TAKING CARE: Perspectives for the End of Life

26TH ANNUAL CONFERENCE
June 20–22, 2019
on the campus of Trinity International University
Deerfield, IL USA

Preconference Institutes: June 17–20, 2019
CONFERENCE: JUNE 20–22, 2019
Postconference Seminar: June 24–26, 2019
Thanks to you and many others, we are celebrating another year of advancing Christian bioethics. Because you care, we are able to sustain focus on the unique dignity of every human being, and the joy of flourishing as people made in God’s image.

Our strategic priorities this year concentrate on two arenas. First, influencing young thinkers as they become the next generation of leaders in the academy, healthcare, and the church. Second, equipping pastors to help guide their congregations in making wise decisions about medicine, science, and technology.

Your faithful generosity keeps us going. Whether it’s providing a scholarship to bring a future doctor or nurse to the summer conference, underwriting a free workshop for pastors, funding other key initiatives, or supporting our operations, you make a difference.

Gracias. Merci beaucoup. Danke sehr. 감사합니다. And many more thanks!

The Staff of The Center for Bioethics & Human Dignity
“Christian belief can prepare humans to confront the realities of suffering and dying with true compassion and a God-given dignity without killing the sufferer.”
- John Kilner, Arlene Miller, and Edmund Pellegrino, 1996

Welcome to our 2019 conference on Taking Care: Perspectives for the End of Life.

Whether we choose to think about it or not, we are each subject to a universal reality: we will die. How we die is a different matter. An increasingly dominant claim is the right to control the timing and manner of one’s own death. Not surprisingly, media devotion to the narrative of attractive young patients with terminal cancer expands the attraction and support for physician-assisted suicide.

An exclusive focus on alleviating physical pain can distort historical notions of patient care. Hastening a patient’s death via terminal sedation disregards the many dimensions of a person’s life as they face death: physical, emotional, relational, financial, and spiritual needs. It paints a grim picture of life as mere bodily existence, blind to the larger reality and possibilities.

As Christians, we live in the larger reality. Death is not the final defeat of our humanity, even though we long for resurrection and through it the perfection of our bodies. We see larger possibilities. While many readily agree that our identity impels us to live differently, does it lead us to die differently? How can we die well? How do we face our own suffering?

We are also called to take care for others. Can we do so in a secular context? Can we suffer with those at the margins?

Whether we are the patient, physician, nurse, pastor, or family member, giving and receiving care is a path toward a deeper understanding of our humanity, in its frail and weakened state. Even—perhaps especially—in that vulnerability, we may find that we most truly live.

“When I was dying, I found that I was flourishing.”
- Allen Verhey, 2013

On behalf of our partners, sponsoring organizations, and exhibitors, welcome! We are glad you are here. Even before you registered, we were praying for you. Be stimulated, encouraged, challenged, renewed. Make new friends. Rejoice in reconnecting with old ones. Take care, and live well, to the glory of God.

Paige Comstock Cunningham, JD, PhD
Executive Director
The Center for Bioethics & Human Dignity
Trinity International University

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# SCHEDULE

## MONDAY, JUNE 17

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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>9:00am–5:30pm</td>
<td>Intensive Bioethics Institute (BE5100)</td>
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<td>Advanced Bioethics Institute (BE6500)</td>
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## TUESDAY, JUNE 18

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<tr>
<td>9:00am–5:30pm</td>
<td>Intensive Bioethics Institute (BE5100)</td>
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## WEDNESDAY, JUNE 19

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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>8:30am–5:30pm</td>
<td>Preconference Workshop*</td>
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<tr>
<td></td>
<td>Conscientious Practice in Healthcare: Ethical, Clinical, and Legal Issues</td>
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<td></td>
<td>Steven Aden, JD</td>
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<td></td>
<td>Lauris Kaldjian, MD, PhD</td>
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<td></td>
<td>Co-Sponsored by: Americans United for Life</td>
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<tr>
<td>8:30am–5:30pm</td>
<td>Contemporary Issues in Bioethics (BE7700a)</td>
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<tr>
<td></td>
<td>Undergraduate Bioethics Institute / Bioethics for Professionals (BE476x)</td>
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<tr>
<td>9:00am–5:30pm</td>
<td>Intensive Bioethics Institute (BE5100)</td>
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<td>Advanced Bioethics Institute (BE6500)</td>
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## THURSDAY, JUNE 20

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<tbody>
<tr>
<td>8:30am–3:30pm</td>
<td>Preconference Workshop*</td>
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<tr>
<td></td>
<td>Suffering, Pain, Opioids, and Compassionate Care for Patients: Controversies and Hope</td>
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<td></td>
<td>Ryan Nash, MD, MA</td>
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<td></td>
<td>Nicole Shirilla, MD, MEd</td>
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<td></td>
<td>Co-Sponsored by: The Ohio State University Center for Bioethics</td>
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<tr>
<td>8:30am–3:30pm</td>
<td>Contemporary Issues in Bioethics (BE7700a)</td>
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## THURSDAY, CONT’D

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<tr>
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<tbody>
<tr>
<td>9:00am–12:00pm</td>
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<td>Advanced Bioethics Institute (BE6500)</td>
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<tr>
<td>9:00am–4:30pm</td>
<td>Undergraduate Bioethics Institute / Bioethics for Professionals (BE476x)</td>
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<tr>
<td>10:00am–4:00pm</td>
<td>Pastors Workshop</td>
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<td></td>
<td>Co-sponsored by: Center for Transformational Churches</td>
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<tr>
<td>4:45pm</td>
<td>Bioethics National Conference Course (BE477x/BE5900)</td>
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<tr>
<td>5:30pm</td>
<td>Registration</td>
</tr>
<tr>
<td></td>
<td>Dinner available for purchase in Hawkins Dining Hall, Waybright Center</td>
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<tr>
<td>7:00pm</td>
<td>Conference Welcome</td>
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<tr>
<td>7:15pm</td>
<td>Opening Plenary Session</td>
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<tr>
<td></td>
<td>Reclaiming the Lost Art of Dying</td>
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<td></td>
<td>Lydia S. Dugdale, MD, MAR</td>
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<td></td>
<td>Yale School of Medicine</td>
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<tr>
<td>8:00pm</td>
<td>Plenary</td>
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<td></td>
<td>Biblical and Theological ‘Givens’ for Responsible Christian Thinking About Death</td>
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<td></td>
<td>D. A. Carson, PhD</td>
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<td></td>
<td>Trinity Evangelical Divinity School</td>
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## FRIDAY, JUNE 21

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<tbody>
<tr>
<td>7:45am–8:15am</td>
<td>Prayer</td>
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<tr>
<td></td>
<td>A.T. Olson Chapel</td>
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<tr>
<td>8:30am</td>
<td>Plenary</td>
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<tr>
<td></td>
<td>Empirical Perspectives on Care at the End of Life</td>
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<tr>
<td></td>
<td>Tracy A. Balboni, MD, MPH</td>
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<td></td>
<td>Harvard Medical School</td>
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<tr>
<td>9:30am</td>
<td>Welcome Gathering for New Attendees</td>
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<td></td>
<td>A.T. Olson Chapel</td>
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## FRIDAY, CONT’D

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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>9:30am</td>
<td>Break</td>
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<tr>
<td>10:00am</td>
<td>Sponsored Workshops</td>
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<tr>
<td></td>
<td>Rights of Conscience for Healthcare Professionals</td>
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<td></td>
<td>Alliance Defending Freedom</td>
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<td></td>
<td>Bioethics, Autonomy, and Clashes of Values</td>
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<td></td>
<td>American Association of Pro-life Obstetricians &amp; Gynecologists</td>
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<td></td>
<td>Fatal Flaws: Turning Back the Legalization of Assisted Suicide</td>
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<td>Americans United for Life</td>
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<td></td>
<td>Whither Futility? Seeking a New Vocabulary for Difficult End-of-Life Decisions</td>
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<td>Christian Legal Society</td>
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<td></td>
<td>Organ Procurement Strategies: Protecting the Sacredness of Donor and Recipient</td>
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<tr>
<td>11:30am</td>
<td>Lunch &amp; Informal Networking</td>
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<tr>
<td>1:00pm</td>
<td>Parallel Paper Sessions</td>
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<tr>
<td>2:10pm</td>
<td>Break</td>
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<tr>
<td>2:30pm</td>
<td>Plenary</td>
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<td></td>
<td>PAS and Aid in Dying: Lessons from the Netherlands</td>
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<td></td>
<td>Theo A. Boer, PhD</td>
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<td></td>
<td>Protestant Theological University</td>
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<tr>
<td>3:30pm</td>
<td>CBHD Members Meeting</td>
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<td>6:00pm</td>
<td>Dinner &amp; Movie Screening</td>
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<td>Three Identical Strangers</td>
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<td>Sponsored by: The Tennessee Center for Bioethics &amp; Culture</td>
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### SATURDAY, JUNE 22

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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| 7:45am–8:15am | **Prayer** | Faculty Lounge  
|           | **A. T. Olson Chapel**  |
| 8:30am    | **Plenary** | **A. T. Olson Chapel**  
|           | **Care Taking in Secular Bioethics**  
|           | **Jon C. Tilburt, MD, MPH**  
|           | **Mayo Clinic**  |
| 9:30am    | **Break** | Hinkson Hall  
|           | **(Exhibitor Hall Open)**  |
| 10:00am  | **Sponsored Workshops** | **Rodine Building**  
|           | **Euthanasia and Eugenics: The Pediatric Connection**  
|           | **American College of Pediatricians**  
|           | **Anatomy of a Perfect Crime? How to Dissect the Typical Assisted Suicide Statute and Expose Its Harmful Nature**  
|           | **Bioethics Defense Fund**  
|           | **Dignity and Dementia**  
|           | **Christian Medical & Dental Associations**  
|           | **Disability and End-of-Life Care: Unique Perspectives, Enduring Ethical Issues**  
|           | **Joni and Friends International Disability Center**  
|           | **Caring for the Suffering: Drugs, Consciousness, and Becoming Human**  
|           | **The Ohio State University Center for Bioethics**  |
| 11:30am  | **Lunch & Informal Networking** | **Lunch available for purchase in Hawkins Dining Hall, Waybright Center**  |
| 1:00pm   | **Parallel Paper Sessions** | **Rodine Building**  |
| 2:10pm   | **Break** | Hinkson Hall  
|           | **(Exhibitor Hall Open)**  |

### SATURDAY, CONT’D

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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| 2:30pm   | **Plenary** | **A. T. Olson Chapel**  
|           | **Eyes to See, Ears to Hear: Seeking Shalom for Those Dying at the Margins**  
|           | **Patrick T. Smith, PhD**  
|           | **Duke Divinity School**  |
| 3:30pm   | **Plenary** | **A. T. Olson Chapel**  
|           | **Dignity and Life on the Line: Ending Well**  
|           | **John F. Kilner, PhD**  
|           | **Trinity International University**  |
| 4:30pm   | **Conference Close** | *** |

### MONDAY–WEDNESDAY

#### JUNE 24–26

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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| 8:30am   | **Human Nature, Personal Identity, and the Ethics of Brain Technologies Seminar** | **(BE7700b)**  
| 4:30pm   | **Conference Close**  |

*Additional registration required*

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**Continuing Medical Education (CME) credit is available for qualified sessions.**
## Conference History

<table>
<thead>
<tr>
<th>Conference</th>
<th>Theme</th>
<th>Year</th>
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<tbody>
<tr>
<td>25th Annual Summer Conference</td>
<td>Bioethics and Being Human</td>
<td>2018</td>
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<tr>
<td>24th Annual Summer Conference</td>
<td>Genetic &amp; Reproductive Technologies</td>
<td>2017</td>
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<tr>
<td>23rd Annual Summer Conference</td>
<td>Transformations in Care</td>
<td>2016</td>
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<tr>
<td>22nd Annual Summer Conference</td>
<td>Science, Research, and the Limits of Bioethics</td>
<td>2015</td>
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<tr>
<td>21st Annual Summer Conference</td>
<td>Bioethics in Transition</td>
<td>2014</td>
</tr>
<tr>
<td>20th Annual Summer Conference</td>
<td>Health and Human Flourishing</td>
<td>2013</td>
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<tr>
<td>19th Annual Summer Conference</td>
<td>Reclaiming Dignity in a Culture of Commodification</td>
<td>2012</td>
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<tr>
<td>17th Annual Summer Conference</td>
<td>Beyond Therapy: Exploring Enhancement and Human Futures</td>
<td>2010</td>
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<tr>
<td>16th Annual Summer Conference</td>
<td>Global Bioethics: Emerging Challenges Facing Human Dignity</td>
<td>2009</td>
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<tr>
<td>15th Annual Summer Conference</td>
<td>Healthcare and the Common Good</td>
<td>2008</td>
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<tr>
<td>13th Annual Summer Conference</td>
<td>Neuroethics: The New Frontier</td>
<td>2006</td>
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<tr>
<td>12th Annual Summer Conference</td>
<td>Genetic &amp; Reproductive Ethics</td>
<td>2005</td>
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<tr>
<td>11th Annual Summer Conference</td>
<td>Conflict &amp; Conscience in Healthcare</td>
<td>2004</td>
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<tr>
<td>9th Annual Summer Conference</td>
<td>Bioethics at the Bedside</td>
<td>2002</td>
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<tr>
<td>8th Annual Summer Conference</td>
<td>Aging, Death, and the Quest for Immortality</td>
<td>2001</td>
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<tr>
<td>7th Annual Summer Conference</td>
<td>Bioethics in the New Millennium</td>
<td>2000</td>
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<tr>
<td>6th Annual Summer Conference</td>
<td>Making a Difference</td>
<td>1999</td>
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<tr>
<td>3rd Annual Summer Conference</td>
<td>The Christian Stake in Genetics</td>
<td>1996</td>
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<tr>
<td>2nd Annual Summer Conference</td>
<td>The Christian Stake in Dignity and Dying</td>
<td>1995</td>
</tr>
<tr>
<td>1st Annual Summer Conference</td>
<td>The Christian Stake in Bioethics</td>
<td>1994</td>
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</table>
Taking Care: Perspectives for the End of Life

26th Annual Summer Conference

SPKAKER BIOGRAPHIES & ABSTRACTS

Tracy A. Balboni, MD, MPH
Tracy A. Balboni is associate professor of radiation oncology at Harvard Medical School and associate physician of radiation oncology at the Dana-Farber Cancer Institute. She also serves as the clinical director of the Supportive and Palliative Radiation Oncology Service at Dana-Farber/B Brigham and Women’s Cancer Center. Her primary research interests are in palliative care, including the psychosocial aspects of advanced cancer and radiotherapy for palliation. Within the psychosocial aspects of advanced cancer, she has a particular focus on the role of religion and spirituality in the experience of cancer. This includes the impact of religion/spirituality on coping and end-of-life medical care and the impact of spiritual care in the medical setting on patient end-of-life outcomes.

Theo A. Boer, PhD
Theo A. Boer is senior lecturer of ethics at the Protestant Theological University in Groningen, the Netherlands. From 2005–2014 he was part of a governmental review panel overseeing the PAD practice. He is now part of the Dutch Health Council, a governmental advisory board. He also serves as a fellow in CBHD’s Academy of Fellows. Boer has extensive experience in the relations between ethics, institutional healthcare, and Christian faith, as well as in the ethics of euthanasia and assisted suicide. He chairs the Committee on Bioethics and Biotechnology of the Conference of European Churches, is a board member of the Dutch Research School of Philosophy (Section Ethics and Practical Philosophy), chairs the Dutch and Belgian Research Group in Theological Ethics, and co-chairs the Interest Group Evangelical Ethics of the (American) Society of Christian Ethics. His present research includes end-of-life decisions, new diagnostic methods, human enhancement, and the ethics of war and peace.

D. A. Carson, PhD
Donald A. Carson is emeritus professor of New Testament at Trinity Evangelical Divinity School where he has served since 1978. He is also president of The Gospel Coalition. Carson has served as assistant pastor and pastor and has done itinerant ministry in Canada and the United Kingdom. He is an active guest lecturer in academic and church settings around the world. Carson has written or edited more than fifty books, including The Pillar New Testament Commentary, The Gagging of God: Christianity Confronts Pluralism, and the long-popular New Testament Commentary Survey.

EMPIRICAL PERSPECTIVES ON CARE AT THE END OF LIFE

Formed in the embrace of spiritual life and thought, modern biomedicine owes much of its founding principles to its spiritual heritage. However, passage through modernity has yielded a largely estranged relationship between religion/spirituality and the practice of medicine; bodily and spiritual care are now largely performed in isolation from one another. And though the complexities of body and spirit can be served well by specialization, the lack of integration of spiritual and material care has led to notable tensions in the care of the sick, particularly at the end of life. The empirical perspective, though certainly fraught with limitations, can act as a critical tool to shine light on the complex interplay of spiritual issues, faith, and the experience of illness. Research thus far has demonstrated the multifaceted roles of spirituality within illness and how the integration of spiritual care can serve to uphold patient and family well-being at the end of life.

PAS AND AID IN DYING: LESSONS FROM THE NETHERLANDS

The Netherlands was the first country to legalize Physician-Assisted Dying (PAD). From 1985 on, PAD was officially tolerated, followed in 1994 by a makeshift law and in 2002 by a fully-fledged euthanasia law. More than thirty years of experience—with rising numbers and expanding pathologies underlying PAD-requests—make the Netherlands a laboratory from which lessons can be learned for other countries worldwide. In this lecture we will ask some of the most pressing questions: has the possibility of PAD led to a slippery slope? Are the legal ‘due care criteria’ sufficient? Have there been consequences for the level of palliative care? Has it led to risks for vulnerable people? What is the attitude of physicians, patients, and of Christians and churches in particular?

BIBLICAL AND THEOLOGICAL ‘GIVENS’ FOR RESPONSIBLE CHRISTIAN THINKING ABOUT DEATH

Christians, who gratefully submit to the authority of God’s self-disclosure in Scripture, invariably hold distinctive ideas about death, including ideas about what comes next. For example, unlike supporters of reincarnation, they do not think they might come back after death as a butterfly, a bullfrog, or a rich prince, but anticipate resurrection existence in the new heaven and the new earth. Unlike certain philosophical materialists, they do not think that death ends all personal consciousness, but that death, though it may rightly be called the last enemy, doesn’t have the last word. The distinctive substance of Christian belief about life after death necessarily constrains the way Christians think about death itself, and that in turn ought to have a bearing on how Christian medical professionals, not to mention relatives and friends, ought to treat people with terminal illnesses. This lecture surveys some of these distinctive Christian beliefs about death and suggests ways in which our view and treatment of the dying ought to be influenced by such considerations.
Lydia S. Dugdale, MD, MAR

Lydia S. Dugdale is associate professor in the Section of General Internal Medicine and the associate director of the Program for Biomedical Ethics at Yale School of Medicine. Her teaching commitments at Yale include clinical medicine and general ethics to medical students and residents. Dugdale’s scholarship focuses on biomedical ethics, with particular emphasis on care at the end of life. She is editor of the book Dying in the Twenty-first Century: Toward a New Ethical Framework for the Art of Dying Well, has published widely in peer-reviewed and popular press journals, and has been interviewed on television and public radio. She practices primary care medicine with Yale Internal Medicine Associates.

RECLAIMING THE LOST ART OF DYING

Many people today are not prepared for death, but this has not always been the case. In the early to mid-fifteenth century, there developed a series of Ars moriendi (“art of dying”) handbooks on the preparation for death. Although the original Ars moriendi emerged out of the Catholic Church in response to the high mortality rate of the Bubonic Plague, Protestants and others quickly adapted them. They were wildly popular in the West for more than 500 years. But about a century ago, the “art of dying” died out, and Westerners became increasingly ill-prepared for death. Is it possible to revive the Ars moriendi, and if so, what will it take?

John F. Kilner, PhD

John F. Kilner is the Franklin Forman Chair of Ethics, professor of bioethics and contemporary culture, and the director of bioethics degree programs at Trinity International University. From the 1994 founding of The Center for Bioethics & Human Dignity until 2005, Kilner served as the Center’s president and CEO. He presently serves as a senior fellow in the Academy of Fellows of CBHD. An author of numerous articles, he has also written or edited over twenty books, including his award-winning Dignity and Destiny: Humanity in the Image of God. A frequent speaker and seminar leader, he most commonly addresses issues related to resource allocation, age-based and other forms of rationing, treatment termination, physician-assisted suicide, euthanasia, human cloning, assisted reproduction, genetic intervention, stem cell research, ethical methodology, cultural values, and social change.

DIGNITY AND LIFE ON THE LINE: ENDING WELL

The field of bioethics has matured in many ways, including replacing a focus on human life with a range of concerns about human dignity—human life being among them. Even arenas where human life is front and center, such as end-of-life healthcare, are devoting increasing attention to the ways that human dignity—and not life alone—is on the line. But what is human dignity, why does it matter, and what are its implications for end-of-life care? Does the way that a person approaches life’s ethical challenges make a difference in how well they can face death? This presentation will tackle such questions, bringing to bear both ethical analysis and personal experience.

Patrick T. Smith, PhD

Patrick T. Smith is associate research professor of theological ethics and bioethics at Duke Divinity School and senior fellow for the Kenan Institute for Ethics. He is also associate faculty with the Trent Center for Bioethics, Humanities, and the History of Medicine at Duke University School of Medicine. Smith has worked professionally in clinical contexts dealing with the ethics of hospice care. As a student and product of the black Baptist church tradition that flows from the African-American Christian experience, he seeks to integrate its spiritual, theological, and ethical resources for a public theology that bears witness in the form of a robust social ethic. He currently serves on the board of directors for the American Society for Bioethics and Humanities and is a fellow in CBHD’s Academy of Fellows.

EYES TO SEE, EARS TO HEAR: SEEKING SHALOM FOR THOSE DYING AT THE MARGINS

Many challenges face patients, families, medical professionals, faith communities, and clergy concerning how people die in the United States. Hospice and palliative care have made positive contributions in helping people live well while dying. However, African-Americans and non-white Hispanics are less likely to take advantage of quality hospice and palliative care than their white American counterparts who are similarly situated at the end of life in circumstances regarding their health. This might be considered another example of the mounting evidence of healthcare disparities with respect to these groups. This talk explores both the social roots of health disparities and the impact of the complex social nexus of socioeconomic status and race on how people die in the United States. It appeals to Christian tradition and a vision of shalom in order to challenge the church to have “eyes to see” the bodies and “ears to hear” the cries of those image bearers.
who are dying at the margins of our society. This deep theological vision compels us to consider not only what it means to value life at the end of life, but also to go a bit deeper with respect to these groups to ask what does it mean to value life before the end of life?

Jon C. Tilburt, MD, MPH

Jon C. Tilburt is a consultant in the Division of General Internal Medicine and the Division of Health Care Policy & Research, as well as professor of medicine and biomedical ethics at the Mayo Clinic—Rochester. His research and writing interests include biomedical ethics, healthcare decision-making, and improving care and human connection in health systems, including how best to incorporate the beliefs and values of patients and clinicians into clinical care. Tilburt is a member of the Ethics Committee for the Society of General Internal Medicine and recipient of the Professionalism Article Prize from the American Board of Internal Medicine Foundation (2013). Tilburt's studies help clinical caregivers respond to the hopes, fears, beliefs, and values in the routines of healthcare organizations, as well as advocate for humane health policy.

CARE TAKING IN SECULAR BIOETHICS

Current debates in end-of-life ethics exemplify how difficult it can be for Christians to speak into contemporary culture. Yet, some Christians are called specifically to the field of secular bioethics. Dr. Jon Tilburt, a practicing internist and professor of biomedical ethics at Mayo Clinic will explore how working within secular bioethics can be construed as care taking—a form of cultural stewardship. Drawing on examples from end-of-life care and healthcare rationing, he will illustrate challenges and opportunities for a model of cultural engagement within secular bioethics that opens up conversations and hints at realities beyond the imminent.

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Conscientious Practice in Healthcare: Ethical, Clinical, and Legal Issues
WEDNESDAY, JUNE 19

Conscientious practice (moral integrity) is essential in the life and work of a healthcare professional. However, the moral pluralism of Western democratic societies results in ethical differences that challenge this practice. Disagreements can raise pivotal questions about competing ethical values, concepts of health, the moral dynamic of shared decision making, the meaning of conscience, and the extent to which society will accept ethical differences in professional practice. 

Regarding ethical and clinical issues, the workshop will discuss historical and contemporary concepts of conscience, describe conscientious practice as moral integrity, relate conscientious practice to the moral dynamic of shared decision making and the influence of contrasting concepts of health, and clarify the relationship between conscience and love in Christian ethics. Regarding legal issues, the workshop will allow participants to articulate an understanding of the basic federal and state statutory and regulatory protections for healthcare professionals in federal programs and how to secure those protections. Participants will also be able to identify the relative strengths and weaknesses of claims of conscience under relevant federal and state statutes and understand the legal procedures afforded by the court system to vindicate such claims.

CO-SPONSORED BY AMERICANS UNITED FOR LIFE Workshop led by:

Steven H. Aden, JD, is Chief Legal Officer & General Counsel at Americans United for Life. He is a highly experienced litigator and has been appointed by the attorneys general of six states to defend pro-life laws. A prolific author and analyst on sanctity of life issues and attorneys general of six states to defend pro-life laws. A prolific author and analyst on sanctity of life issues and constitutional jurisprudence, Aden is admitted to the bars of the District of Columbia, Virginia, and Hawaii (inactive), and is a member of the bars of the U.S. Supreme Court and numerous federal circuit and district courts. He earned his JD (cum laude) from Georgetown University Law Center and his BA from the University of Hawaii.

Lauris Kaldjian, MD, PhD, is director of the Program in Bioethics and Humanities at the University of Iowa Carver College of Medicine, where he is also professor in the Department of Internal Medicine. He received his MD from the University of Michigan, an MDiv and PhD in Christian ethics from Yale University, and he completed his residency and fellowship training at Yale in internal medicine and infectious diseases. His research interest in clinical decision making and conscientious practice led to the publication Practicing Medicine and Ethics: Integrating Wisdom, Conscience, and Goals of Care (Cambridge University Press, 2014).

Suffering, Pain, Opioids, and Compassionate Care for Patients: Controversies and Hope
THURSDAY, JUNE 20

In the setting of a medical system influenced by a technological imperative, increased resource pressures, a growing opioid crisis and external judgements on quality of life, both America’s population over age 65 and the palliative care movement are on the rise. While society may present that “suffering is the enemy,” sometimes even requesting to eliminate the suffering person to eradicate suffering, Christian teaching calls for an accompaniment of the suffering person, seen as a positive duty of charity, that ultimately offers a faith and hope-filled presence. Furthermore, in the suffering person who is approaching death, Christian teaching further recognizes that utmost care must be taken to not disregard the “dignity” of the person—neither by hastening death nor by therapeutic obstinacy. Many questions exist regarding what is morally permissible, obligatory, or to be avoided according to Christian perspectives of relief of pain and suffering, and how such perspectives compare and contrast to those of the modern hospice and palliative medicine movement. We will explore Christian understandings of pain and suffering, differentiating Christian understandings of pain and suffering from those of modern hospice and palliative medicine. This workshop will evaluate tensions that exist at times between the “right” and the “best” thing to do and ultimately work to integrate Christian teaching and understandings of the good life and good death into compassionate care for patients.

CO-SPONSORED BY THE OHIO STATE UNIVERSITY CENTER FOR BIOETHICS Workshop led by:

Ryan R. Nash, MD, MA, FACP, FAAHPM, is the Director of The Ohio State University Center for Bioethics and Division of Bioethics in the OSU College of Medicine. He is a tenured associate professor of medicine and holds the Hagop S. Mekhjian, MD, Chair in Medical Ethics and Professionalism. In addition to practicing palliative medicine, Dr. Nash is a clinical bioethics consultant and healthcare ethics advisor for the OSU Medical Center. He is the editor of a book series on bioethics and medical humanities. He also serves on editorial and editorial advisory boards of several journals, has published a book and several book chapters and essays related to bioethics, and has presented numerous scientific papers and invited lectures. Dr. Nash has served on committees related to government, insurance, POLST, and AAHPM, among others.

Nicole Shirilla, MD, MEd, received her medical degree from the University of Pittsburgh School of Medicine and her master’s degree in education from the University of Notre Dame. She completed a family medicine residency and a palliative medicine fellowship at the University of California Irvine. She is a clinical assistant professor with the Division of Palliative Medicine at The Ohio State University College of Medicine, as well as a fellow and MA candidate in bioethics with The Ohio State University Center for Bioethics.
working toward the day when everyone is welcomed in life and protected in law.
**PASTORS WORKSHOP**

**THURSDAY, JUNE 20**

In this workshop, pastors are invited into end-of-life discussions and decisions away from the stressful setting of an intensive care unit (ICU) or hospital room in order to equip them to interact with the healthcare team and to help families with difficult choices.

This workshop is designed to increase understanding of what happens in the ICU, how to interface with doctors and nurses, and how to give ethically sound counsel. Additionally, it will familiarize participants with advance care planning documents such as living wills, advance directives, and Do Not Resuscitate orders.

**CO-SPONSORED BY CENTER FOR TRANSFORMATIONAL CHURCHES**

Workshop led by:

**Allen H. Roberts, II, MD**, completed his MD at George Washington University; MDiv at Reformed Theological Seminary; and MA Bioethics at Trinity International University. In 2003 he retired from the U.S. Navy Medical Corps after a 20-year career in internal medicine, pulmonary, and critical care, during which time he served as White House Physician under President George H. W. Bush. For the past 16 years, he has practiced critical care medicine at Georgetown University Hospital, where he now serves as the associate medical director for the hospital and Chair of the Clinical Ethics Committee. Dr. Roberts has been extensively involved in postgraduate medical education, specifically, resident education in critical care. He has a keen interest in end-of-life care and ethics and transplantation ethics. Dr. Roberts lives in Washington, DC, with Afsoon, his wife of 23 years, and two daughters, Ariana and Sara.

**C. Ben Mitchell, PhD**, is the Graves Chair of moral philosophy at Union University. He is also editor of *Ethics & Medicine: An International Journal of Bioethics* and serves as a Research Fellow with the Ethics & Religious Liberty Commission of the SBC. He taught ethics, bioethics, and contemporary culture for a decade at Trinity Evangelical Divinity School and was the director of CBHD from 2006–2008. Dr. Mitchell took his PhD from University of Tennessee and his MDiv from Southwestern Baptist Theological Seminary. He has done additional study in genetics, consults frequently on public policy, and is interviewed regularly. Among other works, he is the author of *Ethics and Moral Reasoning* (Crossway, 2013) and a co-authored volume, with D. Joy Riley, MD, *Christian Bioethics: A Guide for Pastors, Health Care Professionals, and Families* (B&H, 2014).

**COURSE LECTURERS**

**Linda R. Duncan, RN, DNP, CCRN, CNE** | North Park University  
**Claretta Dupree, RN, PhD** | Chair, Academy of Fellows, The Center for Bioethics & Human Dignity  
**Elizabeth Hensley, MD, MA** | Center for Bioethics and Medical Humanities  
**Samuel D. Hensley, MD** | Mississippi Baptist Medical Center  
**Fabrice Jotterand, PhD** | Medical College of Wisconsin  
**Michelle Kirtley, PhD** | Advisory Board, The Center for Bioethics & Human Dignity  
**D. Joy Riley, MD, MA** | The Tennessee Center for Bioethics & Culture  
**Kathleen Waller, PhD** | Saint Xavier University

**COMBINED SESSION LECTURERS**

**Gregory E. Manship, MDiv, DBe** | Order of St. Francis Healthcare  
**“Keeping our Eyes on the Prize: The Five “I”s of Research Ethics and the Research Enterprise”**  
**Martha L. Twaddle, MD, FACP, FAAHPM, HMDC** | Northwestern Medicine  
**“The Intersection of Ethics and Patient-Centered Care”**  
**Luann E. Van Campen, PhD, MA** | Ethics Matters, LLC  
**“An Introduction to Biopharmaceutical Bioethics”**
PROFESSORS OF RECORD

William P. Cheshire, Jr., MD
Human Nature, Personal Identity, and the Ethics of Brain Technologies Seminar (BE7700b)

William P. Cheshire, Jr. is Professor of Neurology at the Mayo Clinic in Florida, where he chairs the Ethics Committee and leads the Program in Professionalism & Values. He is a Senior Fellow for The Center for Bioethics & Human Dignity. Following an AB in biochemistry from Princeton University, he received his MD from West Virginia University and his MA in bioethics from Trinity International University (TIU). He completed a residency in neurology and a fellowship in pain management at the University of North Carolina in Chapel Hill and is board certified in neurology and in autonomic disorders. Dr. Cheshire is past president of the American Autonomic Society. He chairs the Ethics Committee of the Christian Medical and Dental Associations and is an adjunct professor of bioethics at TIU. In 2015, at the Mayo Clinic in Florida, he received the Neurology Department’s Teacher of the Year award.

Paige Comstock Cunningham, JD, PhD
Intensive Bioethics Institute (BE5100)

Paige Comstock Cunningham is the executive director of The Center for Bioethics & Human Dignity. Cunningham is also an affiliate professor at Trinity Law School and Trinity Graduate School and is a past president and board chair of Americans United for Life. Cunningham has published numerous articles, editorials, and book chapters in the areas of law, bioethics, and public policy, has testified before Congress and state legislative committees, and has made numerous television appearances. She lectures on bioethics, public policy, reproductive ethics, abortion, and global women’s health. She is married to Jay Cunningham. They have three adult children and six grandchildren.

Co-Teacher Todd T. W. Daly, PhD
Human Nature, Personal Identity, and the Ethics of Brain Technologies Seminar (BE7700b)

Todd Daly is associate professor of theology and ethics at Urbana Theological Seminary and writes in the areas of medicine and human enhancement. He has been a Paul Ramsey Fellow at the Center for Bioethics and Culture and currently serves as a fellow at The Center for Bioethics & Human Dignity. Dr. Daly is also an active participant on the ethics committee of Carle Foundation Hospital in Champaign-Urbana, Illinois.

Hans Madueme, MD, PhD
Bioethics National Conference (BE477x/BE5900)

Hans Madueme is associate professor of theological studies at Covenant College in Lookout Mountain, Georgia. Born in Sweden, he grew up in Nigeria, Austria, and England. After completing a residency in internal medicine at the Mayo Clinic in Rochester, Minn., he received an MDiv and a PhD in systematic theology from Trinity Evangelical Divinity School (TEDS). While completing his dissertation, he served as the managing director of the Henry Center and the associate director of the Jonathan Edwards Center at TEDS. He was on the editorial board of Trinity Journal and is presently a review editor for the journal Themelios. His research interests are in systematic theology and the interface between science and theology.

Joyce A. Shelton, PhD
Bioethics for Professionals (BE476x)

Joyce Shelton is director of the Division of Science, Technology, and Health at Trinity International University. Her pre-doctoral research was in immunology and developmental biology. Prior to coming to Trinity, she did postdoctoral research at Northwestern University in biochemistry, immunology, and reproductive biology and has publications in these areas. She also has interests in the field of bioethics. She has served as the director of The Center for Bioethics & Human Dignity’s undergraduate bioethics institute for a number of years and is on the editorial board of two bioethics journals. While at Trinity, she has been chair of the Health Sciences Department, associate dean of Trinity Graduate School, and interim dean of TGS and REACH.

Michael J. Sleasman, PhD
Advanced Bioethics Institute (BE6500) Contemporary Issues in Bioethics (BE7700a)

Michael J. Sleasman is the managing director and research scholar for The Center for Bioethics & Human Dignity (CBHD). He is an affiliate professor of bioethics at Trinity Graduate School and has served as an adjunct instructor and online course tutor at the college and graduate level in the areas of philosophy, theology, ethics, and cultural engagement. His current areas of research include the theological engagement of bioethical issues with particular emphasis on biotechnology, other emerging technologies, and human futures. He is the co-editor of Everyday Theology: How to Read Cultural Texts and Interpret Trends, and has published a number of essays, book chapters, articles, and book reviews in the areas of theology, bioethics, and technology.
Anatomy of a Perfect Crime? How to Dissect the Typical Assisted Suicide Statute and Expose Its Harmful Nature*

This workshop will discuss in detail several state statutes authorizing assisted suicide and highlight the radical dangers to Hippocratic Medicine. It will then provide concise arguments against these statutes that can be persuasively made in the secular public square.

Sponsored by: Bioethics Defense Fund with Dorinda C. Bordlee, JD and Nikolas T. Nikas, MA, JD

Dorinda C. Bordlee is Vice President and Senior Counsel of Bioethics Defense Fund (BDF). In the public policy realm, Bordlee has drafted legislation and educational pieces for dozens of states on the full range of bioethics issues. She also has wide-ranging litigation and appellate advocacy experience defending the constitutionality of life-protective laws in U.S. federal courts and the U.S. Supreme Court via the drafting of amicus briefs for national medical organizations. She has consulted with members and legal staff of the President’s Council on Bioethics. Bordlee is the author of a chapter on abortion alternatives in The Cost of Choice, and has published articles and opinion pieces on authentic feminism, healthcare conscience rights, and human cloning. She received her BA in Finance (summa cum laude) and JD from Loyola University, New Orleans, where she served as managing editor of the law review. She clerked for the Chief Justice of the Louisiana Supreme Court before joining a practice in law enforcement defense.

Nikolas T. Nikas is Co-founder, President, and General Counsel of Bioethics Defense Fund (BDF). Nikas is a frequent speaker and lecturer on a range of bioethical issues and has litigated ballot initiatives regarding human cloning and embryonic stem cell research, healthcare rights of conscience, clinic regulations, and state-passed limits on late-term abortion. Nikas has organized and participated in the oral argument preparation for attorneys arguing before the U.S. Supreme Court addressing the issues of partial-birth abortion, Stenberg v. Carhart (2000), and free speech for peaceful sidewalk counselors, McCullen v. Coakley (2014). In the realm of model legislation, Nikas has consulted with policy leaders and lawmakers in state legislatures, along with members and legal staff of the President’s Council on Bioethics. He has also testified before the U.S. Senate on abortion and First Amendment rights.

Bioethics, Autonomy, and Clashes of Values*

Current cultural thought values diversity, tolerance, and other ideologies that are at odds with long-standing ethical principles. Current bioethics overvalues autonomy and has shifted from classical Aristotelian ethics to relativistic and utilitarian ethics. This workshop will review these phenomenon, contrast ethical frameworks, review bioethical principles, and present cases for discussion.

Sponsored by: American Association of Pro-life Obstetricians & Gynecologists with George Delgado, MD

George Delgado is the medical director of Culture of Life Family Health Care and president of Steno Institute. He has published two peer-reviewed articles in the medical literature describing the reversal of mifepristone (RU 486) using progesterone. Delgado received his medical degree from the University of California, Davis and completed his residency at Santa Monica Hospital/UCLA. He is board certified in family medicine and in hospice and palliative medicine. He completed the one-year Certification Program in Health Care Ethics with the National Catholic Bioethics Center.

Caring for the Suffering: Drugs, Consciousness, and Becoming Human*

In a world of competing visions of the good, the right, and the valuable, we also observe competing visions of what suffering is, whether it has purpose, and what limits ought be in place to relieve it. Even among the disputing Christianities, a shared view of suffering is elusive. This presentation will focus on a patristic and traditional Christian understanding of suffering. This view will be compared and contrasted with the contemporary view of the same in the dominant medical culture. The presenter will share his significant experience in care of patients in hospice and palliative care and will engage practical dilemmas demonstrating how disparate views of suffering lead to differing ethical judgments and clinical practices. Special attention will be given to the prescribing of drugs that alter the mind and consciousness and how this may influence the spiritual work of dying. Finally, a Christian approach to modern pain and symptom management will be furthered.

Sponsored by: The Ohio State University Center for Bioethics with Ryan Nash, MD, MA, FACP, FAAHPM
**Dignity and Dementia***

One of the best ways to improve the quality of life for patients with dementia is to recognize that, as made in the image of God, we must respect their dignity. This flows out of a robust understanding of what it means to be made in God’s image. This talk will develop a theologically based understanding of dementia and discuss the medical context. It will then present practical ways to show this respect. Caregivers are the other victims of dementia, and this talk will demonstrate ways they can be used by God to honor him without themselves burning out.

**Sponsored by:** Christian Medical & Dental Associations with John Dunlop, MD

**John Dunlop** earned his MD at The Johns Hopkins University School of Medicine in 1973. He continued postdoctoral training in internal medicine at Johns Hopkins, was board certified in internal medicine, and was in practice for 38 years in Chicago, Illinois. In 1986 he was board certified in geriatrics and in 2003 earned an MA in Bioethics at Trinity International University. In 2014 he relocated and now practices part-time and teaches at the Yale University School of Medicine. He has written *Finding Grace in the Face of Dementia*.

**Disability and End-of-Life Care: Unique Perspectives, Enduring Ethical Issues**

For members of the disability community, end-of-life care presents both timeless, enduring ethical considerations and some unique concerns. For example, while recognizing the value of the exercise of “autonomy” in the context of end-of-life decision making, disability advocates are also keenly sensitive to the potential intrusion of social coercion, manipulation, discrimination, and/or bias into such decision making processes. This workshop will explore some of the ways in which end-of-life care, along with its attendant ethical issues, looks both “the same” and “different” from the perspective of persons with disabilities.

**Sponsored by:** Joni and Friends International Disability Center with D. Christopher Ralston, PhD

**D. Christopher Ralston** is Manager of Public Policy and former senior editor of the *Journal of the Christian Institute on Disability* at Joni and Friends International Disability Center. He is the co-editor of two edited book volumes—*Philosophical Reflections on Disability* and *The Development of Bioethics in the United States*—and serves as a Fellow of The Center for Bioethics & Human Dignity’s Academy of Fellows. He is a graduate of Biola University (BA, Communications; MA, Philosophy of Religion and Ethics), Trinity International University (MA, Bioethics), and Rice University (PhD, Philosophy). His research and writing draws on his own experience as a person with a physical disability, and centers around issues at the intersection of disability, theology, and ethics.

**Euthanasia and Eugenics: The Pediatric Connection***

Euthanasia, traditionally associated with the killing of the elderly and infirm patient, at present includes the killing of children whose lives are considered unworthy of living. The ideology of eugenics developed in the Western world over 100 years ago. Discredited as nonscientific and discriminatory, it has resurfaced as a new scientific eugenics. The focus of the new eugenics is children. The “old” eugenics proposed the hegemony of the fit and the elimination of the unfit; the new eugenics, using modern techniques, attempts to do the same. *Continued on next page.*
Promoters of euthanasia from the time of Hippocrates to present times have attempted to involve the physician in the killing of the weak and vulnerable—to call the killing medical practice. The medical community must resist this attack; the physician must remain a healer and reject the role of executioner.

**Sponsored by:** American College of Pediatricians with Felipe E. Vizcarrondo, MD, MA

Felipe E. Vizcarrondo attended Temple University Medical School in Philadelphia, PA. He completed a residency in pediatrics and subspecialty training in pediatric cardiology. He completed a master's degree in bioethics and has written on a variety of issues ranging from freedom of conscience of healthcare workers, the doctor-patient relationship, and end-of-life issues. Dr. Vizcarrondo is associate professor (voluntary) of Pediatrics at the University of Miami Miller School of Medicine and affiliate faculty for the Institute of Bioethics and Health Policy.

**Fatal Flaws: Turning Back the Legalization of Assisted Suicide***

In an effort to both survey the landscape of the law of "suicide by physician" and consider how we may best oppose this dangerous trend, this workshop will cover the history of medicalized suicide, the law on medicalized suicide, and strategies to counter the push of suicide activists. The focus will be on law and legal developments, but medical and philosophical viewpoints will also be addressed.

**Sponsored by:** Americans United for Life with Catherine Glenn Foster, MA, JD

Catherine Glenn Foster is president and CEO of Americans United for Life (AUL), America's first national pro-life organization and the nation's premier pro-life legal team. AUL's legal strategists have been involved in every pro-life case before the U.S. Supreme Court since *Roe v. Wade*. AUL is the pioneer of the state-based model legislative strategy, which works to save lives today while undermining the so-called "reliance" interest adopted by the Supreme Court in *Planned Parenthood v. Casey*, the false idea that women “rely” on abortion to succeed in American society.

**Organ Procurement Strategies: Protecting the Sacredness of Donor and Recipient***

In an effort to close the procurable organ “supply-demand” gap, a number of initiatives have begun to appear in critical care, ethics, and transplantation literature which tout innovative methods for procuring the maximum number of optimally viable organs. A number of these proposed methods involve the expansion of the criteria for the diagnosis of death, or the jettisoning of long-held ethical tenets of organ procurement, such as the “Dead-Donor Rule (DDR).” Still other proposed methods include “organ conscription” programs that default to a concept of “state ownership” of all potential organs.

In this workshop, we will explore the ethical dimensions of current organ procurement practice and evaluate the potential implication of these innovations on maintaining the sacredness and dignity of those in need of a transplant, as well as those who may become an organ donor at the end of life.

**Sponsored by:** Pellegrino Center for Clinical Bioethics with Allen H. Roberts, II, MD, FACP, FCCP, MDiv, MA

Allen H. Roberts, II completed his BA at the University of Virginia; MD at George Washington University; MDiv at Reformed Theological Seminary; and MA Bioethics at Trinity International University. In 2003 he retired from the U.S. Navy Medical Corps after a 20-year career in internal medicine, pulmonary, and critical care, during which time he served as White House Physician under President George H. W. Bush. For the past 16 years, he has practiced critical care medicine at Georgetown University Hospital, where he now serves as the associate medical director for the hospital and Chair of the Clinical Ethics Committee. Dr. Roberts has been extensively involved in postgraduate medical education, specifically, resident education in critical care. He has a keen interest in end-of-life care and ethics and transplantation ethics. Dr. Roberts lives in Washington, DC, with Afsoon, his wife of 23 years, and two daughters, Ariana and Sara.
Rights of Conscience for Healthcare Professionals*

The purpose of this workshop is to educate medical professionals about the existing legal protections for conscientious objections in medical care and how to advocate for better conscience protections. The workshop will explore: what laws protect rights of conscience in the medical field; specific circumstances in which these laws protect conscience, and where they do not; how to make a conscientious objection; real life cases involving conscience rights; and practical steps to be prepared in the event that a conscience issue arises during the course of medical practice.

**Sponsored by:** Alliance Defending Freedom with Denise Burke, JD

**Denise Burke** serves as senior counsel with Alliance Defending Freedom (ADF), where she is a member of the Center for Life. In this litigation role, Burke’s efforts are directed toward limiting the 1973 *Roe v. Wade* decision and ultimately overturning it. She also works to defend pro-life speech and to challenge physician-assisted suicide laws. Prior to joining ADF, Burke served as Vice President of Legal Affairs for Americans United for Life, where she routinely advised legislators, policy groups, and state attorneys general on life issues. In addition, Burke testified before legislative committees on the constitutionality of pro-life legislation. A member of the state bar of Texas, Burke is admitted to practice before the U.S. Supreme Court, the Court of Appeals for the Armed Forces, and multiple federal district and appellate courts. She earned her bachelor’s degree in business management from the University of Maryland, followed by her JD from Southern Methodist University.

Whither Futility? Seeking a New Vocabulary for Difficult End-of-Life Decisions

For decades, the concept of “medical futility” has served as a proxy for some of the most vexing questions in medical ethics: At what point are life-saving or life-sustaining medical treatments “too much?” If physicians determine that point has been reached, should requests by patients or families to continue such treatment be honored, on grounds of “patient autonomy?” In making such determinations, is there always a clear line between saying that treatment is futile and saying that the patient’s continued life is futile? At what point should the state step in to protect physicians’ and hospitals’ abilities to refuse treatment they deem to be “futile?”

This workshop will explore these various uses of “medical futility” and propose that, where possible, the term should be avoided in favor of more precise language directed to the specific questions described above. Adopting a teleological framework that avoids “means” being confused with “ends” will help clinicians, patients, and families better navigate through the ethical difficulties posed by human illness, suffering, and mortality.

**Sponsored by:** Christian Legal Society with Edward R. Grant, JD

**Edward R. Grant** is an assistant professor of bioethics at the Pellegrino Center for Clinical Bioethics, Georgetown University School of Medicine. He holds degrees from Georgetown (AB) and the Northwestern University School of Law (JD) and is currently a candidate for the MA in Theology at the Pontifical Faculty of the Immaculate Conception, Dominican House of Studies, Washington, DC. His publications in the field of law and bioethics have concentrated on end-of-life issues. He is a member of CBHD’s advisory board, has spoken at several CBHD conferences, and is a frequent contributor to *Dignitas*. As a practicing attorney, he has held several positions in private practice and government, and since January 1998 has served as a board member on the Board of Immigration Appeals, U.S. Department of Justice.

*CME Approved Workshop*
JCID offers a platform for discussions at the intersection of Christian faith and disability.

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## PARALLEL PAPER & POSTER SESSION SCHEDULE

UNLESS OTHERWISE INDICATED, ALL ROOM NUMBERS PERTAIN TO THE RODINE GLOBAL MINISTRY BUILDING.

### FRIDAY, JUNE 21

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<th>POSTERS (9:30–10:00AM)</th>
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<td>Posters are displayed in Rodine Global Ministry Building Lobby. Designers available for questions.</td>
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<td><strong>SUBHA SAEED, MBBS</strong></td>
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<td>Dire Need for Ethical Reforms in Present Era of Growing Cross-Cultural Research Collaboration</td>
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<td><strong>ROBERT CRANSTON, MD, MA, MSHA, FAAN &amp; Coauthor COLEMAN SOLIS</strong></td>
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<td>A Retrospective Review: 18 Years of Ethics Consults at a Large Community Hospital</td>
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<td>Inclusion and Disabilities: Experience at a Regional Hospital</td>
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### SESSION A (1:00–1:30PM)

| 124 – RICHARD WEIKART, PHD | Is the Slippery Slope Argument Valid? The Trajectory of Assisted Suicide and Euthanasia* |
| 125 – CHRISTINE TOEVS, MD, MA | Brain Death – When are You Dead? Depends on Who Says* |
| 126 – J. ALAN BRANCH, PHD | Puberty Suppression for the Purpose of Exploring a Transgender Identity: A Christian Critique* |
| 127 – BENJAMIN PARKS, MDIV, MA | Pygmies and Astomi and Scioopods, Oh My! Augustine, Disability, and the Resurrection |
| 128 – EDWARD MANZO, JD, MA | Human Germline Editing: A Theological and Bioethical Discussion* |
| 129 – NICHOLAS BROWN, PHD | Taking Care: Conatus Passio, Healing and the (Re)Embracing of Mortality in End-of-Life Medicine* |

### SESSION B (1:40–2:10PM)

| 124 – TODD T. D. DALY, PHD | For the Greater Good? Death by Organ Donation as the Loss of Tragedy, the Body, and the Identity of Medicine* |
| 125 – EDWARD GRANT, JD | The Ethics of Cessation of Eating and Drinking |
| 126 – FAHIMEDA HOSSAIN, MDIV, MA | Third-Party AI Actors: Can They Preserve Human Dignity?* |
| 127 – COLLEEN MCCORMICK, APRN, CRNA, MA | What’s It All About, Alfie? The Role of Government in Health Care* |
| 128 – KYLE MCNAMARA, MA | Made in the Image of Man: A Christian Response to CRISPR-Associated Germline Editing |
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| 129 – THEO A. BOER, PHD & A. STEF GROENEWOUD, MPHIL | Is Regional Variation in Euthanasia in the Netherlands Explained by Inhabitants’ Religious Beliefs? A Claims-Data Based Longitudinal Cohort Study* |

**CME Approved Parallel Paper Session**
Is Regional Variation in Euthanasia in the Netherlands Explained by Inhabitants’ Religious Beliefs? A Claims-Data Based Longitudinal Cohort Study

It is a well-known phenomenon that healthcare utilization, costs, and quality considerably differ between regions. It has also been described in the literature that both patients’ and providers’ attitudes toward euthanasia are highly associated with their religious beliefs. However, the literature on geographical differences in the application of euthanasia in countries where assisted dying is allowed is scarce. Regional variation in the Netherlands is only discussed in one publication and uses highly aggregated data of cases that were reported to the five Regional Review Committees (RRCs). Besides, no analyses were performed on the association between regional variation and religious beliefs of inhabitants.

The aim of our research is (1) to study longitudinal claims-data to explore regional differences in the incidence of euthanasia in the Netherlands, (2) to explore the degree to which data on religious beliefs are related to this practice variation, and (3) to discuss the most likely explanations for the relations we find.

We used insurance claims data of all insured (97.5%) inhabitants of the Netherlands who died between January 1, 2013, and December 31, 2017, including those who died after euthanasia. Data included reference to neighbourhoods (‘4-digit ZIP-codes’) and were anonymized and stripped from any traceable personal data. We used similar data from the Central Bureau of Statistics (CBS) about religion. Analyses (descriptive, ANOVA, and correlations) were performed in IBM SPSS Statistics 25.

Puberty Suppression for the Purpose of Exploring a Transgender Identity: A Christian Critique

Drugs used for puberty suppression are called Gonadotrophin-Releasing Hormone Agonists (GnRH Agonists). These drugs were originally developed in the early 1980s to help children experiencing “precocious puberty,” or puberty at unusually early ages, such as six or seven, and were merely administered so the child could experience puberty at a more developmentally appropriate age. In 1998, researchers in Holland published an article explaining how the same drugs could be used to postpone normal puberty in children with gender dysphoria so the children could explore their own gender identity and the possibility of being transgender. Since then, GnRH Agonists have become a preferred method for addressing childhood gender dysphoria among some advocates of transgenderism. Males who receive these drugs will not develop any of the secondary sex characteristics associated with puberty such as deepening voice, increase in height, development of body hair, or genital growth. Females taking these drugs will not develop breasts or start their menstrual cycles. While using GnRH Agonists for treatment of precocious puberty is morally acceptable, the practice of giving pre-adolescent children puberty-suppressing drugs for the purpose of encouraging them to explore a transgender identity is incompatible with Christian ethics. To prove this thesis, the paper will begin with a brief history of the development of GnRH Agonists for the treatment of precocious puberty. Next, the history of the use of these drugs for purposes of intentionally suppressing puberty in order to explore a transgender identity will be summarized along with a review of the outcomes of children receiving these drugs. Finally, the Christian claim that one’s birth-gender is part of the goodness of God’s creation will be used to critique puberty-suppression as treatment for childhood gender dysphoria.

Taking Care: Conatus Passio, Healing, and the (Re)Embracing of Mortality in End-of-Life Medicine

When examining the current state of clinical discourse surrounding end-of-life medicine, there is oftentimes little, if any, distinction made between treatment and care. Thus the decision to prolong/forego end-of-life treatment is viewed synonymously and interchangeably with the decision to prolong/forego end-of-life care. Nevertheless, this conventional elision obscures a crucial conceptual and normative difference that distinguishes the two terms. The purpose of this paper is to illuminate this difference by fleshing out its philosophical, theological and ethical dimensions. Accordingly, my argument will be divided into three sections. In the first section I will appropriate William Desmond’s contrasting of the conatus essendi with the passio essendi to establish the different metaphysical postures treatment and care assume. More specifically, I will demonstrate that the concept of treatment is expressive of the conatus
essendi with its ontic/subjective grasping of being while care is instead rooted in the passio essendi’s giftedness of being. The second section of the paper builds upon this metaphysical appropriation by discussing how it is homologous with the theological distinction John Pilch observes between curing and healing as they are conceived of in the medical and theological imagery of the New Testament. That is, while the healing narratives of the synoptics depict Jesus curing people of certain physical and/or psychological ailments, they also show him healing and restoring those suffering from disease of their attendant social alienation and isolation. Finally, the paper concludes by arguing that, while certain clinical judgments may well commend the termination of end-of-life treatment, these judgments do not entail a concomitant abjuring of the duty to care by healthcare professionals. Indeed, it is precisely by continuing to care for terminally-ill patients that healthcare professionals most powerfully and paradigmatically embody an ethical commitment to honoring our mortality as articulated by Atul Gawande and Ephriam Radner.

Manuel A. Cota, Jr., MA
**The Virtues and Vices of ‘Evidence-Based Medicine’ from a Christian Perspective**
This paper will critically examine the philosophy of “Evidence-Based Medicine” (EBM) from a Christian theological perspective. There have been myriad critiques leveled against EBM, many of which center on charges of scientism and reductionism. These critiques have mostly been very general and not overly concerned to precisely pick out the forms of scientism they claim are present in EBM. I will argue that not all charges of scientism leveled at EBM are justified, but that EBM is vulnerable to certain types of scientism when accompanied by an epistemology that ignores the evidential value of what is called “clinical knowledge” and “mechanistic reasoning.” I will examine what I take to be the most sophisticated and nuanced description of the EBM hierarchy presented by Jeremy Howick. A primary strength in Howick’s presentation is his acceptance of the evidential value of clinical knowledge and mechanistic reasoning. Nevertheless, Howick’s presentation is in line with traditional EBM in so far as he holds that randomized clinical trials generally provide the highest evidential support for the efficacy of a proposed treatment. Finally, I will argue that while EBM is vulnerable to certain weaknesses, its strengths are congruent with fundamental epistemic virtues in Christian theology. I will draw on the themes of epistemic finitude and limitation and argue that humility is a virtue that may be promoted by a thoughtful application of EBM. In addition, I will draw parallels between the epistemology of theology and the hierarchies of evidence presented by EBM.

Robert E. Cranston, MD, MA, MSHA, FAAN & Coauthor Coleman Solis
**A Retrospective Review: 18 years of Ethics Consults at a Large Community Hospital**
A chart review was conducted, examining 180 ethics consultations that occurred over an 18 year time span at a large 413 bed community-based hospital. All were analyzed to determine which ethical issues arose most often and when the ethics committee’s involvement was sought. Three categories of consults were identified: unnecessary, potentially helpful, and helpful. We present the most significant findings: 1) common inappropriate uses of the ethics committee, 2) common appropriate uses of the ethics committee, and 3) situations that could have been averted before necessitating the committee’s input.

Twenty-six (15%) of the cases could easily have been resolved through other means, rendering them inappropriate. Of the remaining 154 cases, sixty-nine (38%) were potentially appropriate consults, but were readily resolved based on existing hospital policies. Decisional capacity was the most frequent purpose for these consults; however, an ethics consult is not necessary to determine decisional capacity as this can be evaluated by the attending physician.

Eighty-five cases (47%) were highly appropriate for committee consultation given the circumstances. These cases primarily involved ethical gray areas or interminable conflicts between family members and the care team. Some of these encounters might have been avoided by more frequent, consistent, and prompt communication between care team members and between caregivers and the patient’s family. Input from ethics consultants appears to assist with issue resolution, particularly in ethical dilemmas and interminable conflicts, when coupled with effective tools such as full-team and family conferences. Better communication between all parties was essential in obtaining optimal patient outcomes.

**Parallel Paper & Poster Abstracts**
Todd T. W. Daly, PhD

For the Greater Good? Death by Organ Donation as the Loss of Tragedy, the Body, and the Identity of Medicine

Recently, two doctors from Western University in Ontario and Harvard bioethicist Robert Truog have argued for the abolition of the ‘dead donor rule’ to facilitate organ donation from patients seeking the recently legalized (in Canada) physician-assisted suicide or voluntary euthanasia. They argue that the dead donor rule, which establishes a “firewall” between the medical team treating the patient and the organ procurement team, a protocol that depends on a circulatory determination of death marked by a varied period of pulselessness, often compromises organ viability due to ischemia. If, however, organs could be extracted through voluntary euthanasia, patients could achieve a more rapid and peaceful death, and the donated organs would have the highest potential of serving the greatest good. As far as the authors are concerned, a change in the Canadian criminal code and allowances for conscientious objectors are the main ethical hurdles.

By drawing on the work of Jeffrey Bishop, in particular, The Anticipatory Corpse, I will argue that the organ donation enterprise, while motivated from legitimate concerns, nevertheless suppresses the tragic element of death and thus more potentially formative responses to it. Moreover, with the help of Bishop as an able interpreter of Foucault, I will explore how the medical perspective on death is rooted in a reductionist epistemology and metaphysic of embodiment, ultimately giving rise to a “decisionist” or voluntarist ethic that all but mutes the moral significance of the body. I will also show how Truog’s rhetoric reflects this muting, being animated by the principles of modern bioethics and a nascent utilitarianism. Finally, Paul Ramsey’s prescient reflections on the tensions inherent in organ donation and the limits to ‘laying down one’s life for another’ will be appropriated in laying the groundwork for a more properly Christian approach to organ donation vis-à-vis the moral significance of embodiment.

Clareetta Y. Dupree, RN, MSN, PhD

Using Works of Fiction to Explore End-of-Life Issues: The Works of Jason Mott

Conversations about end of life in both the classroom as well as in the clinical area are difficult to raise. The issues are many and vary due to culture, personal experience with death/dying, and belief systems. Author Jason Mott has written three works of fiction that explore thinking about end-of-life. The Returned (2013) describes a situation in which people who had died decades earlier randomly and inexplicably returned to life. Among other things, this work can be used to examine terms used synonymously with returning to life (as opposed to examining terms used for dying/death); to imagine life before and after a granted wish (“I wish she was still alive”). The Wonder of All Things (2014) tells the story of a young teenager whose touch can heal and with each healing action takes a bit more of her life. This storyline can be used to explore the limits of healing and life-extension and questions of whose life is more important. The Crossing (2018) tells of a society in which lives are ended by war as well as by people simply falling asleep and not awakening. This can be used to open conversation about the type of death one wishes, as well as who (government or individual) gets to make decisions about the type of death.

Adele Flaherty, MA; Fahmida Hossain, MS; and Alexa Vercelli, MS

Meeting at the Crossroads of Stigma and Health Care: Achieving Ethical Palliative Care for Individuals with Opioid Use Disorder

A growing number of individuals live with an Opioid Use Disorder (OUD). While many go on to recover from such disorders, certainly there will be individuals in palliative care at some point who still suffer with OUD. One of the major barriers to palliative care for individuals recovering and currently suffering from an OUD is the stigma related to having an OUD. Therefore, in the context of palliative care it is important to understand the relationship that exists between palliative care, OUDs, and how stereotypes related to substance use disorders affect patient engagement in palliative care. For this paper, the focus will be on how stereotypes affect pain management in palliative care for persons with an OUD. A review of current literature regarding OUDs and pain management indicates a need for care specific to the needs of those in palliative care who formerly and/or currently suffer from an OUD in order to avoid relapse or worsening of their affliction while still managing their pain. The striking lack of knowledge and resources regarding opioid use disorders and their treatment indicates a need to strengthen/increase resources for physicians to educate on treating OUDs as well as alternatives for pain management. Finally—and perhaps most importantly—it is important to emphasize person-centered care so that individuals with an OUD are treated fairly, with humanity and dignity.
Edward R. Grant, JD  
**The Ethics of Cessation of Eating and Drinking**

In recent years, the practice of “voluntarily stopping eating and drinking” (VSED) has moved from the realm of speculative possibility to that of proposed routine, quietly making its way into mainstream healthcare. It is accepted by those who endorse physician-assisted suicide (PAS) and voluntary active euthanasia (VAE), but also by some who oppose these practices. For these PAS/VAE opponents, VSED is closely linked to decisions to forego “artificial” nutrition and hydration, as well as to the natural course of anorexia that attends the dying and is thus clearly distinct from PAS/VAE.

I propose to address the notable ethical issues that attend VSED: Under what circumstances does VSED constitute suicide? Are those who counsel or assist VSED complicit in suicide? What is the relationship between VSED and decisions to forego “artificial” means of nutrition and hydration? Is there a legal “right” to VSED? Assuming such a right exists, does one have a right to be informed of that option in the case of terminal or debilitating illness, or even profound but non-life-threatening disability?

The chief concern in addressing these questions is to assess the viability of the “middle position,” maintained by those who oppose PAS/VAE but endorse VSED as an acceptable alternative. By demonstrating the close links between VSED and more direct means of “hastening death,” in both theoretical (philosophical) and practical (clinical) terms, this paper will conclude that the “middle position” can only be justified by setting aside the fact that self-starvation with the deliberate intent to cause death is a species of self-destruction. The “middle position,” therefore, is likely to further weaken what barriers still exist against PAS and VAE as accepted practices in law and medicine.

Mary E. Homan, MA, MSHCE, DrPH  
**Developing a Shared Decision-Making Tool and Approach to Pediatric End-of-Life Treatment Decisions**

Almost 50 years ago, the Supreme Court of Kansas ruled that a minor’s ability to give informed consent is gauged by the minor’s understanding of the risks and benefits of any given medical procedure. The United States Supreme Court addressed the common law mature minor doctrine in 1981 and permitted a child to consent to medical treatment if capable of appreciating its nature and consequences. Minors who are considered mature or emancipated are understood to have the same capacity as adults to make healthcare decisions. The mature-minor rule focuses not on markers of independence, but rather on the minor’s capacity to give informed consent. Therefore, one might argue that mature minors would have the authority to refuse treatment or to seek treatment, regardless of parental wishes.

Some pediatricians have agreed that a child-patient should be included in end-of-life discussions, but that child should not be the decision-maker. Pediatricians have argued that parents have a legal and moral responsibility to make medical decisions in the best interest of the child even though there is the need to respect the rights and autonomy of every person regardless of age.

I will argue that parents and physicians should not exclude children over fourteen from medical decision-making without persuasive reasons. I will also seek to address the question posed by pediatric ethicist Rony Duncan on whether it is ethical to alter the degree of autonomy we afford adolescents based on how closely their choice reflects our own view of their best interest.

Fahmida Hossain, MS  
**Third-Party AI Actors: Can They Preserve Human Dignity?**

As Artificial Intelligence (AI) and the big data behind it become ever more sophisticated, AI increasingly becomes a more integral and familiar tool for healthcare diagnoses and decision making. AI technologies are being piloted and implemented as the assumed and “believed-to-be” future of healthcare. The proliferation of AI, in turn, gives cause for concern in areas such as healthcare ethics, decision-making biases, and the definition of human dignity.

It’s well established that clinicians can be influenced by subconscious bias, but the biases in health data are also common and can be life threatening when not addressed properly. Biased health data is one of the great threats for AI. Apart from its intent to aid society, AI will continue to perpetuate bias in global health due to its contribution on accessibility and accuracy on decision-making capacity due to inherent bias in the health data collected. As we perceive, AI happens to be nonbiased, but it may contain its creator’s biases. Therefore, given the increasing global use of AI in bioethics, where should we draw the line in delegating healthcare decision-making capacity to software and robots?
Peter L. Jaggard, MD, MA
*Ethics Dilemmas from a Geriatrician’s Casebook*

Geriatricians and other health professionals face a growing number of ethical dilemmas in the care of older adults. These situations are in part due to the demographic wave of ageing in America and the confluence of technological advances in medicine and rising costs of care. However, there are also value-driven factors contributing to, or in some cases, creating these dilemmas. These value-driven factors include functional views of personhood, rejection of the intrinsic sanctity of human life, and a youth-oriented culture that sees older adults as a burden on society. Christians are called to respect older adults by speaking for them when they cannot and by honoring them in the day-to-day process of taking care of them.

This presentation will examine the above tension facing Christian healthcare professionals in the context of several representative cases. These cases will include advance care planning, request for euthanasia, requests for stopping eating and drinking (by proxy or by advance directive), and the perception that older adults are a burden. Discussion of these cases will include biblical responses, as well as ways of articulating secular reasons for making life-affirming choices.

Bryan Just, MA
*Trying to Live Forever? Christian Views on and Responses to Radical Life Extension*

From companies such as Google’s Calico to shows like Netflix’s *Altered Carbon*, modern society has become enamored with the idea of extending life beyond its current limits. As Christians, though, we experience an odd tension. On the one hand, death is viewed as the enemy, a force that, though conquered by Christ at his resurrection, is one to which we still succumb, and thus one to be fought. On the other hand, death is seen as an inherent part of being an embodied creature, the final step in the journey of life and necessary for bringing us into full communion with our God and creator. Added to this tension is the reality that many of the modern efforts at radical life extension (RLE) are led by self-described transhumanists hoping to overcome the bonds of their humanity, an effort that strikes many Christians as inherently wrong, even if they cannot articulate exactly why. These various tensions make RLE a controversial topic, with some Christians giving cautious support while others recommend rejecting it.

The purpose of this paper is not to provide definitive solutions to the problems surrounding RLE, but to survey recent responses on this issue from leading Christian theologians and bioethicists. I then propose to compare these responses, determining what points of commonality they share, as well as where they differ in their conclusions. Finally, I wish to raise some questions that I have not seen discussed in the literature, especially regarding a Christian response in light of eschatology.

Aaron Klink, ThM
*Your Sickness Is Not Your Cross: Illness, Suffering, and Theologies of Discipleship for the Dying*

Jesus commands his disciples to “Take up your cross daily and follow me.” The writer of the Letter to the Colossians (which is authoritative for Christians regardless of debates over the letter’s authorship) states that his bodily suffering “completed Christ’s afflictions,” a passage Pope John Paul II made foundational for his theology of suffering. In my hospice chaplaincy work in the southeastern United States, Christian patients often refer to their illness as a “cross” and their experience of that illness as “carrying their cross.” I believe that this metaphor is not a faithful application of Scripture. Jesus was crucified because he preached a message of God’s salvation and forgiveness that offended the authorities of his day. It was Paul’s proclamation that brought about his suffering. However, most contemporary illnesses do not result from a patient’s decision to proclaim the gospel or any other reason related to their faith. Hence, I believe that a different metaphor is needed to think about faithful discipleship during illness. Roger Vanstone notes in his book *The Stature of Waiting* that during his passion Jesus allows himself to be “handed over” to the experience of suffering, trusting in God to deliver him. This paper argues that we follow Jesus to this “handing over” to suffering, which we are called to faithfully endure trusting in God, but we should not see illness as a “crucifixion.” By using the metaphor of being “handed over” by circumstances beyond our control, this paper seeks to find another image of suffering faithfully, other than “the cross” to use in pastoral ministry with those at the end of life.

Wing Cheong Lee, MBBS
*Inclusion and Disabilities: Experience at a Regional Hospital*

Inclusion is an established policy in caring for individuals with intellectual disabilities. It is hoped that the policy enables the individuals to make use of mainstream services, and to be fully included in the local
community. Yet little had been known for the individuals transitioning to adulthood.

A retrospective cohort in a regional hospital specialist clinic was reviewed. All individuals with intellectual disabilities exiting the clinic from July 2015 to June 2018 were identified. The focus is to evaluate aspects of mainstreaming, independent living, employment, activity and relationships.

Of the nine patients identified, none was graduating from mainstream school irrespective of their degree of intellectual disabilities. Upon reaching the adult age of 18 years, none had independent living. Three were in residential hostels, and five remained at home. Only one individual was successful in getting employed in a sheltered workshop. The primary caretaker for all of them were close family members, in which some of them expressed disharmony as from the work of caring. One patient died three years exiting the clinic, presumably from the underlying medical condition.

Inclusion for individuals with intellectual disabilities continued to be challenging. In this particular cohort with individuals having intellectual disabilities and medical complexities, the outlook on exiting specialist clinics was fair. Continued support, in particular from family members, is expected.

Lester Liao, MD, MTS

Deserting Patient-Centered Care: A Genealogy and Critique of Contemporary Ethics in Ending Life

Contemporary bioethics in Western society has largely abandoned the underlying Judeo-Christian heritage that provided the ideological foundations for human equality and the inherent value of life. In its place, a new popular ethic has emerged amongst a generation of clinicians that is built on the three pillars of secularism, individualism, and existentialism. Consequently, the notion of what constitutes a valuable life is built without reference to the divine, the wider community, or meaning outside personal wellbeing and desire. In this vein, the lives of many children with disabilities are deemed of lesser value. Ending life in the young is increasingly favoured, whether through the ongoing Canadian conversation regarding pediatric euthanasia or through passive means of withdrawing life-sustaining treatments.

This paper sketches an overview of how this predominant bioethical framework has emerged. Secularism is examined as both a philosophical and sociological phenomenon, drawing on the work of Peter Berger and the idea of subtraction stories by Charles Taylor. Individualism is explored through its ideological heritage alongside ongoing economic and technological developments. Finally, the rise of existentialism is explored as an increasingly prominent philosophy in medicine. This genealogy emphasizes the construction that was necessary to create the contemporary framework and the inherent non-neutrality of modern medicine. Each idea is subsequently critiqued and contextualized from within the same framework of medicine that emphasizes patient-centered care. The Christian worldview is contrasted as providing the most robust foundation to valuing and caring for patients.

Paul K. Lim, MD

Brain Death and Cardiac Death: Scientific Discoveries or Legal Fiction to Permit Organ Harvesting?

Irreversible coma was defined as a new criterion for death (brain death) over half a century ago, becoming widely accepted to allow for organ harvesting from individuals who met this new criteria and, so, who were deemed cadavers (dead donor rule). Indeed, an even “earlier” death criteria was subsequently established, donation after cardiac death (DCD), when patients did not meet the neurologic criteria for brain death but could then be pronounced dead based on cardiac criteria to allow for organ harvesting immediately following that pronouncement. For the past few decades, some authors, principally, Robert Truog, have been making the case that brain death and cardiac death are not, in fact, death but are examples of legal fiction, and, furthermore, have been arguing that the dead donor rule should be rescinded because it impairs the quantity and quality of organs available for transplantation. The purpose of this paper is to analyze this line of reasoning regarding brain death and cardiac death, as well as the ethical implications for solid organ harvesting if the dead donor rule is revoked.

Edward D. Manzo, JD, MA

Human Germline Editing: A Theological and Bioethical Discussion

CRISPR/Cas9 technology can edit the human genome and human germline. Theological considerations provide some limits on using this reproductive technology. It is unclear whether the Bible interdicts mankind from editing the human germline. The obligation to love one’s neighbor and providing medical care must be balanced against what appears to be reserved to God. Some scholarship suggests that curative medical intervention is obligatory. Editing the human germline raises bioethical issues
No universal rule declares whether edits are ethically and theologically proper, but conclusions can be drawn in specific cases. Therapeutic edits to prevent progeny from inheriting a genetic disease are presumptively beneficent. Theologically, such an edit seems proper because it forestalls a future medical need. Germline edits for purely cosmetic enhancement are likely unsound both theologically and bioethically. An edit seeking to give an advantage over others raises severe issues of social justice, and from a theological perspective, would be unsound when it changes mankind from its God-given and God-taken form, usurps God’s role, or tends to glorify man rather than God.

Colleen McCormick, APRN, CRNA, MA
What’s It All About, Alfie? The Role of Government in Healthcare

Throughout late 2017 and early 2018, the case of Alfie Evans focused international attention on the British National Health System. Born on May 9, 2016, Alfie was identified at six months as having a developmental delay. On December 14, 2016, he was admitted through the Emergency Department at Alder Hey Pediatric Hospital for high fever and seizures.

Alfie remained at Alder Hey, where although physicians acknowledged they could not diagnose his condition, within a month they declared it progressive and terminal. He was intubated, ventilated, and tube fed for 15 months. Alder Hey sought a court mandate to withdraw life sustaining treatment from Alfie. Alfie’s parents sought a second opinion, medical transfer, and continued care—at no cost to Alder Hey or the NHS.

The parents’ request was denied. Life sustaining treatment was withdrawn. Although “terminally ill,” Alfie managed to live five days after withdrawal/limitation of nutrition and hydration and withholding of antibiotics for iatrogenic infection.

Alfie’s case reopened a recent wound in Britain, just a year after the case of Charlie Gard. In the U.S. we have had incidents of our own: Alyssa Gilderhaus, the Diegel sisters, and Justina Pelletier, to name a few.

One of the long-held corollaries of the principle of autonomy in medical ethics is the surrogacy of the next of kin, absent malice on their part. The paper will engage in a discussion as to the ways changing conceptual systems have profoundly altered approaches to clinical decision making and “end-of-life” treatment.

Kyle J. McNamara, MA
Made in the Image of Man: A Christian Response to CRISPR-Associated Germline Editing

In the recent boom in biotechnologies over the last few years, one tool stands out with arguably the most potential to shape what it means to be a human person. CRISPR-Cas9 is a genomic editing system that has allowed scientists and researchers—cheaply, easily, and precisely—to “copy and paste” DNA from one source to another. With the raw potential of this biotechnology to allow manipulation of virtually any genetic trait comes the need for a rigorous and multidisciplinary debate regarding how it should be used responsibly in today’s society. One of the most significant implications that deserves ethical consideration is the use of CRISPR-Cas9 as an agent to edit the germline of human embryos. This paper will develop a Christian response to the secular notion that it is permissible to alter the germline of the human genome. Concerns regarding use of CRISPR-associated germline editing for enhancement purposes notwithstanding, the social and ethical implications of therapeutic genomic editing of the germline will be considered. Arguments will be presented to support the premise that germline editing is a violation of the autonomy and consent of future generations. Furthermore, its uncontrolled use could lead down a slippery slope to a new eugenics. The prospective scope and power of the CRISPR-Cas9 technique enhances the urgency for a thorough assessment of potential negative consequences and strategies for safeguarding against them.

Timothy Mrowiec, MA
A Christology of Mental Illness

Attention to the topic of mental illness has noticeably increased in recent years. With every new tragic report of a celebrity suicide or unconscionable mass shooting, the call for more open and productive discussions of mental health is issued, whether heeded or not. Many brave women and men have shared their own stories to battle the ungodly shame and stigma, and Christian leaders are starting to address the Church’s insufficient response to the matter (which has often ranged from merely neglectful to sadly harmful). This is certainly a
commendable step in the right direction.

However, these responses are essentially reactive. They demonstrate (sometimes very well) how to respond sensitively to the sharing of something very vulnerable, or how to ensure the immediate safety of an individual. But they do not display a rigorous theology of mental illness. My project aims to develop that, primarily by articulating a Christology of mental illness and how it can inform our witness to the world. If Christ truly became incarnate with a body like ours, then he has intimate familiarity with the limitations and frustrations of neurotransmitters. The world is paying close attention to mental illness right now, and people are trying to learn how to love themselves when their bodies fail them. My project will address the significance of Christ’s incarnation and ascension to the experience of mental illness, the distinction between love of self and lust for self, and how an orthodox doctrine of creation supports evidence-based treatment for mental illness.

**Stephen O. Muhudhia, MSc, MBChB, MMed**

**The Quest for Harmony in Ethical Decision-Making in Healthcare in Kenya**

Ethical decision-making in healthcare can be complex and may be influenced by social, cultural, religious, and economic factors. Various ethical theories are considered in search for suitable basis for making decisions. Principles of ethics proposed by Beauchamp and Childress are often applied with various degrees of weightings. In this principlism approach, the principle of respect for persons — autonomy—is usually the most dominant ethical value.

In Kenya and several African countries, the concept of autonomy in decision-making is complex. Decisions are more collective with strong input from nuclear and extended family members. Religious people are often consulted by families. The application of the principle of respect for persons often involves respecting the family and social support systems that the person relates closely to.

A desktop study using philosophical methods was carried out to explore the major factors that influence ethical decision-making in healthcare in indigenous Kenyans. The role of the concept of “Ubuntu” was analyzed. Ubuntu is a philosophical concept encompassing the relational and communitarian lifestyle common in indigenous African societies. The study found that the most significant factor in decision-making during periods of serious illness is a quest for family and communal harmony. This is an important finding for members of hospital clinical ethics committees in Africa. The knowledge is valuable in analyzing ethical dilemmas and providing culturally and socially appropriate solutions.

**Benjamin Parks, MA, MDiv**

**Pygmies and Astomi and Sciopods, Oh My! Augustine, Disability, and the Resurrection**

It’s common at American Christian funerals of people with disability for the minister to speak of the departed as now existing in a perfect body free from all suffering. While in a sense that is true, such language often turns to describe the heavenly body in ableist terms: the resurrected body is described in a way that reifies a particular understanding of the perfect body. Although such language is often well intended, it can fuel eugenic and transhumanist dreams.

Though his soteriology and understanding of the resurrected body is often misunderstood, Augustine offers a way of imagining the resurrected body that challenges ableist understandings of what constitutes a properly human body while not disregarding the suffering that can come with a disability. More succinctly, Augustine provides a middle ground for the social and biomedical models of disability. In this paper I will argue that given Augustine’s understanding of creation, beauty, and providence, he is able to conceive of a wide array of bodily difference in the resurrection, even of bodies that we may think of as “disabled,” without suffering and pain. Since he allows for there to be such a level of bodily (and cognitive) difference in the resurrection, he also provides a safeguard against using the resurrection to fuel eugenic projects of human perfection.

In order to make my argument, I’ll engage a number of Augustine’s works including *The Confessions, City of God, On Christian Teaching*, and select sermons in addition to recent Augustinian scholarship and disability literature.

**Lillian Quiñones, BS**

**Reconciled Paradigms? Perspectives from Belgium on Integrated Palliative Care**

In the months following the decriminalization of euthanasia in 2002, the Belgian Parliament passed two additional laws: every patient’s right to palliative care and the patient’s right to refuse medical treatment. Integrated palliative care (IPC) is an example of such a phenomenon arising from the confluence of the three laws comprising the Belgian Act of 2002 and represents the decisive normalization of euthanasia into the medical profession.
IPC is defined by the “reconciliation” of euthanasia with the traditional understanding of palliative care established by Cicely Saunders. Adamantly opposed to euthanasia, Saunders defined palliative care as the medical professional holistically attending to the patient and their family until a natural death. IPC in Belgium aims to maintain this vision while providing euthanasia as a licit medical act. The question guiding this paper asks, “What is at stake in the reconciliation, and is authentic reconciliation possible?” Answering this question led to examining the new demands placed on the physician within IPC.

By focusing on the physician’s moral agency, two conflicting paradigms emerge in the license to intentionally kill a patient versus the “do no harm” directive under the auspices of the Hippocratic Oath. Framing IPC in terms of Kuhnian paradigms reveal the physician acting with incommensurable intentions and their role as a permeable border between the two paradigms. Furthermore, this paper features the personal testimonies of Belgian physicians and bioethicists, which indicate the unsustainability and inhuman demands of the permeable border to reveal that the physician effectively practices medicine in a single paradigm.

Subha Saeed, MBBS

Dire Need for Ethical Reforms in the Current Era of Growing Cross-Cultural Research Collaborations

Recently, there has been a significant increase in internationally-sponsored clinical and biopharmaceutical researches in developing countries, accounting for 17% of the total global participation, partly due to reduced operational costs of research in developing countries and the potential to recruit a large number of participants. However, while researchers are generally privileged people from developed countries, the research subjects are vulnerable people of developing countries who are living under the conditions of deprivation and exploitation. A Washington Post investigation into research in developing countries revealed a “booming, poorly regulated testing system that is dominated by private interests and that far too often betrays its promises to patients and consumers.”

David E. Smith, MD, MA

Compassionate Ventilator Withdrawal: Can Euthanasia Be Disguised by Misapplication of Double Effect?

The intensive care unit (ICU) is the location of a majority of end-of-life decisions. Most patients who die in the ICU die following the limitation of life support and allowance of the underlying disease process to continue. As many as 75 percent of ICU deaths occur after a deliberate decision to withhold or withdraw some type of life-support therapy. The ICU features not only a concentration of life-support technologies but also a potential minefield for ethical decision making. Challenges persist in reconciling medical judgments regarding prognosis, outcomes, and the potential utility and futility of ongoing intensive care pursuits.

Decisions are often faced regarding compassionate ventilator withdrawal (CVW) for the imminently dying. Key issues include the distinction between allowing patients to die with comfort care provided by potentially deadly opiates and benzodiazepine drugs and allowing the administration of these drugs to intentionally hasten death (euthanasia). Previous legal rulings, as well as ethical principles, guide the making of this distinction. The doctrine of double effect is often used as justification for giving large doses of potentially lethal drugs and for allowing a great deal of freedom in therapeutic decisions. Misunderstanding of how this doctrine should be applied has led some practitioners to administer inappropriately large amounts of medications that undoubtedly accelerate the dying process. Guidelines and institutional protocols regarding this practice need to be established more widely.

Mario Tafferner, MA

The ‘Good Life’ in Biblical and Theological Perspective

The “good” life represents an important category for bioethical reasoning. Particularly, assumptions connecting the value of human life to an experience of wellbeing have significant consequences for the ethics of selective reproduction. Ethicists such as Julian Savulescu argue for procreative principles according to which only the child who “is expected to have the best life” should be born. Moreover, in 2000, a French court agreed that a child had a “right not to be born” if he or she was to suffer from severe disabilities. Disagreement with such views is often argued on the basis of testimonies about satisfaction and quality of life.
in the disabled community. Nevertheless, both positions share a similar premise: the experience of satisfaction constitutes a life worthy to be lived. However, within the bounds of Christian reasoning, such experiential approaches are problematic. While ill or disabled persons can and should experience satisfaction, suffering is a reality that must be addressed and taken seriously. This paper will, thus, argue that the worldview presented in Genesis demands a conceptual and theological distinction between the pursuit of the “good life” and the pursuit of the “best life” during which almost unhindered satisfaction can be experienced. In particular, the Genesis narrative introduces a distinction between “good” and “bad,” between “life” and “death,” and between “blessing” and “curse” by pointing out that the “good” life consists in living in accordance with God’s installment of humanity as regent and priest. Rather than constructing the goodness of human life around the absence of suffering, the book of Genesis describes it as the living-out of a God-given role for humanity. What is more, Genesis takes seriously the human experience of the limiting force of “evil” and suffering, yet nevertheless prompts its readers to hold on to the “good” life in hope for vindication and, ultimately, blessing. Thus, this paper will further integrate the worldview conceptualized in the Genesis narratives into a salvation-historical framework of creation and redemption within which the good life that is worthy to be lived is not constituted by the subjective experience of satisfaction, but the anticipation of eschatological vindication while living out the human creational-role in the midst of the post-Fall limitations of human life.

Christine Toevs, MD, MA

Brain Death – When Are You Dead? Depends on Who Says

Death by Neurological Criteria was developed in 1968 as a mechanism to declare death for the neurologically devastated patient to allow for organ donation. The procedure for declaring brain death has been “simplified” and now only requires a single exam and apnea test, rather than two exams six hours apart, or an exam and a confirmatory radiological study. Death by Neurological Criteria is increasingly not recognized by families who struggle with a beating heart and insist upon cardiopulmonary standstill for the declaration of death. The casual use of the term “brain death” by physicians for patients who are neurologically devastated has also created confusion and conflict for families. Some states now require family consent for an apnea test, brain death exam, or confirmatory test. Several states allow families not to accept the diagnosis of brain death, and New Jersey specifically does not recognize brain death at all. This session will review the current legal and medical status of brain death, explore multiple cases of increasingly protracted conflict around the diagnosis, describe what happens to patients on organ support after the declaration of brain death, and discuss the momentum for elimination of declaration of death requirement for solid organ donation.

Richard Weikart, PhD

Is the Slippery Slope Argument Valid? The Trajectory of Assisted Suicide and Euthanasia

The slippery slope argument is commonly used by opponents of assisted suicide and euthanasia to warn of the dangers of legalization. Assisted suicide proponents, however, often dismiss it, because they claim it lacks logical rigor. Proponents argue, for instance, that legalizing voluntary assisted suicide with careful safeguards (often Oregon’s law is taken as a model here) does not lead to a slippery slope toward involuntary euthanasia.

In this presentation I will examine both historical and philosophical reasons that the slippery slope argument is nonetheless valid. Historically, we can see that many proponents of assisted suicide have indeed supported involuntary measures. Further, in some jurisdictions, such as the Netherlands, once assisted suicide becomes socially accepted, it has widened to include more people. Philosophically, it is true that support for voluntary assisted suicide does not logically entail support for involuntary euthanasia. However, support for voluntary assisted suicide undermines values, such as human equality, that would otherwise prevent the descent down the slippery slope. Further, some of the limitations that are supposed to prevent the slippery slope from happening are rather arbitrary and, thus, ultimately ineffective.
The American College of Pediatricians is a professional medical organization created in 2002 by pediatricians concerned that social consensus and political correctness rather than sound research and time-honored standards was driving the recommendations of many medical organizations. To accomplish its mission, the College seeks to produce sound policy, based upon the best available research, to assist parents and to influence society for the well-being of the child.

Will You Join Us? If you have a passion for protecting the child, preserving the family and honoring life, please join us. Membership in the College is open to pediatricians, pediatric surgeons, medical students and other health professionals with a pediatric emphasis.

Further information and an application for membership can be found on the College website: www.Best4Children.org.
CONTINUING MEDICAL EDUCATION (CME) ACCREDITATION

This Live activity, *Taking Care: Perspectives for the End of Life*, with a beginning date of June 19, 2019, has been reviewed and is acceptable for up to 23.00 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician’s Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as Category 1.

CME activities approved for AAFP credit are recognized by the American Osteopathic Association (AOA) as equivalent to AOA Category 2 credit.

OBJECTIVES

- Identify the prospects and challenges for the evolving landscape of bioethical engagement within the context of shifting global and societal realities and advances in medicine and biotechnology.
- Explore and discuss the ethical implications of recent developments in medicine, science, and technology with respect to our individual and common humanity.
- Evaluate contemporary bioethical discourses in light of ethical approaches that include philosophical, religious, and other perspectives from the medical humanities.
- Promote interdisciplinary engagement on pressing bioethical issues.

TAKING CARE: PERSPECTIVES FOR THE END OF LIFE CONFERENCE
Thursday, June 20–Saturday, June 22, 2019
10.50 CME AAFP Prescribed Credits

ONE-DAY CONFERENCE CME CREDITS
Thursday, .75 CME AAFP Prescribed Credits
Friday, 4.5 CME AAFP Prescribed Credits
Saturday, 5.25 CME AAFP Prescribed Credits

CONSCIENTIOUS PRACTICE IN HEALTHCARE: ETHICAL, CLINICAL, AND LEGAL ISSUES
PRECONFERENCE WORKSHOP
Wednesday, June 19, 2019, 8:30am–5:30pm
7.0 CME AAFP Prescribed Credits

SUFFERING, PAIN, OPIOIDS, AND COMPASSIONATE CARE FOR PATIENTS: CONTROVERSIES AND HOPE | PRECONFERENCE WORKSHOP
Thursday, June 20, 2019, 8:30am–3:30pm
5.5 CME AAFP Prescribed Credits

To document participation and claim credit, complete the CME Activity Evaluation Form and request a CME Participation Certificate.
ABOUT THE CENTER:
The Center for Bioethics & Human Dignity (CBHD) is a Christian bioethics research center at Trinity International University that explores the nexus of biomedicine, biotechnology, and our common humanity. CBHD fosters a distinctly Christian conception of bioethics that is both academically rigorous and broadly accessible.

WHAT WE DO:
Within a Judeo-Christian Hippocratic framework, we anticipate, interpret, and engage the pressing bioethical issues of our day. As a center of rigorous research, theological and conceptual analysis, charitable critique, and thoughtful engagement, we bring clarity to the complex.

OUR ORIGINS:
In 1993, more than a dozen leading Christian bioethicists gathered to assess the noticeable lack of explicit Christian engagement in the crucial bioethics arena. This group sponsored a major conference in May 1994, “The Christian Stake in Bioethics,” and concurrently launched The Center for Bioethics & Human Dignity. In 2007, CBHD formally became a center of Trinity International University.

WEBSITES:

CBHD.ORG | Our flagship site dedicated to rigorous scholarly engagement.
- Bioethics Weekly, Monthly, & Event update emails
- @bioethicscenter
- facebook.com/bioethicscenter
- youtube.com/bioethicscenter

EVERYDAYBIOETHICS.ORG | Accessible resources to help the church understand tomorrow’s bioethical issues today.
- Everyday Bioethics emails
- @edb.bioethics

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CHRISTIANBIOWIKI.ORG | Online resources providing denominational statements on bioethical issues.
- @edbioethics

HERDIGNITY.NET | Network of resources on global health for women & girls.
- @herdignitynet
- fb.com/herdignitynetwork

Bioethics.com | Global source for bioethics news and issues.
- @bioethicsdotcom
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The Center for Bioethics & Human Dignity continues to work on increasing the value of membership. In addition to the one-year subscription to both *Dignitas* and *Ethics & Medicine: An International Journal of Bioethics* and discounts on our annual conference, we are pleased to offer the following discounts to individual members of the Center. If you would like to redeem any of these, contact us at membership@cbhd.org or 847.317.8180.

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Two main cannabinoids, or active ingredients, are in marijuana tetrahydrocannabinol (THC) and cannabidiol (CBD). Cannabis-derived products (dried flowers, resin, oil, sprays, creams, foods, capsules) may be delivered via smoking, inhaling, vaporizing, eating or drinking food products or beverages, topical applications and suppositories. These products may contain THC alone, CBD alone or some combination of both. THC is the euphoria-producing component sought by recreational users and levels have been steadily rising in marijuana plants and products.

The natural levels of THC and CBD in Cannabis are under 1 percent. Using powerful lights, selective breeding, hydration, chemical fertilizers and special soils, the industry has created a new and more potent marijuana plant than the one of the 1960s and 1970s. The average THC content in the “new” marijuana exceeded 12 percent nationwide in 2014. Marijuana concentrates may contain 75 percent or more THC.

CMDA’s two new public policy statements analyze the biological, biblical, social, medical and legal issues surrounding both medical marijuana and recreational marijuana, while also providing recommendations to Christians in healthcare.

To access the FREE statements and learn more about this issue, visit www.cmda.org/marijuana.
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The Center for Bioethics & Human Dignity (CBHD)
The Center for Bioethics & Human Dignity (CBHD.org) is a Christian bioethics research center at Trinity International University in Deerfield, Illinois, that explores the nexus of biomedicine, biotechnology, and our common humanity. Within a Judeo-Christian Hippocratic framework, we anticipate, interpret, and engage the pressing bioethical issues of our day. As a center of rigorous research, theological and conceptual analysis, charitable critique, and thoughtful engagement, we bring clarity to the complex.

IN PARTNERSHIP WITH
American Association of Pro-life Obstetricians & Gynecologists (AAPLOG)
AAPLOG (aaplog.org) exists to encourage and equip its members and other concerned medical practitioners to provide an evidence-based rationale for defending the lives of both the pregnant mother and her unborn child.

American College of Pediatricians (ACPeds)
The American College of Pediatricians (acpeds.org) is a national organization of pediatricians and other healthcare professionals dedicated to the health and well-being of children. The College produces sound policy, based upon the best available research, to assist parents and to influence society in the endeavor of childrearing.

Americans United for Life (AUL)
Americans United for Life (aul.org) serves as the legal architect of the pro-life movement. Our vision is a nation in which everyone is welcomed in life and protected in law. Our work takes us from state legislatures to Capitol Hill and from American courtrooms to international tribunals. We promote life-affirming laws and policies as a vehicle to restore a culture of life. The legal and policy areas on which we focus include abortion, legal recognition, and protection for the unborn in contexts outside of abortion, bioethics and biotechnologies, end-of-life issues, and health care freedom of conscience.

Charlotte Lozier Institute (CLI)
The goal of the Charlotte Lozier Institute is to promote deeper public understanding of the value of human life, motherhood, and fatherhood, and to identify policies and practices that will protect life and serve both women’s health and family well-being. Our profound conviction is that the insights available through the best science, sociology, and psychology cannot help but demonstrate that each and every human is not only “fearfully and wonderfully made” but blessed to be born at this time in human history. We desire and seek that the benefits of modern medicine and the wealth of nations be put to the service of human life and that the scourges of abortion, physical disease, euthanasia, and human exploitation will be diminished and ultimately overcome.
Christian Legal Society (CLS)

Founded in 1961, CLS (christianlegalsociety.org) defends the religious liberties of all Americans in the legislatures and the courts and serves those most in need in our society through Christian Legal Aid. By inspiring, encouraging, and equipping Christian lawyers and law students, both individually and in community, to proclaim, love, and serve Jesus Christ through the study and practice of law, the provision of legal assistance to the poor and needy, and the defense of the inalienable rights to life and religious freedom, we are fulfilling the command of Micah 6:8 and ensuring the next generation of Americans has the same opportunities to share their faith in community.

Christian Medical & Dental Associations (CMDA)

Christian Medical & Dental Associations (cmda.org) is a national organization of more than 19,000 members. We exist to motivate, educate and equip Christian healthcare professionals to glorify God. For nearly nine decades, CMDA has pursued one main goal—to transform the lives of healthcare professionals to transform the world. Through student ministry, medical missions, creating a unified voice on public policy and more, CMDA members have been a driving force in ethical, Christian medicine—touching hundreds of thousands of lives every year.

Nurses Christian Fellowship (NCF)

Nurses Christian Fellowship (ncf-jcn.org) is a professional organization and a strategic ministry of InterVarsity Christian Fellowship that equips and encourages students and nurses to be faithful followers of Jesus and to practice nursing from a biblically based, Christian perspective. NCF publishes the Journal of Christian Nursing, exploring spiritual, ethical, and clinical issues in nursing and healthcare since 1984, as well as resources for Bible study, spiritual care, and ministry to others.

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Joni and Friends International Disability Center
The Ohio State University Center for Bioethics
Pellegrino Center for Clinical Bioethics
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(To learn more about AAPLOG [aaplog.org], see the partner directory.)

AMERICAN COLLEGE OF PEDIATRICIANS
(To learn more about ACPeds [acped.org], see the partner directory.)

AMERICANS UNITED FOR LIFE
(To learn more about AUL [aul.org], see the partner directory.)

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Baker Academic (bakerpublishinggroup.com/brazospress) serves the academy and the church by publishing works that further the pursuit of knowledge and understanding within the context of Christian faith. Building on our Reformed and evangelical heritage, we connect authors and readers across the broader academic community by publishing books that reflect historic Christianity and its contemporary expressions.

CHARLOTTE LOZIER INSTITUTE
(To learn more about Charlotte Lozier Institute [lozierinstitute.org], see the partner directory.)

CHRISTIAN LEGAL SOCIETY
(To learn more about CLS [christianlegalsociety.org], see the partner directory.)

CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS
(To learn more about CMDA [cmda.org], see the partner directory.)

JONI AND FRIENDS INTERNATIONAL DISABILITY CENTER
Since 1979, Joni and Friends International Disability Center (jonifandfriends.org) has been dedicated to extending the love and message of Christ to people who are affected by disability, their family members, and friends. The mission of the Joni and Friends Christian Institute on Disability (CID) is to impact the church, Christian and public institutions, and societies with a biblical worldview and life-giving truth on issues pertaining to life, dignity, justice, and equality that affect people with disabilities.

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Scripture tells us we’re fearfully and wonderfully made (Ps. 139:14). This divine view of humanity is what drives Life Matters Worldwide [lifemattersww.org] to courageously challenge others to value everyone God has made. Through ministries such as LIFT, our focus is to unite, encourage, and build community around what the Bible says about valuing people, in an embodiment of Christ’s love.

NURSES CHRISTIAN FELLOWSHIP
(To learn more about NCF [ncf-jcn.org], see the partner directory.)

THE CARL F. H. HENRY CENTER FOR THEOLOGICAL UNDERSTANDING
The Henry Center (henrycenter.org) is dedicated to the advancement of Christian wisdom in all areas of life and thought for the glory of God, the good of His Church, and the welfare of the world.

THE TENNESSEE CENTER FOR BIOETHICS & CULTURE
The Tennessee Center for Bioethics and Culture (tennesseebcbc.org) is dedicated to promoting human dignity in the face of challenges to what it means to be human, and to informing and equipping people to face the vital bioethics issues of the 21st century.

TRINITY GRADUATE SCHOOL
Trinity Graduate School (graduate.tiu.edu) equips students with a transformative understanding of their disciplines so that they can engage culture from a biblically based, Christian worldview.

WIPF AND STOCK PUBLISHERS
Wipf and Stock Publishers is a creative, and forward-looking theological publisher engaging biblical studies, theology, ethics, history, and even poetry. Our authors are academics, activists, pastors, and artists. Since 2000, we’ve grown to publish an impressive list under our four main imprints: Cascade Books, Pickwick Publications, Wipf & Stock, and Resource Publications.
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*Institutional listings are for identification purposes only and do not imply support for CBHD by the respective institution.
**Campus Map**

1. A.T. Olson Chapel  
   Kantzer Lobby

2. Gundersen Building  
   The Center for Bioethics & Human Dignity

3. University Administration  
   & Advancement (Mansion)  
   Rockford Room

4. Rodine Global Ministry Building  
   Hinkson Hall

5. Waybright Center  
   Hawkins Dining Hall  
   Lantern Lounge  
   Campus Post Office  
   Melton Hall  
   Nyberg Meeting Room  
   Student Life (lower level)

6. La Quinta Inn & Suites

P Parking  
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Immerse yourself in a community of students and faculty on our Deerfield campus. Discuss bioethical challenges through exposure to real-world contexts like the Lawndale Christian Health Center (offering reduced-cost health care in a high poverty, high crime Chicago neighborhood).

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