization. Robert Oppenheimer wisely stated: "The history of science is rich in the example of the fruitfulness of bringing two sets of techniques, two sets of ideas, developing in separate context for the pursuit of truth, in contact with each other."[9]

Religion can contribute to the making of moral medicine, and can in that very act be transformed. Sometimes spiritual things are best scientifically discerned. Religion can bring the best of science out of science, and science can bring the best of religion out of religion. Anatomically speaking, both are joined at the hip. There is indeed a duality of labor, but a unity of spirit. Jewish theologian Abraham J. Heschel said it best: "The art of healing is the highest form of the imitation of God…. Religion is not the assistant to medicine, but the secret of one's passion for medicine." ■

REFERENCES

[1]Jack W. Provonsha, "Editorial: Religion and the Bioethical Enterprise," *UPDATE* (January 1986), Volume 2, No. 1

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[3]Ibid.

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[5]Ibid.

[6]Ibid.

[7]Ibid.

[8]Ibid.

[9]Ibid.

S. Cromwell Crawford, ThD, joined the University of Hawaii faculty in 1965 and has had a long and distinguished career as professor and chair of the department of religion. His publications focus primarily on Hindu bioethics, world religions, and global ethics. His most recent book, Hindu Bioethics for the Twenty-first Century, *was published in 2004.*

Editorial

We highlight two of our recent graduates in this edition of *UPDATE*. Warren Libby, DDS, MA, and Sarah Gebauer, MA, are stellar examples of the type of student that we are proud to have been involved in educating. Warren Libby is now practicing dentistry in Anchorage, Alaska, together with his father, also a graduate of LLU School of Dentistry. But life has certainly not settled into any sort of boring routine for Warren. He is a pilot, a commercial fisherman, and most especially a new dad! Congratulations to Warren and Cindy on the arrival of Ellison Tate Libby.

Warren Libby, DDS, MA, with newborn son Ellison

Sarah Gebauer now holds the position of coordinator, ethics services, in the Fraser Health Authority, the largest health care system in British Columbia, Canada! We are very proud of the fact that one of our graduates will be so important in the development of this position in British Columbia. Involved in both consultation and education services for the FHA, her position there is a tremendous testament to her capabilities as well as her time spent here at Loma Linda University. Congratulations Sarah, on a job well done and a job well found!

Our two articles in this issue of *UPDATE* are not closely related but nonetheless important topics for us here at Loma Linda University and around the world. Many have questioned the role of religion in the recent resurgence of interest in bioethics in America and elsewhere. No small measure of ink has been spilled over the issue. Some secular bioethicists have sought to marginalize those who approach bioethics from a religious or theological point of reference. Indeed, some have felt marginalized, needing to voice complaints.

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Sarah Gebauer, MA

Personally, I have never faced what I felt to be a prejudicial attitude toward my theological/religious approach to bioethics. I am certain that the tradition established by my predecessors and colleagues Jack Provonsha, David Larson, James Walters, and Gerald Winslow here at Loma Linda University helped develop our fine reputation across the country and around the world.

Furthermore, those who might argue that theological perspectives have little or no voice in bioethics today must not realize that many of the field's early leaders were theologians. One simply cannot fully address the literature in bioethics without reading essential works of theologians. What is particularly interesting about the article we have included in this issue is that it comes from the perspective of Dr. Cromwell Crawford. As a child of a British father and an Indian mother, raised and educated in India under the British system, he brings a unique perspective on this issue. He is a practicing Hindu and has studied and published on this issue from that perspective. We are privileged to have collegial relations with Dr. Crawford.

The article on aging research by Aubrey de Grey may seem a bit odd at first thought. Claims of dramatic increases in longevity are striking to hear when one has not read much in the field. Rest assured the research, is strong, accurate, and dramatic! We have grown used to hearing of dramatic possibilities in the field of stem cell research; being drawn into its promise and finding strong levels of assurance in its veracity. And while there are some who say the promise of stem cell therapies are way overstated, no doubt in the years ahead we will find many promising results. This will surely be true of the therapies that will result from biomedical research in aging as well. This is no new Tower of Babel that promises humankind an eternal life, but it seems appropriate to be excited about the possibilities of easing the often devastating effects of aging.

Finally, thank you to those who sent in additional financial support for the budget of the Center. We deeply appreciate it. ■

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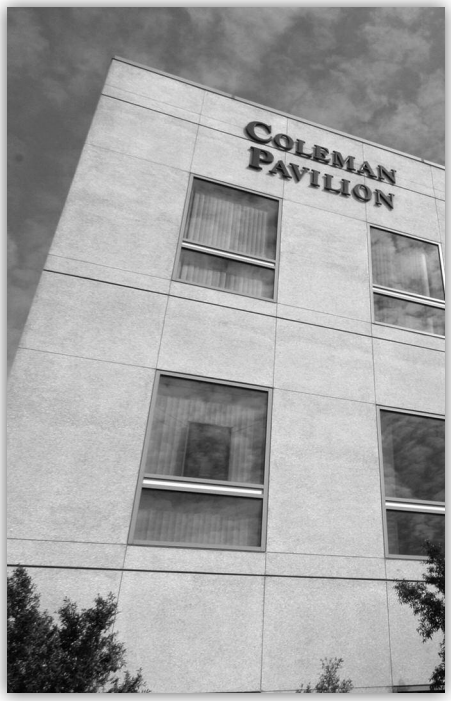

Coleman Pavilion, location of the Center for Christian Bioethics, as viewed from the west

The Urgency Dilemma: Is Life Extension Research a Temptation or a Test?

Aubrey D. N. J. de Grey, PhD
Department of genetics, University of Cambridge

The prospect of greatly postponing, or even reversing, the aging process has in recent years moved emphatically from the realms of science fiction to being science foreseeable. While many differences of opinion between experts remain concerning likely timeframes, an increasing number of specialists in the biology of aging (including the author) now take the view that we (a) know enough about the molecular and cellular basis of aging, and (b) possess versatile enough tools for modifying cells and molecules, that aging may well come within range of effective medical intervention within the lifetimes of many people alive today. In this essay I will explore some of the issues this raises for people in general and Christians in particular. I will focus especially on what I feel the Christian ethical framework says about the rights and wrongs of developing life-extension medicine and thereby postponing death.

The pro-aging trance

Anti-aging medicine is big business, despite being a blatant misnomer. Why is this, and does it matter?

The above questions will not form the basis for the bulk of this essay, but they are key aspects of the background information on which I will build. The fact that so many people choose to spend so much money on products that do not do what they are superficially advertised to do is a sociological phenomenon that we should understand, or at least explore, if we are to do justice to the issues that will be raised in the future by products and therapies that will more accurately be described as anti-aging medicine. Therefore, it is also key to any discussion of what we—Christians and/or non-Christians—should do today to influence the pace of development of those future therapies.

The quest for a "cure" to aging long predates Christianity—and so does our ambivalence concerning that quest. The tale of Gilgamesh is an obvious example. More instructive, perhaps, is the myth of Tithonus, the warrior who won the heart of the goddess Eos. Eos, who was of course immortal already, asked Zeus to make Tithonus immortal, and Zeus obliged—but Eos forgot to ask Zeus to make Tithonus eternally youthful, so he became frailer and frailer as time went on and eventually Eos turned him into a grasshopper. The relevance of this myth to the present discussion is the fact that it was invented at all (and has survived so well, even finding its way into popular culture such as "The X-Files"). The idea that if we extend lifespan we will necessarily do so by keeping frail people alive, rather than by keeping youthful people youthful, is of course ridiculous in principle and could never be introduced in rational debate, yet here it is introduced by the back door through a story. The message being surreptitiously conveyed is that postponing aging is tempting but ultimately a bad idea, even though we can't quite put our finger on what's bad about it. Evidently this is a message that we subconsciously like to hear, or else the myth would have been forgotten long ago.

The anti-aging industry has many of the same features. The actual, specific claims made for products that form the anti-aging industry are modest—as they must be, given the lack of evidence to support anything more robust. But the slipperier language that is given prominence on packaging and advertising is another matter entirely, including phrases such as "grow younger." This is possible mainly because aging is very hard to measure, and vendors know that advertising language is only illegal if it can be proved to be false, rather than if it cannot be proved to be true. But as with the "Tithonus error" (as it has come to be known), this ambiguity seems to be a positive attraction to the general public, who seem to like to suspend disbelief enough to engage in cosmetic efforts to combat aging, possibly comforted by the back-of-the-mind knowledge that they are indeed merely cosmetic. The alternative interpretation that most purchasers of "anti-aging" products truly believe they will live much longer as a result is, I feel, too harsh an estimation of the typical consumer's acumen.

In summary, my answer to the first question I posed above—why is anti-aging medicine big business?—is that society is deeply conflicted concerning aging, on the one hand recognizing that it is a curse to be combated, but at the same time shying away from all-out determination to combat it, for reasons that it cannot adequately crystallize. So to my second question: Does this matter?

If we take the view that modest postponement of aging is all that humanity will ever achieve by medical means, there is a good case that this incongruous attitude does not matter—indeed, that it is positively rational. Quite apart from the point

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that adults are entitled to spend their money on whatever they like so long as they are not palpably misled into doing so, and that the anti-aging industry is hardly alone in rose-tinting the efficacy of its wares, we must acknowledge that when faced with a fate that is both ghastly and unavoidable, there is a certain logic to putting it out of one's mind so as to make the most of what time one has left. Once this is accepted, we can go further and note that since such people are in the business of psychological self-management, it does not actually matter how irrational are the lines of reasoning that they may resort to in order to achieve that objective. In short, humanity's tendency to cling to the Tithonus error and its friends is a perfectly reasonable, rational response to the inevitability of aging. I have termed it the "pro-aging trance."

However, as soon as the inevitability of aging begins to look a little less certain, the above logic collapses. Worse, the depth of the pro-aging trance means that what was once a valid psychological strategy is transformed into an immense barrier to reasoned, objective debate concerning the desirability of postponing aging. This is why, as a fairly high-profile member of the life extension research community, I currently spend as much of my time on the social context of this field as on the science. Thus, the answer to my question "does the anti-aging industry matter?" is, in a nutshell: "It used not to matter, but now it matters a great deal."

"I feel that Christians face a particularly formidable challenge to reasoning objectively about the merits of life extension."

Thus far I have discussed the attitudes of society in general and have not addressed issues that might relate specifically to Christians. The latter will be the focus of the remainder of this essay. As will be seen, I feel that Christians face a particularly formidable challenge to reasoning objectively about the merits of life extension. Paradoxically, however, when that challenge is overcome, it can be seen (or so I shall argue) that the imperative to do all one can to postpone aging is even more profound for Christians than for those who do not look forward to the prospect of God-given immortality.

Indefinite life extension and immortality: an unfortunate confusion

Aging is a side-effect of living. The immensely complex network of biochemical processes that maintain our bodies in a fully functional state until middle age has side-effects, some of which build up throughout life. This molecular and cellular "damage" is initially harmless because our metabolism is able to work around it, but eventually it becomes abundant enough that metabolism is impaired and physical and mental decline ensue. There are seven main types of damage, encompassing cell loss, mutations, indigestible molecules, and stiffening of elastic tissues.

My work focuses on the development of therapies that will repair the various types of damage just mentioned. Others in the life extension research field are focusing on therapies that do not seek to repair pre-existing damage but instead to slow its subsequent accumulation. Repairing damage may sound harder than pre-empting it—after all, prevention is usually better than cure—but in this case it turns out, in my view at least, that while preventive measures are ideal in principle, truly effective ones are not in sight, simply because our understanding of the immense complexity of metabolism is still so superficial that we have no foreseeable prospect of designing interventions that do not do more harm than good. Additionally, of course, repair therapies can in principle rejuvenate those who are already suffering the effects of aging, whereas retardation therapies cannot. This is not in any way to say that retardation therapies are useless, but it does mean that they should be pursued mainly as potential adjuncts to rejuvenation therapies.

There is another difference between repair and retardation that must be emphasized at this point. Just like all other pioneering technologies, life extension technologies will be highly imperfect when they first arrive and will be progressively improved thereafter. For both repair therapies and retardation therapies, this means that the benefits someone can expect to obtain from access to the latest advances will exceed what they would get from the first therapies they receive. But this disparity is much more pronounced for repair therapies. In fact, it is highly likely that, once repair therapies exist that can confer 30 or so extra years of youthful life on those who are in their 50s or younger when the therapies arrive, the rate of improvement of the therapies will outpace the rate at which the types of damage that are not yet reparable are accumulating. In other words, even though aging will still be happening in the sense that damage is being laid down, and even though the problem of eliminating more damage is getting more difficult (because the easy types of damage have yielded to the

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already-developed therapies), the overall amount of damage in these people's bodies will be declining: they will be getting progressively more youthful, and further from the prospect of dying of old age. This therefore constitutes indefinite life extension—indefinite maintenance of the probability of dying in the next year at a level typical of young adults.

I have called this situation "longevity escape velocity." I think that is quite a pithy, evocative phrase—it captures the idea that there is a threshold rate of progress beyond which a qualitatively different end result occurs, and the use of "escape" (from aging) seems apposite. However, despite my best efforts, the media predictably describe my work as an attempt to engineer "immortality."

Let me, therefore, be quite clear: That description is erroneous. Immortality is not what I'm engineering. Aging is one cause of death—a very common one, to be sure, killing roughly twice as many people worldwide as all other causes of death combined, but still just one cause. If aging was eliminated, we would in many ways be restoring our lives to the state they were in a few thousand years ago, when death from infections, starvation, and violence were each considerably more common than death from aging: Death would still occur, but the likelihood that you would die in the coming year would not be strongly influenced by your age.

The above answers the first key question that arises whenever the concept of indefinite life extension is discussed—that such work constitutes "playing God," depriving God of His right to decide when we should die. It quite clearly does nothing of the kind. Whether you die of aging at 80 or of being hit by a truck at age 800, God's influence over that event is the same. So when you see my work and similar efforts being described as engineering immortality, I hope you will count to 10, remind yourself that that is simply journalistic hype, and read on in the knowledge that what I actually seek to engineer is the elimination of one major cause of death.

Aging doesn't just kill people, it kills them horribly

Having disposed of an issue that is terminologically problematic but logically (and thus ethically and theologically) simple, I now turn to issues that are of more substance. In this short section I will discuss the pros and cons of various causes of death from the point of view of the suffering associated with them, and in the next section I will discuss some aspects of life extension research that I feel are wrongly thought by some to be relevant to the ethical (whether Christian or otherwise) status of that endeavor. That will conclude the groundwork for my discussion in the final section of the "urgency dilemma" to which the title of this essay refers—a dilemma that applies specifically to those who believe in an afterlife.

Death before the age of 60 is now relatively rare in the developed world—rare enough that when a friend dies that young we typically consider it a great loss (whether to us, to their family, or to the world in general). Conversely, when someone dies in their 80s, people tend to take the view that he or she had a "good innings"—there is a sense that the loss is somehow less. Is this rational?

I would like to suggest that it is not rational, because it neglects the fact that death at an advanced age invariably follows an extended period of physical decline, and usually mental decline too. That decline varies greatly in its severity and duration, to be sure, and the stated aspirations of many biogerontologists are centered on minimizing both those variables. But as compared to the severity and duration of the decline associated with death from age-independent causes, it is immense in almost everybody. And decline means suffering—for the individual concerned, for their loved ones, and even (in a more low-grade way) for society in general, which allocates resources to modestly alleviating that suffering and thus increases suffering of others through lack of those resources. The suffering caused by the shock of losing a loved one in a fatal accident is meaningful, certainly, but it cannot and must not be considered to outweigh the aging-derived suffering just described—it does not compare.

A hasty perusal of the preceding paragraph might lead you to believe that I favor the banning of seat belts and crash helmets and, more generally, the compulsory adoption of highly risky lifestyles in order to minimize aging-related suffering. Of course I favor no such thing. I favor the bringing about of a shift in the causes of death, so that fewer people die of old age and more die of accidents, but I favor doing this by enabling people to stay biologically young and thereby avoid dying of old age, not by raising the risk of having a fatal accident in any given year. In this way, the suffering of aging will be eliminated. There will be a modest side-effect, however…we can expect to live at least 10 times as long as we do today.

Action, inaction, and urgency

I hope by this point to have reminded you that aging is rather a pity. What I will discuss next is where it objectively ranks in the canon of things that are undesirable and against which we have reason to expend our effort. As noted, I will not yet move to arguments that apply specifically to Christians.

One aspect of this issue that is often raised is whether action and inaction are morally equivalent. The logical position here is blindingly clear: If you're not doing something,

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you're doing something else, so there's no such thing as inaction, only choices between actions. Hence, if it's wrong to cause suffering by an action that directly inflicts it, it's also (and equally) wrong to cause that same suffering by an action that you do instead of an action that alleviates it. But there is a good reason why this question comes up so much: However clear it may be that action and inaction are logically identical, they are very far from identical psychologically. It's emotionally easier to pass by on the other side and put someone's suffering out of your mind than it is to cause the same result by actually doing something. Or conversely, it's easier to find the strength to refuse to do something that causes suffering (but which has some upside for you) than to find the strength to "act" to alleviate the suffering when "doing nothing" would have that upside. But being easier doesn't change the ethics of the situation.

Another way in which some influences on suffering might appear to differ importantly from others is the time that elapses between the action (or "inaction") that alters the suffering and the actual outcome (the occurrence or otherwise of the suffering). Intuitively, one may feel that priority should be given to alleviation of more imminent suffering, because there will be time to work on the more delayed potential suffering afterwards. But this is only correct if the opportunity to alleviate the more delayed suffering will still exist at that later time, and it may not: Events may be beyond one's control unless one acts now, even if those events will take time to unfold. In many real-world situations this is not a particularly important argument, because events that are a long way in the future almost always can still be influenced even if one attends to more urgent matters first. But there are exceptions.

The exception I'm thinking of—one to which my action/inaction point also sharply applies—is, of course, postponement of aging. On both counts, even once we appreciate that aging is the cause of immense suffering and thus should be combated, we are in danger of deprioritizing the postponement of aging in favor of other good deeds, either because those good deeds are not deeds so much as the avoidance of bad deeds, or because the suffering that we can alleviate in other ways is imminent, whereas any attempt (however concerted) to postpone aging will certainly not achieve its objective for at least a decade or two and probably longer. It is thus imperative to understand that, as I have just explained, these apparent justifications for leaving aging unchallenged are not ethically sound.

"...such work constitutes 'playing God,' depriving God of His right to decide when we should die. It quite clearly does nothing of the kind."

The urgency dilemma

The urgency that I discussed in the last section, i.e., the importance (or not) of prioritizing the alleviation of imminent suffering—is not the urgency to which I refer in the title of this essay. The urgency in the title concerns the afterlife.

For all those who believe in heaven, or that the soul survives after the body is gone, or that God will in due course make his chosen people immortal, or any other variant on this theme, death is the beginning of a new life that is incomparably more, well, heavenly than this life ever was. Thus, from a selfish point of view, the sooner death comes, the better. The fact that it's from a selfish point of view is the stumbling block, of course: Selfishness is a sin, so engineering one's own premature death might not have the desired effect.

But what does a belief in a better life to come mean for one's desire to postpone aging? For some devout Christians with whom I have discussed this issue, it means rather a lot—but for very poor reasons. Specifically, it causes them to view the postponement of aging as a double-edged sword: They accept that it would alleviate suffering, but they note that it would also postpone bliss, so they see it even less as a priority than others do. Added to this is that the action/inaction argument often features in these discussions, despite the clear relevance of the parable of the Good Samaritan.

So I come, at the end of this essay, to the question in its title. Is life extension research a temptation for those of faith—something that would be sinful, taking control of a matter that should be God's prerogative—or is it a test, something that we should energetically embrace even though it will postpone our entry into the kingdom of heaven? It seems incontrovertible to me that the latter is the case—that by treating the prospect of the afterlife as a reason not to strive to combat aging, we are making a decision ethically no different from the person who commits suicide in order to reach God sooner. In some ways it is a more problematic decision even than that, because by committing sui-

Please turn to page 10

"The Urgency Dilemma" continued…

cide one turns down the opportunity to continue doing good in the world, but by not participating in the "war on aging" one is not only acquiescing in others' possibly avoidable suffering but also helping to deprive them of a longer life of doing good. These do not seem to me to be outcomes of which we are taught God would approve.

Conclusion

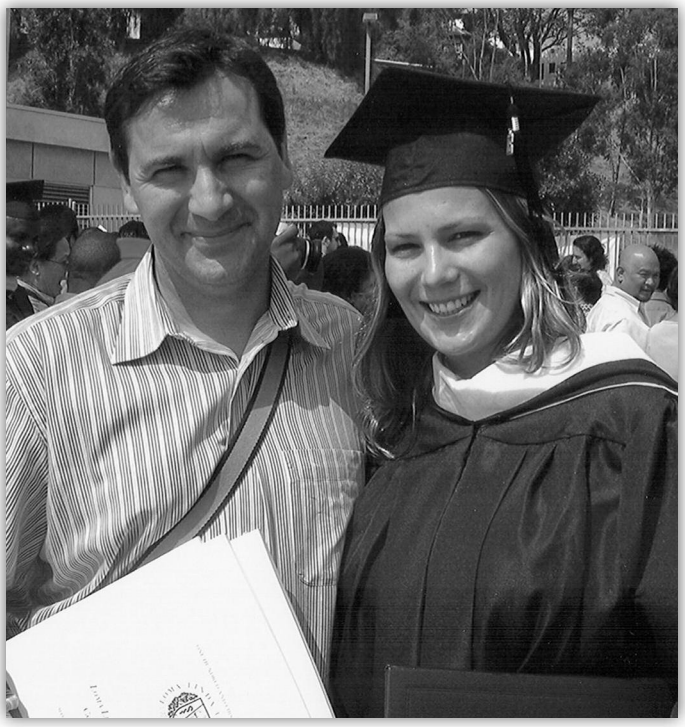
In this essay I have attempted to show that the popular belief that working to postpone aging would be "playing God" and thus sinful is in fact the exact opposite of the correct interpretation of Christian doctrine: In fact, it is a sin not to work to postpone aging. I have dwelt at length on issues that are not specific to Christians, such as the relationship between lack of aging and immortality or between action and inaction, for two reasons. First, without these underpinnings the argument that life extension research is imperative is weakened, whether or not one believes in the afterlife. Second, Christians are just as susceptible as others to the psychological traps that can make sinning easy; as such, it is vital to remind Christians that they are indeed traps, in order to give the inevitable conclusion that we have a duty to combat aging with our full force. By this essay I hope to have opened a few eyes to the horror of a phenomenon that humanity has always been so determined to ignore, and to the duty that I feel we all have to consider what we can contribute to the war on aging. ■

Aubrey D. N. J. de Grey, PhD, does biogerontology research while promoting the reversal of various aspects of aging to a broad range of audiences, reaching well beyond biologists in hopes of creating a "more proactive approach to extending the healthy human lifespan sooner rather than later."

2006 Biomedical and Clinical Ethics Master's Degree Graduates

There were two graduates of the biomedical and clinical ethics program this June, although only one could attend graduation ceremonies. We find the graduates of our program to be among some of the very best who graduate from Loma Linda University.

Graduate Warren Libby, DDS, MA, with wife, Cindy, and son, Ellison



Graduate Sarah Gebauer, MA, and fiance, Yannick

Changes for the Center's Bioethics Grand Rounds

Traditionally the Center for Christian Bioethics and the Center for Spiritual Life & Wholeness have collaborated throughout the year on Bioethics Grand Rounds. The Center for Spiritual Life & Wholeness sponsored one grand rounds session in the fall and one in the spring quarter. Recently, Mark Carr, PhD, director of the Center for Christian Bioethics, and Carla Gober, PhD, director of the Center for Spiritual Life & Wholeness, decided that more presentations dealing with wholeness were needed and thus was born the new Bioethics Grand Rounds, now known as the Health and Faith Forum.

2006–2007

Health and Faith Forum

Claritas: Exploring issues in ethics and wholeness across the disciplines

Wednesday, October 11, 2006
Sponsored by the Center for Christian Bioethics
Whitny Braun
Biomedical and clinical ethics graduate student
Loma Linda University

Wednesday, November 8, 2006
Sponsored by the Center for Spiritual Life & Wholeness
Paul J. Zak
Director, Center for Neuroeconomic Studies
Claremont, California

Tuesday, December 5, 2006
Sponsored by the Center for Christian Bioethics
Elizabeth Johnston Taylor, PhD, RN
Associate professor, School of Nursing
Loma Linda University

Wednesday, January 10, 2007
Sponsored by the Center for Christian Bioethics
William Hurlbut, MD
Neuroscience Institute
Stanford University Medical Center

Wednesday, January 24, 2007
Sponsored by the Center for Spiritual Life & Wholeness
Barbara Hernandez, PhD
Counseling and family sciences
Loma Linda University

Wednesday, February 14, 2007
Sponsored by the Center for Christian Bioethics
Andrew Klein, MD
Director of the Comprehensive Transplant Center
Cedars-Sinai Heart Center

Tuesday, February 27, 2007
Sponsored by Richard Rice, PhD, Religion and the Sciences
TBD

Wednesday, April 18, 2007
Sponsored by the Center for Spiritual Life & Wholeness
TBD

Thursday, April 26, 2007
Sponsored by the Center for Christian Bioethics
Willie Davis, PhD
Assistant professor, School of Pharmacy
Loma Linda University

Wednesday, May 16, 2007
Sponsored by the Center for Christian Bioethics
Andy Lampkin, PhD
Assistant professor, Faculty of Religion
Loma Linda University

All Health and Faith Forum presentations will be held in the Wong Kerlee International Conference Center from 12:00 noon to 1:00 p.m.

Going Electronic with *UPDATE*

Loma Linda University Center for Christian Bioethics *UPDATE* newsletter currently enjoys a readership of 5,000 and a mailing list of more than 3,500. In an effort to reduce the costs associated with publication of the newsletter, we would like to begin offering delivery of *UPDATE* electronically.

We would greatly appreciate a moment of your time to let us know which format of *UPDATE* you would prefer receiving by filling out the form below. Thank you for taking the time to let us know how we may better accommodate our readership in the future.

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Please tear off the completed form and return it in the envelope provided in *UPDATE*, or go to our website at <www.llu.edu/llu/bioethics> and click on *UPDATE*. You'll find an interactive form that you can fill out and e-mail to the Center for Christian Bioethics at <dpgordon@llu.edu>.

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