Medical Ethics and What it Means to Be Human

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Introduction

Modern science has impacted people’s lives in many ways, particularly when applied to medicine. Some of these advances have become common place, but others remain dramatic and awe-inspiring. The numerous hospital dramas on television attest to the popular fascination with high-tech medicine. Medical advances have radically changed the Western developed world, resulting in a whole new approach to health, illness and healing.

Ethical dilemmas sometimes accompany these developments. Resolving these dilemmas has led to profound social changes. Things once unheard of are becoming more and more commonly accepted. In many countries, abortion is commonly practised as a medical way to deal with social and personal problems. Some hold that certain behaviours can be modified better by drugs and genetics rather than counselling. Physician-prescribed overdoses and lethal injections are regarded in some places as valid alternatives to dealing with chronic illness, pain and death. With the limited nature of modern medical resources, the idea that some lives are not worth living is gaining acceptability.

New technology forces people to make profoundly important decisions about those they love. Parents have to decide whether to have their unborn children tested for genetic problems. If one is detected, they then have to decide whether to abort their unborn child. Couples who cannot have their own children have to decide whether to try the vast array of infertility treatments available. People with chronic, terminal illnesses have to decide how much technology to pursue. Ultimately, we have to decide whether to place “Do Not Resuscitate” orders on our loved ones.
These difficult decisions deal with the tough question: What treatment is best when someone is gravely ill or suffering? No answer to this question comes easily. However, people have traditionally thought this through in terms of what was medically best for the patient. In recent years, a totally different way of answering this question has developed. In some areas of medical research, and in the treatment of certain conditions, we are told we must first answer the question: What is the nature of this patient we are attempting to treat? In other words, is this human patient a human person?

We are thus in the midst of a change in how people view human nature. Discussions in medical ethics are leading many to conclude that some living humans are not persons. Those viewed as non-persons can be treated very differently to those we view as persons. In different cases, experiments can be done on these humans, or organs removed from them, or food and water withheld from them. A living human non-person is given the same moral status as a dead human person.

At the time of writing, 3000 frozen human embryos in British infertility clinics are awaiting destruction. In reaction, the Italian Cardinal Ersilio Tonini has appealed to families to adopt these same embryos. Debates over abortion often focus on the personhood of the foetus. As this debate intensifies in Ireland, more people will be asking how to determine when a human is a person. The 1995 Irish Supreme Court decision in the Ward case permitted withholding artificially administered food and fluids from a patient. In spite of opposition from the Irish Medical Council and An Bord Altranais, Ireland may be in danger of sliding down the same path taken in the United States. There is a movement towards viewing those at the edges of human life as no longer deserving of the same respect given human persons. How we resolve this issue will have profound consequences for how we view all humans.
Two Views of Personhood

Early writing on the topic of personhood in the context of medical ethics was published by Joseph Fletcher, author of the well-known book *Situation Ethics*. He viewed every situation as ethically unique, so we can never say that a certain act is always right or always wrong. One Irish medical ethicist uses such thinking to justify abortion by avoiding discussions of personhood: “A feminist theological ethics avoids such discussions since in reality no two abortion decisions are alike.”

However, Fletcher and many others on both sides of these issues, believe personhood must be defined. He proposed a tentative list of 20 criteria which described “what it means to be a truly human being.” Included among these, in no particular order, were minimal intelligence, self-awareness, self-control, a sense of time, communication, curiosity, and neocortical function. He later condensed these to four: self-consciousness, potential for relationships, happiness, and neocortical function, concluding that “neocortical function is the key to humanness, the essential trait, the human *sine qua non*” (emphasis original).

In philosophical terms, this position is known as empirical functionalism. This diverse group of views is united in the assumption that a human being is not necessarily a human person. Some set of abilities or functions is selected by which we can determine which humans are persons. These functions or abilities, not just their potential, must be present in a human before he or she can be declared a person. We can often catch ourselves drifting into this way of thinking when we value ourselves or others on the basis of our abilities. If we feel we are worthless because we cannot do the things others do, we have taken on a functionalist perspective.
Christian authors have similarly proposed criteria for establishing personhood in terms of being an ‘image of God.’ Debate over the meaning of this phrase has raged for centuries, without conclusive results. One Christian physician concluded that under certain conditions a living patient “is no longer the image of God because physiological life, permanently devoid of relationality and cognition, is not adequate to be *imago Dei*.” A Christian ethicist, sounding very much like Fletcher, concluded, “A body without neocortical functioning cannot image God . . . Neocortical destruction is both a necessary and sufficient condition for declaring an individual dead theologically.” A Jesuit ethicist wrote that with the extent of neocortical damage in some patients “. . . it seems impossible to argue that a substantial union of body and soul remains or that an obligation to sustain life remains.”

In contrast to this perspective is ontological personalism. This view, traditionally held by Christians, claims that all human beings are also human persons. At the moment of conception, a new and unique individual comes into being. The embryo only needs protection and nourishment to become an adult person. These developmental changes even continue into adulthood. Human embryos, foetuses, children or adults are not human beings becoming persons; they are persons developing in their ability to express their inherent capacities. “Thus the absence of certain characteristics or facets of behaviour (as is inevitably the case with the initial prenatal life) is not equivalent to the absence of the person: one ‘is’ a person, one does not just ‘behave’ as a person.”

These two views lead to radically different conclusions when applied to medical ethics. The empirical functionalist sees it as ethical to treat different humans in different ways. We must respect and protect all the rights of those who are fully persons. No such obligation exists for those who are not persons. As one prominent proponent of this view states, “My suggestion,
then, is that we accord the life of a fetus no greater value than the life of a nonhuman animal at a
similar level of rationality, self-consciousness, awareness, capacity to feel, etc. Since no fetus is
a person, no fetus has the same claim to life as a person.”¹⁵ To figure out how we ought to treat
them, we must look at the consequences of each choice. Whichever action brings the greatest
amount of good becomes the right choice.

In contrast, ontological personalism concludes that all humans should be treated as
persons. Regardless of the possible benefits, some things should never be done to humans.
Hence, abortion at any time takes the life of an innocent human person, and is not permissible.
Research must not deliberately harm any humans, including embryos. All people are to be fed,
hydrated and cared for, regardless of how little they are able to communicate with us. They must
still be treated with the respect we give all others.

Christians should be aware of these changing views of what it means to be human. These
are not just academic questions. These views directly impact how we view and treat all people.
Ideas have effects. Proliferation of untrue ideas about the very nature of human beings will result
in wrong decisions and more suffering. We will examine some areas where the functionalist
view has gained prominence in the United States. Irish Christians should be aware of these
developments so that they can defend Irish medical practice from these views. A clear biblical
response is needed so that Christians can be confident in their position, and give witness to the
love and grace of God.

Embryo Research

The current dilemma over whether or not to destroy frozen human embryos in Britain can
be traced back to its public policy regarding their moral status.¹⁶ In 1984, the Warnock Report
examined the ethical issues involved in embryo research. While refusing to address the question
of personhood directly, it still claimed the respect given human embryos “cannot be absolute, and may be weighed against the benefits arising from research.”\textsuperscript{17} In the United States, the National Institutes of Health (NIH) grants federal funding for medical research. The NIH Human Embryo Research Panel issued guidelines for human embryo research in September 1994 which are explicitly based on a functionalist perspective of human nature.

The Report acknowledged that controversy over embryo research is ultimately based on different views of the moral status of embryos. Having claimed its goal was not to determine which view was correct, the following is one of its three guiding principles:

\begin{quote}
Although the preimplantation human embryo warrants serious moral consideration as a developing form of human life, it does not have the same moral status as human infants and children. This is because of the absence of developmental individuation in the preimplantation embryo, the lack of even the possibility of sentience and most other qualities considered relevant to the moral status of persons, and the very high rate of natural mortality at this stage.
\end{quote}

\textsuperscript{18} Having concluded which view was correct, the Report described some of the qualities required for personhood: genetic uniqueness, sentience, brain activity, cognitive development, human form, viability and relational ability. “Although none of these qualities is by itself sufficient to establish personhood, their developing presence in an entity increases its moral status until, at some point, full and equal protectability is required.”\textsuperscript{19}

The Report did not address the fact that it left no clear way to determine when personhood is conferred on a human. Only one thing was clear: the “absence” from the embryo “of almost all other qualities evoking respect makes it unreasonable to think of personhood as beginning here, and places limits on the degree of respect accorded.”\textsuperscript{20} Other questions remain. How are the different qualities prioritised? Is there a similar spectrum at the end of life? How do we determine the right treatment for humans on different parts of this spectrum?
With the removal of full respect and restraint, the utilitarian balance swung in favour of permitting research on embryos. The potential benefits for others, and the potential harm from having no guidelines, led to the conclusion that some members of the human species could be subjected to research, once they were killed within 14 days of fertilisation.

The Report also claimed that the embryo was not an individual: “Moreover, these cells are unspecialized; they do not form part of a coherent, organized, individual embryo, since one or more of them can be removed without affected the development of the later fetus, . . . [T]he cells giving rise to the fetus are unspecialized and identical in potential developmental fate.”

Yet in contrast to this, a Nobel Prize winning geneticist has stated that “[T]he fertilized egg is the most specialized cell under the sun because it has . . . segments of DNA which shall be expressed and others that shall not be expressed that no other cell will ever have in the life of this individual.”

Also, each embryo is a genetically unique individual from the moment of conception. As one internationally recognised authority in the field of embryology has put it:

> The most amazing aspect of this fascinating time of human life is that the mother and fetus, although locked in the most intimate of physical relationships, are at all times two separate people. They are genetically distinct organisms. . . . Scientists and obstetricians generally refer to the fetus as he and to the mother as she. The gender distinction is convenient and also serves as a useful reminder of the separateness of the two beings. Obstetricians generally refer to the baby before birth as the fetus and after birth as the baby” (emphasis original).

The NIH Report viewed the formation of identical twins as evidence against embryos being individuals. About 14 days after fertilisation, a dark band called the primitive streak appears on the surface of the embryo. “Before the appearance of the primitive streak the embryo has the capacity of twinning, or becoming more than one distinct individual. . . . At the appearance of the primitive streak, the embryo proper is determined to be a distinct developing individual. Twinning of embryos . . . [is] no longer possible.” However, many living organisms
reproduce by one individual giving rise to two. “The fact of twinning says nothing about the individuality of the first individual. Indeed, the history of all living organisms is of one individual giving rise to another individual--but one would certainly not then conclude that there were therefore no individuals ever present, or that the former individual was hopelessly ‘undecided.’”

The functionalist perspective actually leads to a confusing notion of personhood. Many who are clearly persons could be classified as non-persons: those asleep or under anaesthesia or unconscious, new-borns, and some people suffering severe forms of brain injury or dementia. Other arbitrary claims are usually proposed to evade fundamental problems with the underlying premise. However, some functionalists accept the logical conclusions of their position:

A week-old baby is not a rational and self-conscious being, and there are many nonhuman animals whose rationality, self-consciousness, awareness, capacity to feel, and so on, exceed that of a human baby a week, a month, or even a year old. If the fetus does not have the same claim to life as a person it appears that the newborn baby does not either, and the life of a newborn baby is of less value than the life of a pig, a dog, or a chimpanzee. . . . I do not regard the conflict between the position I have taken and widely accepted views about the sanctity of infant life as a ground for abandoning my position. I think these widely accepted views need to be challenged.

Singer reveals how inhumane human rationality can become when allowed to go unchecked. Reason and logic are important tools in resolving ethical dilemmas. But we need the balancing influences of the Holy Spirit, conscience and gut feelings. Singer claims “we should put aside feelings based on the small, helpless and--sometimes--cute appearance of human infants.” Yet sometimes these feelings are the first or only warnings we get that our minds are leading us in the wrong direction. One philosopher notes how difficult it is to prove rationally that the more vulnerable ought to be protected: “Therefore, rather than us deriding the sentiment behind the cry ‘Women and children first!’, its intuitive force should alert us to a serious flaw in any ethical theory which does not endorse it.”
Empirical functionalism claims that the embryo, foetus and new-born do not deserve the respect and protection we give persons. It supports experimenting on the smallest of human beings, and killing any who do not meet our standards. This should disturb us and lead us to question their premises.

**Persistent Vegetative State**

Moves are also afoot to remove the personhood of some humans at the other end of life. The *Ward* case involved a woman “in a near persistent vegetative state (PVS).” The medical information concerning PVS was reviewed recently by the Multi-Society Task Force on PVS (MSTF). PVS can be caused by acute brain injury (e.g. car accidents or lack of oxygen from a heart attack or near-drowning), chronic degenerative disease (e.g. Alzheimer’s disease, Parkinson’s disease), or developmental malformations (e.g. anencephaly). The injury or disease often results in profound damage to, if not complete death of, the neocortex.

According to the MSTF, patients in PVS show no evidence of awareness or thinking, and do not communicate. None of their actions appear purposeful, learned or voluntary. However, the brain stem often functions normally, allowing a much greater range of activities than seen in related syndromes. Most patients in PVS continue to breathe on their own, circulate blood normally, have periods of waking and sleeping, may move their limbs, smile, shed tears and respond to external stimuli. Some may grunt, groan or scream.

Most PVS patients cannot chew or swallow food, though some can. Therefore, food and fluids are usually given artificially. Most often a liquid diet is given via a gastrostomy tube which is inserted directly into the stomach. Insertion of this tube requires surgery, but is a relatively low-risk procedure with almost guaranteed effectiveness. Thus arises the ethical
dilemma, as reflected in the Ward case: should artificially administered food and fluids be withheld or withdrawn from these patients?

While there is no known cure for PVS, spontaneous recovery does occur in some patients, depending on the type of injury, patient age, and length of time in PVS. The MSTF found that about half the PVS patients recovered consciousness within one year, with the recovery rate dropping dramatically after that. Of those who recovered, 54% had severe disability, 33% had moderate disability and 13% had a good recovery. For those who remain in PVS, the average life-expectancy is two to five years, although two patients have survived for 37 and 41 years. The patient in the Ward case had been in her condition for 23 years.

The MSTF report came to some fundamentally important philosophical and ethical conclusions when it claimed, “Patients in a vegetative state are unconscious because, although they are wakeful, they lack awareness.” It is commonly believed that PVS patients are unconscious and unaware, as opposed to acting as if unconscious and unaware. The functionalist perspective is that these patients are no longer persons because they reveal little evidence of rationality, emotions or awareness. As another author puts it, “Thus, in naturally occurring cases of persistent vegetative state, in spite of rather complex brainstem functions, the person is still dead, having left behind a cadaver informed by a vegetative soul.”

The Irish Supreme Court decision did not claim the ward was no longer a person. In fact, it upheld the request to withdraw food and fluids on the basis that other competent persons would be permitted to make such a decision. However, the decision was supported in part by functionalist claims similar to those put forward by those who deny personhood.

The ward, on the other hand, although alive, had no life at all. Mr. Justice O’Flaherty accepted the trial judge’s finding that, although the ward was not fully PVS, she was very nearly so and that such cognitive capacity as she possessed was extremely minimal. It was fanciful to attempt to equate the position of the ward in this case with that of a person whose life has been
impaired by handicap. The analogy was both false and misleading, as the quality of the ward’s life was never in issue - she was not living a life in any meaningful sense.35

While the court was confident that this type of decision would not be applied to similar degenerative conditions, medical ethicists have already proposed doing so. One author states that in the advanced stages of Alzheimer’s disease, “the mind is no longer there. . . . The spiritual soul must have left the body, so that the person is now in the next life, while an animal which looks like the former person remains on earth.”36 Naturally, we have no obligation to continue providing for these patients. In fact, given the relatively high cost of caring for PVS patients,37 this same author concludes, quite logically, “It is improper to assess families, insurance companies, or taxpayers with expensive hospital bills for keeping cadavers warm.”38

Another tragic group of PVS patients are anencephalic infants. This developmental abnormality leads to foetuses and new-borns missing major portions of their brain, skull and scalp. Of those born alive, more than half will die within 24 hours, and the majority within a few days. Like other PVS patients, their brain-stems and other organs are usually healthy, and can often be donated for transplantation. However, numerous studies have shown that when physicians wait until anencephalic infants die naturally, their organs are no longer suitable.39 In Germany this problem is circumvented since anencephalic infants born alive there are declared dead.40

In 1994, the American Medical Association’s Council on Ethical and Judicial Affairs ruled that it is ethical to remove the vital organs of living anencephalic new-borns before they die.41 The Council has since reversed this decision, but still maintains that its original report and opinion “were well-reasoned discussions of an important ethical issue.”42 From a functionalist perspective, anencephalic infants have no intrinsic value and can be used as means towards the ends of others. Reflecting on the fact that these infants will die when their vital organs are
removed, the Council declared, “If there is a loss, it is a loss for others, whether for their parents or for society generally. Similarly, the value in the life of an anencephalic neonate is a value only for others.”

The AMA Council noted that anencephalic new-borns can breathe, digest food, suck, move their limbs and eyes, respond to stimuli by crying or avoidance and exhibit normal facial expressions, yet still concluded, “While all of this activity gives the appearance that the anencephalic neonate has some degree of consciousness, there is none.” This reveals a fundamental problem with all functionalist conclusions regarding PVS patients. The diagnosis of a complete, permanent lack of consciousness is not yet feasible. A recent review of the status of research on consciousness puts it this way:

Even if it is in principle possible to invent a ‘consciousness monitor’, a device that would ‘detect’ the physical signs of the presence of consciousness in a patient, no such technology is anywhere in sight, as it is not even known what exactly is to be measured. The root of the problem lies deeper than the inadequacy of the technology, or the lack of sufficient data, however. What seems to be critically lacking is also a solid theoretical framework to ground and facilitate the experimental research. For example, there is really no established consensus, even in the medical field, as to what should count as the criteria of consciousness, to demarcate the domain of the conscious from that of the unconscious or the nonconscious (second and third emphases added).

In spite of the “common practice in medicine to have a more or less circumscribed set of behavioral and physiological criteria to determine the occurrent presence or absence of consciousness in patients. . . . the issue is not so straightforward” (emphasis original). Rather, we must admit that medical science cannot reliably determine if PVS patients are unconscious. There is significant evidence that they retain some form of consciousness, but this is dismissed because of the prior assumption that extensive neocortical damage leaves PVS patients “noncognitive, nonsentient, and incapable of conscious experience.”

Evidence is mounting that the neocortex is not the only area of the brain involved in cognition. The physical location of our ‘seat of consciousness’ “remains a hotly debated issue.”
Recent studies on the brain of Karen Ann Quinlan, a prominent PVS victim in the United States, revealed little damage to her neocortex. Instead, most damage was in a different area, the thalamus. Other studies suggest that another part of the brain, the cerebellum, is also involved in cognition. Some respected researchers even hold that in some sense consciousness resides in the whole brain. A more honest perspective on the state of this research is that “our understanding of the biological underpinnings of consciousness is relatively primitive.” To draw significant ethical conclusions based on these uncertain medical diagnoses is at least premature.

**A Biblical Response**

Attempts to determine the characteristics necessary to be an image of God have more in common with secular, functionalist thinking than the biblical view of humanity. The Bible nowhere gives a concise definition of what it means when declaring that humans are made in the image and likeness of God (Genesis 1:26-27). Why are we frustrated, or confused, when we ask what seems such an important question of the Bible? Why has God apparently neglected to show us how to determine which humans are his images or persons?

However, the problem may not be with the Bible. Asking “Who is an image of God?” is an abstract, philosophical question, not the type generally addressed by the Bible. Maybe we are asking the wrong sort of question. The image of God passages were not written to show which humans are images and which are not. Nor were they written to show us how to figure out who qualifies as an image of God. They simply state that humans are images of God because God created us as such.

Underlying all attempts to determine who is an image of God, or a person, is the assumption that we can make important moral distinctions between humans. Once we know
which type of human we are dealing with, the level of respect due them will be more clear. Thus, we try to clarify our moral obligations by first categorising humans. Even opponents of embryo research and abortion do this: “Any decision on how the human embryo should be treated must be preceded by a decision on its moral status. We cannot decide how to treat something until we know what it is.”\textsuperscript{54} The Christian authors addressing PVS first proposed certain rational, spiritual, moral, or relational capacities necessary to be an image of God. Any human without these (or the potential to develop them) could not be an image of God. PVS patients inevitably fall into this category. Therefore, we have no obligation to keep these patients alive by feeding and hydrating them, while we do with humans who are images of God.

As the examples have shown, classifying some humans as non-persons justifies doing to them what is still viewed as unethical to do with persons. In medical ethics ‘person’ has traditionally been used as a protective notion. In the same way, humans are granted special protection because they are images of God: from being killed (Genesis 9:6) and disrespected (James 3:9-10). However, in literature arguing that some humans are not persons it is used primarily “as a permissive notion that takes the moral heat off certain quandaries raised by modern medicine.”\textsuperscript{55} In removing this protective aspect, we condone practices we would otherwise view as wrong, if not even repugnant.

The attempt to label people so that we can treat them differently is as old as the Fall. The tragedies of slavery, racism, sexism and Nazism bear witness to what can happen when some people view others as less than fully persons, or unworthy of life.\textsuperscript{56} Jesus encountered a similar issue when a lawyer asked him: “Who is my neighbour?” (Luke 10:29). The lawyer believed that once he knew which people were his neighbours he would treat them accordingly. He obviously
thought that one type of action was required towards neighbours, and something different
towards non-neighbours. He just needed some help figuring out which was which.

Jesus’ reply in the Parable of the Good Samaritan rejects this whole question (vv. 30-37).
This story clearly shows that all humans should be treated as neighbours. Jesus concludes by
asking which of the characters proved to be a neighbour (v. 36). He entreats the lawyer to
similarly show mercy to others (v. 37). Our focus should not be on determining who is our
neighbour, but on how we can act as good neighbours. Similarly, we should not focus on
figuring out who is an image of God, but on how we can act as faithful images of God.

In this way, the image of God concept provides much help in thinking through these
medical dilemmas. Being an image of God brings with it privileges including our rational,
relational, moral and spiritual capacities. Humans are unique in having this combination of
attributes functioning at the levels they do. But humans are not images of God because they have
these capacities. All humans are images of God, and because of this, these types of activities are
part of what it means to be human.

Being an image of God also brings with it certain responsibilities. In the Ancient Near
East the term “image” was used to describe a statue left by a conquering king as a reminder of
his presence, even though he might be physically absent. Seeing the image, people were forced
to remember whose land they occupied, and act in an appropriate manner. Thus the image was
seen as the representative of the ruler.

This helps explain why such an important phrase occurs so infrequently in the Bible. The
focus is not on who is an image of God, but on how we can live as true images of God. As the
lawyer in Luke 10 was told, he should go and act with mercy. The Bible has lots of advice on
how we can act with mercy. To the extent that we do, we image God faithfully to the world. As
the Jewish scholar Abraham Heschel commented, “No image of the Supreme may be fashioned, save one: our own life as an image of His will. Man, formed in His likeness, was made to imitate His ways of mercy. He has delegated to man the power to act in His stead. We represent Him in relieving affliction, in granting joy. Striving for integrity, helping our fellow men.”

Christians are to be God’s ambassadors to the world (2 Corinthians 5:20). Our focus should be on the type of character we exemplify when we act. Only Christ is the true image of God (2 Corinthians 4:4; Colossians 1:15). Everyone else is a “shattered image.” But by establishing a relationship with Christ, and living by the power of the Holy Spirit, according to the example of Christ, we can have the character of God formed in us (Colossians 3:9-10). Part of this renewal is the denial that there are distinctions between different types of humans (v. 11). Thus we can become truer images of God.

When we act, we are to put on a heart of “compassion, kindness, humility, gentleness and patience” (vv. 12-13). We must ask, for example, how we show compassion and gentleness when we experimenting and killing embryos? Rather than exemplifying humility, we are arrogantly using these unique beings for our own purposes. When considering PVS patients, we should remember that God promises to always provide for our food, water and clothing needs (Matthew 6:25-34). He tells us this to remind us of his unfailing care. Similarly, we should continue to give food, water and comfort to those who remain alive, regardless of how damaged their brains may be.

The functionalist perspective claims that because some humans can do so little of what most humans can, they are no longer persons. We should remember that none of us lives up to our potential. All of us fall far short of being true images of God (Romans 3:23). But by the grace of God, we remain images of God (Genesis 9:6; James 3:9). The latter two passages apply
to all humans, even those missing the most basic ingredient needed to act as true images: a relationship with God. These humans retain the privilege and value of being images of God, even though their capacity for moral and spiritual vitality is severely compromised (John 15:4-5; Ephesians 2:1-5).

Therefore, we should remember how God looks upon us when we consider the unborn and the severely brain damaged. God does not assess our worth based on our functional abilities. If he did, we would all fail miserably. Neither can we evoke his respect on the basis of our good works (Ephesians 2:8-9). Our functional abilities and accomplishments are worthless before God (Philippians 3:4-8). We are so far beneath his ways and his abilities that we deserve nothing (Psalm 144:3-4). But God still loves us and provides for us (2 Corinthians 5:18-19). By his grace we are granted more respect than any other creature (Psalm 8).

To be his images, then, we are to treat others like he treats us. Gratitude for what we have been given should be our motivation. We are to respect all humans because we all carry the image of God, regardless of our functional abilities. We respect others because of who we are, and all we have been given, not because of what they can do. Rather than attempting to figure out who is an image of God, we should focus on being faithful images of God to others.

Limits will certainly have to be set on how much we can give to the severely ill. Respect for life is not the same as worshipping life at all costs. There will be times when we must admit there is nothing more we can do to try to cure a patient. Certain treatments will not be warranted in some cases if we are to be good stewards of our limited resources. But these are different, but equally tough, decision. Here, we have focused on how we must not classify some humans as non-persons to make those decisions easier. In deciding how to respond to any human, regardless
of how small or undeveloped or debilitated, Scripture describes us as images of God to encourage us to act as his true representatives.

Conclusion

If a human is not granted personhood unless a certain set of abilities and functions are present, then we are no more than what we do. This makes it difficult to accept weakness in ourselves, and the weak who live among us. How contrary to a functionalist perspective is Paul’s notion that “the members of the body that seem to be weaker are necessary” (1 Corinthians 12:22). The embryo, foetus, new-born, and unconscious are the weakest and most vulnerable among us. If we view them as non-persons for the purpose of not protecting them, and eventually killing them, we are acting contrary to the very purposes of God (Proverbs 14:31). We would do well to remember God’s commendation of Josiah, king of Judah (Jeremiah 22:16):

He pled the cause of the afflicted and needy;  
Then it was well.  
Is not that what it means to know Me?

7 The neocortex is that region of the brain believed by many to be responsible for all higher, cognitive functioning such as thinking, self-awareness and emotions. As discussed as the end of this paper, whether or not this area is the only region responsible for these abilities is still much debated.  

Palazzani, 15.


When a sperm fertilises an egg, a zygote is formed. This undergoes cell division, and is then called an embryo. After eight weeks the embryo is known as a foetus.


National Institutes of Health, p.49.

National Institutes of Health, p.49.

National Institutes of Health, p.21.

Testimony of Professor Jerome Lejeune, MD, Ph.D., Custody Dispute Over Seven Human Embryos, 1989, p.57.

Nathanielsz P.W., Life Before Birth: The Challenges of Fetal Development, 1996, p.2. The context of this passage makes it clear that the author is using the term “fetus” more broadly than its technical meaning and refers to the unborn at any stage of development. This very readable book condenses the vast amount of recent information becoming available in the field of embryology.


Singer, pp.122-3.

Singer, p.123.


Tunissen, p.61; For a thorough analysis of the ethical issues involved with PVS, see D.P.O’Mathúina, “Responding to Patients in the Persistent Vegetative State,” Philosophy Christi, in press.


According to the Glasgow Outcome Scale, patients with severe disability are partially or totally dependent on others for daily living, those with moderate disability can live independently but are not able to participate in some social or work activities, while those with a good recovery can resume normal occupational and social activities, but with some minor physical or mental deficits or symptoms (MSTF, “Second Part,” p.1572).


Tunissen, pp.62-3.

Shewmon, “Metaphysics,” p.60.

The annual cost of long-term care for a PVS patient is estimated between $97,000 and $180,000. This gives an annual cost of between $1 billion and $7 billion for all PVS patients in the United States. MSTF, “Second Part,” p.1576.


43 American Medical Association, p.1615.

44 American Medical Association, p.1615.


46 Güzeldere, “Problems of Consciousness,” p.130.


56 The horrors of Nazi extermination camps did not begin when Adolf Hitler gained power. Many physicians and academics had earlier accepted the notion that some lives are not worth living. The first to be systematically killed were the mentally retarded. See, Wertham F., “The Geranium in the Window: The ‘Euthanasia’ Murders,” A Sign for Cain, 1966, reprinted in Death, Dying, and Euthanasia, ed. D. J. Horan, D. Mall, 1980, pp.602-41; and Alexander L., “Medical Science Under Dictatorship,” New England Journal of Medicine, 241, 1949, pp.39-47.


60 There are some conditions in which administering food and water can be painful, or may lead to no nutritional benefit. These sorts of conditions are not being considered here.