The Core Relation Between Hospitality (Philoxenia), Dignity and Vulnerability in Orthodox Christian Bioethics: A Contribution to Global Bioethics

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THE CORE RELATION BETWEEN HOSPITALITY (PHILOXENIA), DIGNITY AND VULNERABILITY IN ORTHODOX CHRISTIAN BIOETHICS:
A CONTRIBUTION TO GLOBAL BIOETHICS

A Dissertation
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
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May 2018
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ABSTRACT

THE CORE RELATION BETWEEN HOSPITALITY (*PHILOXENIA*), DIGNITY AND VULNERABILITY IN ORTHODOX CHRISTIAN BIOETHICS: A CONTRIBUTION TO GLOBAL BIOETHICS

By

Rabee Toumi, M.D., B.Div., Th.M.

May 2018

Dissertation Supervised by Professor Gerard Magill, Ph.D.

In a pluralistic world, reaching consensus in matters of bioethics has proved to be difficult, especially with the political polarization that nurtures inimical differences. This dissertation argues that a middle ground can be identified between the plurality of value systems in contemporary bioethics based on an anthropological approach. This middle ground that reflects commonalities of the human condition can be explored in relation to the foundational principles of Orthodox Christian anthropology. To identify this middle ground the analysis discusses the core relation between hospitality, dignity, and vulnerability as a contribution to global bioethics.

In general, based on Orthodox Christian theology and hermeneutics, an anthropocentric approach to bioethics is presented to identify a middle ground among various value systems. More specifically, in the context of medical practice, healthcare workers and patients meet as
ultimate strangers; thus, hospitality (*philoxenia*: the love of the stranger) is the core value to bridge the gap that separates them. Hospitable medical practice can be a constructive answer to the human anguish especially at the end of life, because hospitality, as defined in Orthodoxy, takes seriously the dignity and vulnerability of all human beings.

This dissertation explains the hermeneutical apparatus derived from Orthodox Christian theology (chapter 2) to unfold the dimensions of the human condition within the contemporary pluralistic and global context of bioethics (chapter 3). The relationship between hospitality, dignity and vulnerability in Orthodox hermeneutics derives from the triadic Christological mission of priesthood, kinghood and prophecy. To reveal this relationship within an authentic Orthodox Christian bioethics, the meaning of human dignity (chapter 4) and human vulnerability (chapter 5) will be explored at the theoretical/theological level and at the applicable global levels. In the final chapter (chapter 6), the relation of dignity and vulnerability to hospitality (*philoxenia*) will be illustrated with end of life care.
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CHAPTER ONE: INTRODUCTION

I. INTRODUCTION

Bioethics is an interdisciplinary academic venture that has recently developed over the past few decades. Although the study of ethics is an integral component of systematic theology and philosophy, increasingly rapid advances in medicine have raised serious moral dilemmas that can only be addressed on a global scale. The development of medicine accompanied new world politics and economics that gave the effects unprecedentedly broad consequences. Furthermore, since the scientific breakthroughs took place in Western countries, ethical deliberations were shaped by the prevailing western mindset and its premises.

In view of this western orientation, Orthodox scholars and theologians are confronted by the polarity between an Eastern mindset that has a different worldview and a Western medical context that extends beyond geographical boundaries (since medical technologies may be available outside these Western countries). Further, as a result of the prevailing globalized context, Orthodox Christian scholars who are interested in bioethics have to address the global repercussions of modern medicine and the predominant disparities in health in developed and developing countries. Global bioethics is a dynamic movement that is striving to build a genuine consensus on the increased complexities of moral issues related to health while realistically addressing the particularities of the diverse histories, cultures, and traditions of human communities.

One notable exception to the general thrust of contemporary bioethics is the highly respected Orthodox philosopher and bioethicist Tristram Engelhardt. Engelhardt supported early in his academic career the possibility of nurturing a common rational morality building on the
Enlightenment project. However, after converting to Orthodox Christianity, he adamantly opposed any possibility of bridging the moral gap that separates various value systems. Contrary to his position, this dissertation explores the theological foundations on which the development of an inclusive and sustainable global bioethics is possible. Rather than discovering this common ground through the lens of human rationality, this dissertation emphasizes the commonalities of the human condition and experiences (mainly mortality) and their anthropological repercussions for a global agenda for bioethics distilled through the tenets of Orthodox Christian anthropology.

Unlike Engelhardt, Stanley Harakas approached rising ethical dilemmas, social and medical, from a pastoral perspective addressing Orthodox Christian faithful who live in the West. As a prolific author, he did not directly engage in discussing the philosophical and theological premises of other Western authors; he primarily depicted an Orthodox Christian way of life that is unique to that tradition. However, Harakas, like many other theologians, recognizes the global salvific mission of Orthodox Christianity within a church typology that humbly embraces the entire world.

Building on that inclusive typology, this dissertation will present and analyze the theological themes to assist Orthodox Christian theologians and bioethicists in finding a common ground with other value systems adding a block toward building a comprehensive global bioethics. The premise of this work is that the human condition and experiences, understood within the advocated Orthodox Christian hermeneutics, provide the motivation to critically engage other value-systems, disciplines, and a broad array of literature to establish the common ground. Without compromising the dogmatic heritage of Orthodoxy, this dissertation aspires to the Truth of Jesus Christ as the personal savior of the entire humanity to continue His mission in addressing the human suffering in sickness and mortality.
To identify the advocated middle ground, the analysis of this dissertation discusses the core relation between hospitality, dignity, and vulnerability as a contribution to global bioethics. In general, based on Orthodox Christian theology and hermeneutics, an anthropocentric approach to bioethics is presented. More specifically, in the context of medical practice, healthcare workers and patients meet as ultimate strangers; thus, hospitality (*philoxenia*: the love of the stranger) is the core value to bridge the gap that separates them. Hospitable medical practice can be a constructive answer to the human anguish especially at the end of life, because hospitality, as defined in Orthodoxy, takes seriously the dignity and vulnerability of all human beings.

This dissertation explores the hermeneutical apparatus derived from Orthodox Christian theology (chapter 2) to unfold the dimensions of the human condition and experiences within the contemporary pluralistic and global context of bioethics (chapter 3). Building on the suggested hermeneutics, a new theological *phronema* (mindset) will advocate finding anthropocentric ground for a moral discourse that evolves around human dignity and vulnerability. The relationship between hospitality, dignity and vulnerability in Orthodox hermeneutics, it will be suggested, derives from the triadic Christological mission of priesthood, kinghood and prophecy. To reveal this relationship within an authentic Orthodox Christian bioethics, the meaning of human dignity (chapter 4) and human vulnerability (chapter 5) will be explored at the theoretical/theological level and at the applicable global levels. In the final chapter (chapter 6), the relation of dignity and vulnerability to hospitality (*philoxenia*) will be illustrated with end of life care.

Although the suggested moral discourse derives from Orthodox Christian theology and anthropology, it garners support among those who do not belong to that tradition, whether religious or secular. Human dignity and vulnerability will be briefly examined in both
theological and secular frameworks to highlight the centrality of gratitude and compassion in medical encounter. Approaching dignified but vulnerable humanity with hospitality, therefore, paves the road for an authentic anthropocentric medical care. In medical care, ultimate strangers meet; they are not only moral strangers who have different worldviews, but they are ultimate strangers who, more often than not, belong to different worlds. Thus, human dignity and vulnerability, as common attributes among all humans, will be examined through their relationship to hospitality in medical practice, especially at the end of life. This will highlight hospitality as fundamental to navigate bioethical inquiries at the global level.

At this point, it is warranted to provide a brief understanding of *phronema* as a concept that is central to the argument of this dissertation. *Phronema* is understood to represent the mindset within which the Orthodox Church connects her faith to her practice of that faith. The fundamental connection between *orthodoxia* (the right faith) and *orthopraxis* (the right worship) is achieved within a certain mindset that is handed within the ecclesiastical community. This mindset is ecclesiastical in that it is experienced daily inside the community of believers rather than being rationally expressed in dogmatic formulations only. Therefore, the advocated mindset is necessarily communal in that it takes the human experience within the broader social context rather than as an isolated individualistic experience. Moreover, this *phronema* builds on the contemporary human condition and experiences (fallen as it is) while taking the redeemed humanity (in the person of Jesus Christ) seriously as the compass. Therefore, the advocated *phronema* is anthropocentric (or claimed to be derived from authentic anthropology) in that it takes the human experience in its totality rather than a one-sided emphasis on human rationality. At the heart of this anthropology would be the human experience of beauty, love and death, as elaborated in Olivier Clement writings.
II. SUMMARY OF THE ANALYSIS

In the following pages, a summary of each chapter will provide an overview of the argument in the dissertation.

Chapter Two: The Hermeneutics of Orthodox Theology

This chapter will discuss the hermeneutics on which Orthodox theology can actively engage in bioethical issues especially at the global level.

I. Theological Foundations in Orthodox Theology

Under this section, the theological foundations of Orthodox Christian bioethics will be discussed in regard to two dimensions. The first is related to the encounter between Orthodoxy and the West where modern and post-modern ideas have shaped the current understanding of health and practice of medicine. The second dimension is more specific in discussing the theological themes that are central to the suggested involvement of the Orthodox Church in global bioethical discourse.

A. Orthodox Christianity at New Frontiers

Orthodoxy is relatively new to Western academia and society. It has reached America because of the immigration of believers from traditionally Orthodox countries and has since then entered the mainstream of American society. Parishes and monasteries comprise both 2nd and 3rd generation “cradle Orthodox” and many converts. However, the intellectual encounter between Orthodox Christianity and Western thought is not new.

Around the turn of the twentieth century, two schools of thought emerged in the Orthodox Church to engage Western philosophical thought. The Russian school included thinkers such as Florensky, Bulgakov and Berdyaev who critically borrowed from Western philosophy to elaborate on the dialect between Orthodoxy and modernity. Another group of
Orthodox theologians engaged modernity in a different way, namely, *neo-Patristic*, among them are Florovsky and Lossky. These influential thinkers advocated a return to the patristic thought to extract new directives. Patristic treatises are contended to be dynamic, alive texts that are not homogenous, but should be interpreted in context and within the same *phronema* when confronting current circumstances. The immigration of most of these thinkers to the West brought them into a direct dialogue with Western Roman Catholic and Protestant academicians. By the end of the 20th century, the dialogue has shifted to anthropological dilemmas, triggered by three factors at least: globalization, rising bioethical issues and the environmental crisis.

Consequently, Orthodox thinkers today are called to address these threatening issues that haunt humanity within the mindset of Orthodox Church Fathers and tradition by exploring the underdeveloped Orthodox anthropology, within an inclusive and enriching approach. Therefore, a dialogical Orthodox Bioethics should be built on an authentic anthropology that is necessarily inclusive because of the universality (catholicity) of the Orthodox Church. Unlike mainstream anthropologies, however, Orthodox Christian anthropology is derived from a salvific Christology necessitated by the current fallen human condition. Divine revelation, then, is central to authentic Orthodox anthropology. Specifically, Christology becomes the epistemological basis of anthropology. Christ, the New Adam, is the model of redeemed humanity who respects the uniqueness of every human being. In other words, Christ as the model (*The Logos*) gives meaning (*logos, pl. logoi*) to all individual human experiences.

**B. Theological Themes for Contemporary Discussions**

In Orthodox theology, the dogma of the Holy Trinity is central to understanding the created humanity. Briefly put, God is one in *ousia* (nature), but three in *hypostasis* (person). God is utterly transcendent and yet immanent, as the living God, in his creation *kat’ energeian*
(through His uncreated energies). While the three persons have the same divine will, each one of them has His own unique actions.

Because of this way of understanding the Trinity, Orthodox theology is mainly *apophatic* (negatively expressed); that is, humans cannot understand God in terms of who God is but rather in terms of who God is not. For instance, God is merciful (positive or *cataphatic* expression); but God is not only merciful, God is beyond the human understanding of mercifulness. In other words, any linguistic expression is an imperfect attempt to verbalize the human encounter with God. Therefore, knowing God depends on a personal *mystical* experience that goes beyond the dogmas, yet occurs necessarily within the community of believers. Moreover, theological expression of the experience of God is usually *paradoxical* (*antinomical*) because of the ineffable interaction between the divine and human realms, especially in the person of Jesus Christ. For instance, the crucifixion of Jesus Christ has unveiled the humility of God despite His omnipotence. Although omnipotent, God refrains from violating human freedom; rather God works through the universe to address all humans.

The unity between divinity and humanity in the person of Jesus Christ gave Him three distinct, yet intimately connected, missions toward creation. His assumption of these roles has many ramifications on humanity’s mission toward the created world. Christ is the king, the prophet, and the priest. He is *the king*, consubstantial in his divinity with the Creator, and through whom, along with the Holy Spirit, God the Father created the entire Universe. Likewise, Jesus Christ is consubstantial with humankind, to whom he humbly came to serve and save. He is also *the prophet* because he spoke through the prophets to announce the word of God and the meaning (*logos*) of human life. However, through His suffering and death, Jesus Christ has epitomized the human struggle with mortality, and through His resurrection, He overcame death.
Fully assumed human vulnerability by confronting death’s inevitability, He demonstrated, through His Person, the vulnerability of God in His sincere and sacrificial love to His creation.  

Finally, He is the priest of the entire universe, because He incarnated to re-offer the fallen world back to its Creator and to restore the intended unity between God and humankind. However, on the Cross, He was the one who offered and the one who was offered for the salvation of the world (The prayer of the Cherubic hymn in the Orthodox Liturgy).

Being His body on earth (Colossians 1:24), the Church is invited to continue His mission. Thus, Orthodoxy typologically understands its mission on three levels: personal, communal, and global. The personal level represents the unique experience of every person with God through his own mystical inner prayer. Nevertheless, individual prayer, important as it may be, is not enough unless embedded in a community of believers who support each other and together experience God. Yet, authentic Orthodox communities should not exclude the fallen world in a sectarian mindset; being triumphalist for knowing the dogmatic truth contradicts the global mission of the personal Truth (the person of Jesus Christ, John 14:6). Therefore, Orthodox communities cannot live their faith unless they are open to their global mission, and unless they are enthusiastically bringing divine love, care and mercy to those who are outside. Otherwise, if isolated, Orthodoxy denies her catholicity.

This global self-identification manifests in the Eucharistic ecclesiology of the Orthodox Church which extends the liturgical celebration to a liturgical lifestyle beyond the doors of the physical church. Accordingly, she extends the fore-tasting of the eschatological time to the daily life of the faithful. In the eschaton, the sought unity is not understood to be a rational unity or a personal annihilation into the person of Christ. Eschatological unity is a transformative unity in the person of Christ that both preserves personal uniqueness and respects
the uniqueness of every human being. Thus, transfigured humanity fulfills its original divinely-intended eternal vocation.34

II. Anthropological Implications of Orthodox Theology

Building on the above theological foundations, this section will discuss the ramifications of Orthodox theology at the practical-human experience in today’s globalized world. The discussion will include the anthropological tenets that shape the humanity’s mission in the world, especially the central mission to address the human condition.

A. The Divine Image and Likeness in Humans

The ramifications of the fundamental Orthodox doctrines outlined above will now be explored, especially with respect to bioethical dilemmas in a globalized world. In analogy to the Trinitarian dogma, human beings share the same nature (they are consubstantial),35 but are many, distinct and unique persons.36 Unlike the divine persons, they do have different wills. Unless on the right spiritual track, they usually try to achieve selfish fallen desires that contradict their innate divinely-ingrained longing to unite with God and other fellow humans (the paradisiacal condition).37 However, the salvific incarnation of Jesus Christ has radically changed the possibilities of the relationship between God and humanity. In His person, Christ restored the originally-meant divine-human unity and became the prototype for every human being.38 In His footsteps, every human is invited to restore the original divine image which could not be effaced because of the Fall.39 Even those who decidedly separate themselves from God have the chance to restore their forgotten relationship with God. This relationship is not interrupted since God is the only giver of life.40 In other words, although humanity has fallen from its unity with God (in the Fall of Adam and Eve), humanity is still valuable that Christ has incarnated to change the status quo of estrangement and separatedness from God and restore the original divine image.
B. Humanity’s Mission

Similar to the above-mentioned epistemological principles used to know God, humans as persons are mystically knowable and expressing their ontology is equally paradoxical. Thus, to know themselves and each other, humans need to enter into ascetic (self-denying) transparent relationships through which they unfold their personhood and grow closer to each other. However, the more they know, the more they discover the joy of unknowability and further discovery. On the contrary, modern attempts to rationally scrutinize everything (using scientific epistemology) fall short from comprehending the mystical dimensions of humanity. Rather than searching for holistic knowledge, these attempts crucify the human rational faculties while dehumanizing those who seek “neutral/impersonal” knowledge. This epistemology highlights the uniqueness of every human experience (of ailment and suffering for instance) that cannot be comprehended without the intimate personal interaction. In medical practice, care should be embedded within a personal encounter with those who are suffering so that healing may pursue. Genuine Christians, therefore, are expected to follow the ideal that was modeled through Christ’s mission. Christ himself is the image and likeness of humanity since its creation (Gen 1:26), and He clearly asked His disciples to follow His example by being meek and humble in their hearts (Mat 11:29). Therefore, faithful followers of Christ inherit His mission on earth according to which they strive to be the kings, prophets and priests for the entire creation.

III. Eschatology as the Interpretative Lens for Orthodox Theology and Anthropology

Under this section, the discussion will involve the understanding of the Orthodox Church of the eschaton (the End things) as central to authentically address the contemporary human experience, and how this understanding should shape a phronema (mindset) that is inclusive. The
same eschatological *phronema* manifests in a Eucharistic ecclesiology that extends beyond the physical building of the church to engage in the political-social discourse in a salvific and redemptive manner.

**A. A Holistic Eschatological Mindset**

Since the main goal (*logos*) of the human race is to achieve eschatological unity with God, eschatology then plays a central role in shaping temporal perspectives. An eschatological *phronema* is cardinal to frame dogmatic formulae within a pathway toward the desired unifying *eschaton* rather than as a divisive ideology. In simple words, having an eschatological mindset re-directs the human perspective toward the ultimate ideal of unity with God who will become “all in all” (1 Corinthians 15:28).

Consequently, a longed-for eschatological unity justifies searching for commonalities among human beings without necessarily glossing over “dogmatic” differences of their value-systems. One ontological commonality among all human beings is suffering and death. Death is the experience with which all human religions, cultures, cosmologies, and philosophies have struggled to fathom. However different are the meanings that are assigned to this experience, suffering and death still shape humanity’s world-view and warrant a deeper look at the commonalities among the different experiences. More specifically, when ethical dilemmas arise in medical encounters, the unique experience of ailment by each patient is much more important than the end-point decisions that she makes about certain medical interventions. Rational decisions (if rational at all, in some circumstances) are the tip of the iceberg of illness. In other words, there is more in being human than rational decision-making.

More generally, an eschatological mindset contradicts the prominent reductionism in pure rational approaches to bioethics, since the latter reduce humans to their rational faculties only.
For instance, pure moral philosophy, on its own, cannot encompass all the anthropological dimensions involved in bioethical decision making, such as the human sense of suffering, joy, abandonment, and hopelessness. On the contrary, human literature has broader audience than philosophy across cultural and religious differences between authors and readers. When values can be communicated across these differences, it is arguable that narratives of human experiences elicit meaningful associations with their protagonists. However, when only concentrating on the rational components of human experience, one may empty that experience of its ineffable meanings. A simple example in this regard is explaining parental relationship with hormonal factors or evolutionary principles. Parenthood becomes a superficial experience deprived of its aesthetics, love and joy irrationally imbedded in every moment. In summary, anthropocentric bioethics affirms the dimensions of the personal experience that are not comprehensible by pure reason. This approach to bioethics may also prove to be less controversial than pure moral philosophy because it uncovers the experiences that every human shares regardless of religious, social, political, and philosophical backgrounds.

B. A Eucharistic Mission in a Globalized World

Embedded within this mindset is the Orthodox liturgical practices that inspire the faithful to foretaste the eschaton in this life. Therefore, Orthodox Christian liturgy takes aim at changing the faithful’s hearts to embrace the eschaton now rather than pushing for a political agenda to establish the eschaton today. In other words, contrary to the historical instance of establishing a “Christian” Empire, theocracy is intended to be through love not through political systems, for God’s kingdom is not of this world (John 18:36).

More specifically, Orthodox identity is ideally rooted in the liturgical practices of the Orthodox Church. During liturgy, the faithful “re-act” the entire divine salvific providence
through various means, such as liturgical rubrics, read and chanted Scriptural texts and hymns,\textsuperscript{58} censing, and iconography.\textsuperscript{59} Thus, Orthodox liturgy opens the door of the \textit{eschaton} as an icon to foretaste the eternal presence of God, not only during the service but also beyond the church building.\textsuperscript{60} The extension of the things to-come into the daily lives of the faithful is known in Orthodox circles as the “liturgy after the liturgy”.\textsuperscript{61} When the \textit{eschaton} is present on a daily basis, the world is announced to be a place where God is working through His own people. Thus, searching for a common ground with others may arguably be the mission of Orthodox Christians \textit{par excellence} as a foretaste of the things to come. This mindset validates and nourishes the above typology of the Church. When individual believers extend the liturgy into their daily lives, they need each other’s support as a community to live that ideal.\textsuperscript{62} This ideal is not complete without communicating the love of God to the entire world through their good example. Therefore, the cosmic mission of Christianity is not to establish a political theocracy; the mission should establish the kingdom of heaven through the love with which God embraces the entire world. In other words, the church, as the crucified body of Christ,\textsuperscript{63} does not necessarily acquire, nor should she be interested in, the omnipotence of Jesus Christ who willingly surrendered His authority to save the world. Taking the example of Christ seriously, the church should be more interested in changing the hearts of those in the world so that they may seek God.\textsuperscript{64} This should not happen through forcing the world to acquire her morale but through love and hospitality toward those who are suffering in the world whom God is always seeking.\textsuperscript{65}

Generally speaking, this position of the Orthodox Church should be practiced at the political level by taking a middle line;\textsuperscript{66} it is arguably the best way to handle bioethical dilemmas as well.\textsuperscript{67} In a polarized society like that in the U.S., the Orthodox Church should avoid joining political camps, simply because she may lose her freedom to express certain positions.\textsuperscript{68} Pro-life
and pro-choice camps, for instance, may be insensitive to some valid counter-arguments, and may endorse entire packages of political positions that go beyond bioethical issues. Some of these positions contradict the Church’s basic mission of saving humanity and the entire world and bringing them back to God.

Chapter Three: The Interpretive Context of Pluralism in Bioethics

In this chapter, the discussion will concentrate on the status quo of bioethical discourse since the inception of bioethics as an interdisciplinary field of study. The discussion will highlight the trends that developed over the past few decades in the secular and religious approaches to bioethics.

I. Procedural Pluralism in Secular Bioethics

Under this section, the pluralistic context of contemporary bioethics will be explored advocating an open dialogue among different stakeholders and value systems. A brief historical study of the factors behind the development of secular bioethics in the US will be discussed. Further, an inclusive discussion of bioethics will be advocated as the best approach to handle the demands of new medical technologies.

A. Pluralism and Dialogue in Bioethics

In a globalized world, open borders between various and distant countries has brought nations and communities into direct contact with each other. Their divergent values have sometimes fueled conflict, however enriching their encounter may have been. Generally speaking, pluralism has been essential for the development of bioethics. While some bioethicists recognize the possibility of reaching universal values through rational discourse in order to solve bioethical dilemmas, some others contend that ethical judgments are incommunicable among various value systems because of their different premises and hermeneutics. Examples of
enriching dialogue are many. For instance, the dialogue under the World Council of Churches (WCC) has been very beneficial in bringing participating churches into an authentic exchange in many controversial issues. Despite the criticism to the ecumenical movement from various parties, the exchange that took place under its canopy augmented a positive self-reflection among participants, especially among Orthodox theologians.  

Contrary to the divisive issues of theology discussed within the WCC, pluralism in bioethics is arguably less thorny. Bioethicists are not directly engaged in ineffable divine realities, and are mainly interested in tackling the only inevitable human reality which is death in various contexts while (and because of) using sophisticated medical interventions. Thus, despite the importance of dogmatic underpinnings of religious bioethics, extracting anthropocentric foundations for global bioethics may be more accessible and less controversial than philosophically-based and dogmatically-entrenched moral principles.

**B. A Historical Background of Current Trends in Secular Bioethics**

Bioethics as an independent academic discipline has evolved only since the late sixties. The first coiners of the word “bioethics”, Van Rensselaer Potter, and Andre Hellegers, had a global perspective to address new biomedical dilemmas. They recognized the threat that befalls humanity because of environmental crises and the need for medicine to intervene, not only to save individual patients but to protect the entire human species. However, in American academia, the first generation of bioethicists adopted a pluralistic approach within an individualistic secular framework for many reasons. The governmental support and commissioning of the new discipline necessitated a rational normative bioethics aiming at social consensus. The work of the President’s *National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research* had to avoid dogmatic/ideological conflict
through the promulgation of biomedical normative (and neutral) principles. In addition, many social and political factors nourished an individualistic and parochial approach to bioethics that cut it away from global interests, contrary to the aim of its first pioneers.

Moreover, many of those who took the lead were philosophers or theologians who used their long experience in studying moral inquiries to address rising medical dilemmas. However, since many of them were employed in medical schools, their research and interests focused on medical practice rather than on questioning the social ends of medicine. They overlooked the many social determinants of health other than the access to medical care such as healthy lifestyles and food, decent environment, and satisfactory education and employment. More generally, in a world that is dominated by Western medicine, the Western understanding of health, illness, and morality frames the global discussion of bioethics while overlooking their understanding in different cultures.

The harbinger for recent medical development and bioethics flourishing was the burgeoning medical research and its use of human beings as subjects. Many scandals surfaced because of the exploitation of human subjects at international and domestic levels. Medical research on human beings in Nazi Germany raised international awareness of medicine’s violation of human dignity. Henry Beecher also unveiled a variety of medical scandals in the US, thus raising many questions about research ethics in this country. Consequently, the initial governmental support of bioethics intended to protect human research subjects through the promulgation of the Belmont report in 1979. The engineers of the report, Beauchamp and Childress, elaborated on its principles and published their book *The Principles of Biomedical Ethics* in many editions since 1979 to direct the steps of medical researchers. However, because of the ease of using the principles as a checklist, the medical community adopted them as a
roadmap for clinical ethics. Although the authors insisted on the equality among the principles, social and political factors have given priority to patient autonomy so that it now trumps all other principles. On a general note, *Principlism*, however prevailing in today’s medical practice, does encounter many difficulties at the philosophical/theoretical level. Among these are the arbitrary choice of the principles, the difficulty of practically keeping the equality of all the principles, and the checklist mentality imbedded in principlism which reduces ethics to a minimum.  

Other attempts to rationally address bioethical dilemmas in academic circles have advocated the possibility of neutrally reaching moral consensus in secular terms. Some of these attempts have arguably failed that goal because of underpinning hermeneutics that is reductionistic to human nature. Common morality advocated by Bernard Gert, for instance, may only fit certain societies and is already built on a reductionistic rational discourse. His morality overlooks irrational and other innate unverifiable faculties such as love, self-sacrifice, friendship, bias, greed, and cultural make-up and their role in medical decision-making.  

At the global level, the UNESCO *Universal Declaration on Bioethics and Human Rights* is an inclusive secular attempt to reach consensus in bioethics at the international level. The Declaration, adopted in 2005 by all governments, builds on a human-rights discourse to tackle the prevailing bioethical issues at a global level. Although the Declaration adopts a principlist approach to offer a roadmap for a global bioethics, the novelty of its principles resides in their anthropocentric basis. Such basis can perhaps overcome the philosophical impasse in bioethics by highlighting the moral common ground among all humans regardless of their value systems.  

Through this brief survey of secular bioethics, it is clear that the promised rational consensus among bioethicists is not attainable; humans may still be divided among various secular value-systems. Therefore, it seems that other approaches, which espouse rationality
among other human faculties, are necessary to enrich the moral discourse; theological anthropology in this context may have a constructive contribution.

II. Ethical Normativity in Religious Bioethics

This section will discuss two different trends in religious approaches to bioethics. The trends are especially pertinent to the different mindsets that propel these trends.

A. Religious Bioethics: Different Ideology, Same Mindset

On the other side of bioethical discourse, theologians have had important roles in shaping the discussion of bioethics. Because of their training in ethics and morality (long established as theological disciplines), they were invited to elaborate on rising dilemmas and to educate practitioners in framing the moral dilemmas they were facing. Similar to their philosophers-colleagues, they used their old ethics theories to handle new moral concerns. Building on their specific dogmatic and spiritual heritage, religious bioethicists tried to mend the shortcomings of secular bioethics especially in regards to the teleological ends of medical practice and research. It has been rightly argued that without religious input, medicine may lose its compass and social service, and perhaps some of its values. Some religious approaches to bioethics may only use different phraseology and premises from that used by secular approaches, however, without bringing any fresh mindset to the discussion. Two examples may be used here for illustration.

Robin Gill, for instance, advocates a new set of virtues to supplement the secular principles of autonomy, beneficence, non-maleficence, and justice and to bridge the gaps in secular bioethics. He rightly believes that the role of theology in a pluralistic society is to criticize, deepen, and widen the ethical debate in that society. Therefore, through a study of the biblical texts and Jesus’ miraculous stories of healing, he highlights four forgotten virtues that are essential to preserve the morality of medical practice today. These virtues are equally
appreciated in all religious and non-religious traditions as effective tools to heal patients (along with curing them when technically possible). These virtues are: compassion, care, faith, and reticence/humility. Another example is Dennis Macaleer’s published dissertation. In his work, Macaleer attempts to give the three principles of biomedical ethics advanced by Beauchamp and Childress a deep meaning through connecting them to theological themes.

It seems, as the examples of Gill and Macaleer may show, that religious bioethics takes the principles of biomedical ethics of Beauchamp and Childress almost for granted. In the case of Gill, the principles need to be supplemented by virtues, and in Macaleer’s case they need deeper meaning through theological reflection. However, such an approach is analogically reductionistic, since their authors take the principles at a face value without questioning the mindset within which they were developed and how they may be far from representing an authentic Christian worldview. More generally, any religion may run the risk of becoming another social ideology that strives to attract followers and to have a political agenda.

On the contrary, the premise of this dissertation is that a religious approach to bioethics should, and is able to offer a fresh and constructive mindset either by highlighting certain aspects of bioethics that are not otherwise prominent, or through unfolding bioethical dilemmas within a holistic picture of theology, anthropology, and cosmology.

B. Religious Bioethics: Non-Ideological Mindset

In comparison to the above examples, other theologians-bioethicists have offered authentic theological bioethics that derives from a holistic tradition rather than from sporadic dogmatic tenets that fit within a certain ideology. Lisa Sowle Cahill, for example, invites bioethicists to actively engage in public bioethical discourse. In so doing, bioethicists may enlighten the members of the society to envision where the community as a whole should be
heading. Moreover, she aspires for a time when bioethics discussions address all the social, political, and economical determinants of health as essential to the common.\textsuperscript{104} Such a vision ultimately corresponds with a holistic anthropology that respects the complexity of human persons and societies.

In the light of the above examples, it is important to keep in mind the difference between religious/secular discourses and religious/secular mindsets. A discourse that is religious in phraseology may not be framed in a genuine religious mindset.\textsuperscript{105} Conversely, a secular discourse may not employ religious language but still be mindful of the religious/liturgical anthropology (in the broadest sense) of all human beings.\textsuperscript{106} Surprisingly, Olivier Clement, a prominent Orthodox theologian, does not shy away from stating that Christianity needs a creative secularism and inclusive anthropology to become attractive and to minister to those who thirst for meaning in today’s society.\textsuperscript{107} In a few words, elaborating an authentic religious bioethics does not depend on the terminology used or literal resources inasmuch as it hinges on an authentic religious mindset. It will be argued in the following section that this mindset is all-inclusive without glossing over the differences among humans and value systems.

**III. An Orthodox Bioethical Phronema in a Pluralistic World**

This section will further the ideas advocated in the previous one. It will show that an Orthodox phronema will ultimately endorse an inclusive and global approach to bioethical discourse.

**A. An Orthodox Christian Phronema: Inclusive Theocentric Cosmo-Anthropology**

The Orthodox Church recognizes the inevitability of numerous value systems in the current human condition, simply because of the uniqueness of every person and their God-given freedom. However, the relationship among these systems is vital for decision-making and care in
medical practice. To highlight the Orthodox perspective in this regard, it is necessary to briefly underline one important cosmological-anthropological tenet. This tenet is pertinent to the relationship between the created (material and human) realms and the divine ever-presence in creation. This tenet was clearly elaborated in the writings of one of the Cappadocian fathers.  

Basil of Caesarea, one of the major fourth century theologians, has advanced a synergic cosmological framework within which the divine and the cosmic creatively interact. Thus, theological revelation and scientific knowledge are not existentially contradictory, nor are religious and secular beliefs. Further, he contends that the world is a theological school for the faithful so that science may assist humans closely experience the divine. Thus, a dynamic and life-giving relationship between God and humans prevails, which is nourished (rather than hindered) through “neutral” science. Moreover, God is open to all those who are searching for him, whether they are (from among the) faithful or not. Even those who are separated from the church may be virtuous in the Christian sense of the word, since they have a valid possibility of meeting Christ as the logos (the origin and source of meaning) of every created thing. In a few words, an inclusive Orthodox Christian phronema builds on a world view that does not radically separate the divine from the created but defends an interactive relationship between the two realms. There is nowhere where God does not dwell (even where secularism abides).

B. An Orthodox Phronema for Modern Dilemmas

A polarized emphasis on one side of the duality creature-creator cannot be supported in an Orthodox mindset. When evolutionists, for instance, emphasize an ultimate natural self-sufficiency they overlook the continuous presence of the creator in his creation. Similarly distorted is the creationists’ contention of the absolute omnipotence of the creator over -and his intermittent suspension of- natural laws. Thus, it is arguable using Basil’s cosmology that an
absolute attribution of natural phenomena to God is not enough to make the scientific/religious discourse a genuine representation of church’s mindset. An authentic cosmology that leaves a space for synergy between creator and creation is foundational for a Christian phronema.\textsuperscript{114} Similarly, a decidedly advocated separation between spiritual and material realms, and a corollary separation between the religious and secular, does not represent the Orthodox phronema (neither a deep philosophical scrutiny\textsuperscript{115}) and is the first seed of nihilism in modern society.\textsuperscript{116} Similar distortions occur in Orthodox theology when taking some issues to extremes, such as when attributing to biological human life an absolute value, or when idolizing individual autonomy in clinical settings. Both cases negate the divine providence to save all humans and eliminates the Orthodox genuine hope in resurrection at deathbed.\textsuperscript{117}

**Chapter Four: The Meaning of Human Dignity: A Systematic Interpretation**

This chapter will elaborate on the first of the three concepts central to the advocated Orthodox Christian bioethics and the common ground for an inclusive global bioethics. The foundations for human dignity will be discussed within Orthodox Christian theology and secular bioethical discourse to promote a content-full bioethics that nourishes gratitude in healthcare.

**I. The Theology of Human Dignity in Orthodox Bioethics**

This section will explore the theological foundations for human dignity within Orthodox Christian theological hermeneutics and its practical ramifications for the human experience in contemporary pluralistic society.

**A. A Christocentric Hermeneutics for Human Dignity**

Orthodox theology of human dignity derives from the kinghood inherited from the divine prototype. Humans’ *kinghood* analogically relates to Christ’s kinghood since they are all created in the image and aspire to become in the likeness of the Triune God who reigns over all
creation.\textsuperscript{118} The image of God does not manifest in humans as individuals, but in the entire humankind,\textsuperscript{119} as represented in the first ‘anonymous’ human being: Adam.\textsuperscript{120} Therefore, all humans deserve to be treated with respect that befits their royal descent.\textsuperscript{121} What they share with the divine Persons include their personhood (understood as the inter-relationship with other humans),\textsuperscript{122} rationality, and freedom, from which many faculties are derived.\textsuperscript{123} Humans are necessarily social beings, i.e. they have to be born and raised in a society that shapes and their personalities and sustains their livelihood.\textsuperscript{124}

**B. Human Dignity and Humanity’s Mission**

Because of rationality, humans are able to sustain themselves and take care of the creation around them, across many generations, through verbal communication of acquired information. Because of their freedom, humans can choose (or not) to enter into relationship among themselves (and with God) that analogically reflects the relationship between the Persons of the Trinity.\textsuperscript{125} More generally, humans are free to shape their lives in the way they deem appropriate.\textsuperscript{126} Thus, being the kings of the creation, in this sense, gives them a unique value in the eyes of God -and of other fellow humans- above the value of any other creature. However, this divinely-endowed kinghood differs from a humanly-understood (fallen) kinghood in one sense at least; it assimilates divine humility that was unfolded in the sacrifice of Jesus Christ.\textsuperscript{127} Specifically, being co-creators who work in synergy with God, humans owe the entire creation to its Creator; they are responsible to hospitably render the blessings they enjoy back to the Benefactor with gratitude.\textsuperscript{128}

**II. The Anthropological Implications of Human Dignity for Secular Bioethics**
The concept of human dignity will be discussed within the prevalent framework of contemporary philosophical discourse and its use in secular bioethics. This will highlight the non-religious support of the advocated common ground for global bioethics.

A. Human Dignity in a Secular Mindset

Respecting human dignity is not only a theological theme on which theistic traditions unanimously agree. Many philosophers have argued for the legitimacy of using dignity in political, social, and medical discussions. Regardless of the claimed shallowness of the philosophical foundations and the difficulty of reaching consensus in regard to its meaning, respecting human dignity is considered the basis on which the human rights movement has gained momentum in modern societies. However, whether understood from theological or secular perspective, no one can ignore the fact that all human beings have an innate value. The premise of any humanitarian aid in case of a natural disaster, for instance, is that all human beings have immeasurable value. In medical practice, humans are intuitively appreciated; otherwise, pursuing medical knowledge is not necessary.

Furthermore, the secular discussion of human dignity searches for the reasons that make humans valuable apart from any divine power. Although the use of “dignity” in secular ethical discussions may be used to defend contradictory positions (such as, to defend and attack euthanasia), it is a very useful attribute in directing ethical deliberation. Similar to the theological understanding of dignity, it is primarily an intrinsic value, since the other two meanings of dignity (attributed and inflorescent) are derived from it logically and linguistically. For instance, two human attributes are central to dignity as a concept for George Kateb (similar to a fourth-century Christian author, Nemesius of Emesa). The ontological commonality is the Individual Status of every human being. Because of this
individually-held value, torture is abhorred not only due to the unnecessary pain involved, but because torture does not befit human beings as humans. Moreover, in encountering other humans and the cosmos, Human Stature manifests in the uniqueness of humans (compared to other creatures) in their relationship with nature. Humans, collectively, are the only species that can understand and keep the records of nature and appreciate it. They only can be stewards of the cosmos. This sense of human stewardship is essential to confront the complexity and delicacy of the ecosystem.

**B. Human Dignity for Secular Bioethics**

As shown above, human dignity is an ontological attribute that, regardless of its origin, solicits respect and certain societal responsibilities. It is evident, consequently, that even in the most extreme cases of illness, dignity cannot be compromised or depreciated. When a person is afflicted with an illness, her worth as a human being is neither affected not diminished. Rather, her vulnerability is exposed, vulnerability being the other side of human dignity (as will be explained shortly). Being destined to die, every human being, when seriously afflicted, experiences the fragility of her existence, and recognizes her mortality. Reasonably then, the central motive in bioethics should not be to deny inevitable mortality. Instead, it should be aimed at helping those whose vulnerability is exposed when confronting death. In these cases, afflicted persons may feel that their self-worth as social entities is being compromised, partly because of being abandoned by their social support system, narrow or wide.

Contrary to this socially-centered understanding of dignity/vulnerability, autonomy in secular bioethics claims to preserve personal dignity. However, as advocated in this dissertation, human dignity can only be preserved if it is congruent with Orthodox Christian anthropology. Autonomously deciding for oneself is not enough to heal human vulnerability that is possibly
exposed when sick. Social support systems, compassionate healthcare workers, and personal
gratitude in life play as important a role in self-worth and dignity as does autonomy. Therefore,
appreciating human dignity as a socially-centered concept has many ramifications for global
bioethics.

III. A Systematic Interpretation of Human Dignity for Global Bioethics: The Role of
Gratitude

To further the discussion on human dignity, this section will consider the practical
dimensions of respecting human dignity through embracing gratitude as a proper virtue for
dignified humanity.

In a globalized world where human beings of various backgrounds come into contact as
never before, national and cultural boundaries are far less significant, especially in medical
practice. Human dignity in this context has special importance in shaping ethical deliberation
when facing human vulnerability and inevitable death. Two inputs are important for the ethics of
medical practice at a global level:

A. Gratitude for Entangled Human Lives

The connectedness of all human beings is self-evident. Ecological concerns coupled with
the nexus of global economic interdependence and fragility testify to this reality. Additionally,
antagonism between divergent and antithetical political systems and philosophies have
exacerbated the vulnerability of marginalized social groups and seriously compromised their
health. Consequently, it seems unjustifiable to exclude any group of people when discussing
human dignity in medicine at a global level. Many examples are pertinent to show how some
people are disempowered and undignified under the auspices of medicine.
Organ transplantation,\textsuperscript{150} for instance, though a revolutionary step in medical practice, has nourished an international black market.\textsuperscript{151} Monetary exploitation has exposed the vulnerability of the poorest of human beings, especially when policies are weaker than being able to protect citizens of certain nations. Similarly, medical research of Western pharmaceutical companies is outsourced to poor countries to test new drugs on patients who will never benefit from them in the long term.\textsuperscript{152} Therefore, when thinking in terms of human dignity, bioethics should seriously consider the inevitable inter-dependency between all human beings regardless of how apart they seem, culturally and geographically.\textsuperscript{153} Such inter-dependency does not revolve around medical interventions and research only, but it manifests through the contribution of humans across traditional boundaries in agricultural crops, raw materials, or manpower.

\textbf{B. Gratitude as a Sign for Dignified Humanity}

Drawing on the discussed theological premises, human kinghood is imbued with divine humility. Despite the human stature in creation, human beings are limited and draw their authority from God.\textsuperscript{154} Similarly, and in agreement with secular perspectives,\textsuperscript{155} humility is mandatory in front of human limitations and mortality.\textsuperscript{156} With humility, gratefulness to one’s own existence is central to morality and social wellbeing, narrowly and broadly.

Gratitude is cherished in religious and philosophical circles. All religions appreciate a sense of gratitude toward the divine which stands behind the creation of humankind and the entire universe. Christianity considers gratitude toward God as central to a genuine Christian life.\textsuperscript{157} In Orthodox Christianity specifically, a grateful attitude is cherished in an ecclesiology that revolves around the Eucharist (which literally means, the sacrament of thanksgiving).\textsuperscript{158} Gratitude, from a secular perspective, is known to be an emotional stand toward a generous gift and a sense of indebtedness to the benefactor. Gratitude is widely believed to be cardinal to
nourish a healthy social life. Such an attitude may sound difficult to nourish in contemporary society where consumerism and a sense of entitlement prevail. However, recognizing that human life existentially depends on others and is sustained by their generosity, gratitude should be predominant.

Chapter Five: The Meaning of Human Vulnerability: A Systematic Interpretation

This chapter will elaborate on the second of the three concepts central to the advocated Orthodox Christian bioethics and the common ground for an inclusive global bioethics. The understanding of human vulnerability will be discussed within Orthodox Christian theology and secular bioethical discourse to promote a content-full bioethics that nourishes compassion in healthcare.

I. The Theology of Vulnerability in Orthodox Bioethics

This section will explore a theological understanding of human vulnerability within Orthodox Christian theological hermeneutics and its practical ramifications to ameliorate the suffering of those who are afflicted.

A. A Christocentric Hermeneutics for Human Vulnerability

Orthodox theology of human vulnerability is supported through a number of tenets. Human beings are vulnerable simply because of their fallenness and consequent mortality. Because of the ancestral sin, human beings have separated themselves from God, the only source of life, and became mortal. Mortality was not meant by God to be the eventual end of human life, but it was necessary to limit the inevitable evil of fallen humanity. However, it took a few generations for the divine salvific providence to prepare humanity and to restore the lost relationship between God and humankind through many prophets, and finally through the person of Jesus Christ. Human beings inherit prophecy from their prototype. Humanity’s Prophecy
does not mean telling the future, but it unfolds the meaning of life and its purpose.\textsuperscript{163} The only fact about temporal human life is that humans are mortal creatures; this fact has ever since shaped the meaning of life regardless of culture, religion, and political affiliation. The prophets of the Old Testament highlighted the sinfulness and mortality of humans due to their separation from God so that they may bring humanity back to its creator. Mortality is the reason behind the vulnerability of every human being, a vulnerability that is unamendable through human efforts. Further, divine revelation in the person of Jesus Christ has shown that even God is vulnerable, though for another reason, namely, His love and compassion for humanity and all creatures.\textsuperscript{164}

**B. Mending Human Vulnerability**

While human vulnerability inevitably leads to (and is caused by) death, divine vulnerability leads to resurrection; the former is due to fallenness, while the latter is due to divine love.\textsuperscript{165} When aspire to deification (\textit{thesosis}, become like God), humans have to exchange their state of separatedness from God and others,\textsuperscript{166} for divine love and compassion to mend their vulnerability.\textsuperscript{167} Therefore, vulnerability in this sense differs from weakness and helplessness usually associated with it. Vulnerability, theologically understood, leads to resurrection if (and only if) imbedded in a divine sacrificial love toward the entire humanity.\textsuperscript{168} Death for the other becomes the panacea for death itself, paradoxical as it may sound. Thus, in front of inevitable mortality, socially-understood vulnerability cannot lead to despair and loneliness at the end of life.\textsuperscript{169} A more authentic approach will demand an insistence on humane and compassionate care toward those who face their imminent death.\textsuperscript{170} In that sense, to heal mortality and vulnerability, the responsibility shifts from those who are dying to those who accompany them.

**II. The Anthropological Implications of Vulnerability for Secular Bioethics**
The concept of human vulnerability will be discussed within the prevalent framework of contemporary philosophical discourse and its use in secular bioethics. This will highlight the non-religious support of the advocated common ground for global bioethics.

A. Human Vulnerability in a Secular Mindset

Similar to human dignity, human vulnerability can be defended in a secular mindset. Clearly, vulnerability is the other side of human dignity; there would be no need to defend human dignity unless human beings were vulnerable and prone to exploitation. Vulnerability, in secular terms, refers to the susceptibility of some individuals to be exploited, harmed or taken advantage of, because of their inherent finitude and fragility.

Vulnerability has gained grounds in international law due to its adoption in the UNESCO Universal Declaration on Bioethics and Human Rights. Vulnerability is rightly considered an ontological property inherited by all humans that is not related to the contingencies of life and that it cannot be remedied through scientific or medical developments. Although vulnerability runs the risk of stigmatizing some people, understanding it in flexible layers is warranted; some people are persistently vulnerable, while others are occasionally vulnerable and might be vulnerable in different senses. However controversial the concept of vulnerability is, it can always be used as a cautionary principle to steer global discussion regarding health.

Similar to human dignity, human vulnerability works at two levels. First, human beings are vulnerable in their relationships with each other, so they may be unjustly exploited or treated with indignity. Further, human vulnerability is obviously exposed during natural disasters wherever they happen so that individuals may be harmed or experience indignity. Super-storm Sandy was an example of how humanity (even in developed countries) is vulnerable in facing devastating natural calamities. In a few words, secular perspectives regarding vulnerability meet
theological ones since they acknowledge that humans are prone to encounter other people or natural circumstances that bring their mortality and finitude into light. In these cases, vulnerable persons may feel undignified when they are treated as less than invaluable humans.

**B. Human Vulnerability for Secular Bioethics**

In matters of medical ethics, human vulnerability is specially exposed near death. The disease or looming death are not what make humans vulnerable, since vulnerability is innate to their nature. What makes them feel vulnerable is that they have not come into terms with this fact, especially when society pushes death to its fringes.\(^{178}\) They do not find themselves at the deathbed ready to depart so they fear the loneliness and forgetfulness of their situation.\(^{179}\) Thus, the key point in facing death should not be in providing the best medical treatment available; rather, recognizing the social nature of human life and the role of communities in shaping and alleviating human vulnerability is essential to confronting death.\(^{180}\) Near death, when medicine is impotent, patients need, along with their families and friends, compassionate healthcare workers who genuinely understand their vulnerability.\(^{181}\)

**III. A Systematic Interpretation of Human Vulnerability for Global Bioethics: The Role of Compassion**

To further the discussion on human vulnerability, this section will consider the central role that compassion needs to play in contemporary mechanistic medicine to ameliorate human suffering.

**A. Compassion and Mechanistic Medicine**

In a globalized world, healthcare professionals should be attentive to the vulnerability of human beings,\(^{182}\) not only their direct patients but also those who are far away. Physicians should be the advocates for all vulnerable humans on earth as a cardinal part of their mission.\(^{183}\) Hence,
addressing human suffering should not concentrate only on medical interventions (that are not always available) but should genuinely and compassionately address the complicated human condition confronting suffering and death.  

Despite the great strides that medicine has made recently, physicians continue to face the agonizing suffering of terminally-ill patients. Much of this suffering may be attributed to high expectations evolving around the salvific attributes of modern (mechanistic) medicine. Prevailing mechanistic mentality in medicine is reductionistic in that it reduces the human being into a physical body. Modern medicine is imbued with Cartesian dualism that distorts the anthropology on which physicians approach their patients. When patients are treated only as bodies in need to be fixed, the disconnection and estrangement they feel hinder the healing process even if they are cured of their affliction. However, a compassionate physician, who has a full command of medical knowledge, is able to restore the intactness of the afflicted person through humanely embracing the entire person. Thus, through compassion, physicians are able to cross the artificial boundaries put by mechanistic medicine between objective science and subjective encounter with particular patients.

**B. Compassion and Human Suffering**

Compassion is *suffering with others* so that the compassionate observer is moved to alleviate the turmoil of the sufferer. Compassion is a complete virtue in the Aristotelian sense, *i.e.* it is not qualified by the object of feeling with which one has compassion since it is always suffering. Clearly, an objective knowledge of suffering is not enough in itself for genuine care, since it may be used to torture others. In the same vein, an objective-scientific medicine that is deprived of compassion is faceless and inhumane. Patients should not only be encountered for the sake of collecting facts about their diseases but also for the moral and aesthetic side of them
so that healing may accrue to their entire person. Therefore, it can be argued that while physicians have a duty to be competent in medical knowledge, they cannot be successful without being compassionate. If medicine is about healing ailing patients, ‘non-compassionate competent physicians’ is antithetical; psychopaths cannot be admitted to medical schools.

Moreover, compassion serves as the bridge to establish meaningful shared decision making in medical practice. Compassion closes the gap between moral strangers (physicians and patients) to engender a value-laden healing encounter beyond cold professionalism. Compassion also unveils suffering and directs healthcare providers toward genuine care. Since health is medicalized in modern society, it is tempting to think of suffering (as with human body) in terms of mechanistic medicine. However, a broad definition of suffering is warranted according to Eric Cassell: Suffering is the distress that threatens the integrity of the person and is not confined to physical pain. Suffering is then construed not only from a medical perspective but also imbued with the existential jeopardy that the patient faces. A person who is suffering because of a disease may be affected at many levels all of which are sources of suffering, starting at burdensome pain and ending at a sense of absurdity and disconnectedness from community. Since compassionate communities are the source of meaning for any event in human life since childhood, disconnectedness leaves the patient in a state of meaninglessness which fuels suffering and a sense of dehumanization. It is arguable, hence, that compassion should direct physicians to accompany their patients, not by ending their lives through euthanasia or physician-assisted suicide but by palliating their suffering through genuine care.

Chapter Six: The Application of Dignity & Vulnerability to Hospitality: End of Life Care in Global Bioethics
This chapter will elaborate on the third of the three concepts central to the advocated Orthodox Christian bioethics and the common ground for an inclusive global bioethics. The understanding of human hospitality and its relation to dignity and vulnerability will be discussed within Orthodox Christian theology and secular bioethical discourse. This relationship will be applied to the ethical dilemmas that arise in the context of end of life care.

I. Hospitality in Orthodox Bioethics: Theological and Anthropological Perspectives

This section will explore a theological understanding of hospitality within Orthodox Christian hermeneutics and its practical ramifications to furnish a meaningful relationship among strangers in healthcare.

A. A Christocentric Hermeneutics for Hospitality

Hospitality (philoxenia) in Orthodox theology is inspired by the generous divine salvific providence. Hospitality, as understood in its Greek expression of ‘love of the stranger’, is recapitulated in the priesthood of Jesus Christ that inspires the human mission on earth. Humanity’s Priesthood is not restricted to those who serve as clergymen since all the faithful are invited to be members of the Royal Priesthood (1 Peter 2:9) of the eschatological time. Humans are encouraged to imitate the priesthood of Jesus Christ by offering the entire creation and themselves back to the Creator overcoming the estrangement caused by the ancestral sin. Because of the first ancestors, the entire creation fell from the divine state to a fallen state of strangeness and enmity. And, because of the salvific providence, humans may strive to re-establish their lost paradisiacal state although they would not be able to fully achieve it on earth.

B. Hospitality as an Inclusive Basis for Solidarity among Strangers

Doing so in daily life means reminding oneself (and others) that one’s own life and properties are invaluable existential gifts that should be accepted with gratitude. Therefore,
compassionately respecting the dignified and vulnerable existence of others is the proper re-
compensation for one’s own existence.\textsuperscript{207} In other words, practicing hospitality with genuine
love unveils the fact that it is not material possessions or self-centeredness that defend humans
against their vulnerability or death.\textsuperscript{208} Rather, it is love, the divine \textit{raison d’être} of all humans
since their creation, which preserves their dignified personal existence.\textsuperscript{209} By being hospitable
toward each other, humans are being witnesses to the genuine hospitality of God.\textsuperscript{210}

Christian resources are filled with examples that support the centrality of hospitality in
the Christian ethos,\textsuperscript{211} regardless of denominational differences. Luke Bretherton aptly collects
the references to hospitality in the Bible and elaborates on its importance in shaping the people
of God. Many commandments in the Old Testament emphasize hospitality and many stories
incarnate this virtue through role models. Bretherton deploys many other examples in the
Christian tradition over the past two millennia: such as in the \textit{Didache}; in monastic orders like
the \textit{Rule of St. Benedict}; in the social missions of St John Chrysostom in Constantinople and of
St Basil of Caesarea;\textsuperscript{212} and most recently at the time of the Nazi when many Christians
protected Jews from being executed.\textsuperscript{213} The premise of these examples is that what puts
strangers in a vulnerable position is their isolation from a caring community. Contrary to a
prevailing individualistic ethos, only in a community, humans are protected and can flourish.
That is why, probably, hospitality is appreciated in various world religions, since these religions
compassionately acknowledge the vulnerability of humans and recognize the necessity of
hospitable benefactors to protect and care for strangers.\textsuperscript{214}

Even from a secular perspective, hospitality is appreciated as the basis for solidarity
among strangers in any given society. Conceptually, solidarity epitomizes the idea of “standing
in for each other,” even for strangers. Solidarity, then, nourishes reciprocal cooperation among
individuals who belong to the same society or identify with the same situation. In such open belonging, each individual welcomingly admits her dependency on others for her flourishing. Rather than being a sign of weakness, dependency empowers the entire group through ‘organic solidarity’ in which everyone submits her unique talents for the service of others.\textsuperscript{215} Such a secular perspective clearly meets the Christian perspective, and recognizes the social importance of hospitality to preserve human dignity and ameliorate inevitable vulnerability.\textsuperscript{216} More generally, there is no reason to restrict solidarity among strangers to one specific community.\textsuperscript{217} Since dignity and vulnerability are innate to everyone, nourishing hospitable solidarity among all humans is warranted, regardless of culture, ethnicity, or religion.\textsuperscript{218} A global hospitable solidarity gives all human beings a sense of belonging to a vulnerable but invaluable humanity whose mission goes beyond selfishness (and sectarianism) to compassionate care for every member.\textsuperscript{219}

II. Hospitality & Dignity: The Role of Gratitude in Global Bioethics

After establishing the central role of hospitality in graciously (pre)serving human dignity among strangers in healthcare, this section will discuss the role of gratitude in shaping contemporary medical practice from the perspective of healthcare workers and patients. Although gratitude is usually perceived as personal, it is equally relevant to policy making at the international level, such as with medical research in poor communities.\textsuperscript{220} At the personal level, gratitude is relevant for both physicians and patients.

A. Physicians and healthcare workers:

It is rarely discussed that healthcare workers should be grateful to their patients and the many generations of previous patients who shaped medical knowledge through participating in research, willingly or unwillingly.\textsuperscript{221} However, sporadic voices have highlighted the need for practitioners to be grateful toward their patients since the latter have a very deep influence on the
former’s personality. Physicians have to be grateful for those patients who remind them of the original mission of medicine, namely serving the most vulnerable in society.\textsuperscript{222} More generally, physicians and other healthcare workers have to extend their mission to a global one so they may become the authentic advocates for their global community of vulnerable patients.\textsuperscript{223} As it has been clarified earlier, humility embedded in human dignity is quintessential to medical practice.\textsuperscript{224} Despite the unprecedented medical advancements, human beings are still limited in their knowledge and abilities.\textsuperscript{225} Death is still the human dilemma \textit{par excellence} that is unavoidable no matter how advanced medicine will become. Therefore, a humble medicine should tend the existential needs of patients in front of their mortality rather than trying to demolish death.\textsuperscript{226} When starting with such perspective, medical practice and research would attain an agenda that is authentic to a realistic anthropology.

\textbf{B. Patients:}

It is difficult to ask vulnerable patients to be grateful when facing their ailment and looming death. However, it is arguable, from theological and secular perspectives, that being grateful to what they are facing is illumining.\textsuperscript{227} From a psychological standpoint, being ungracious in matters of the inevitable difficulties of life is a distorted attitude that needs to be mended.\textsuperscript{228} Moreover, being grateful despite one’s own illnesses may open the hearts of patients to other kinds of hope: to recognize that medicine cannot be the savior of humanity because of its limitations.\textsuperscript{229} Modern medicine is still impotent to eliminate many diseases and to achieve eternal life.\textsuperscript{230} Similarly, the longevity that human beings enjoy these days was not achieved because of medical advancement but a result of public health measures that were implemented long before the development of modern medicine.\textsuperscript{231} Thus, appreciating one’s life, short as it
may be, is more consistent with authentic anthropology than asking medicine for a longer (but inevitably limited) life.\textsuperscript{232}

**III. Hospitality & Vulnerability: The Role of Compassion in Global Bioethics**

After establishing the central role of hospitality in compassionately ameliorating human vulnerability in healthcare, this section will discuss the role of compassion in shaping contemporary medical practice. This will be established through highlighting the vulnerability of healthcare workers themselves and nourishing compassion during medical education.

**A. The humanness and vulnerability of physicians:**

It is easy for physicians to shift the healing responsibility to their patients through asking for an informed consent. However, because of their vulnerability when sick, patients may not be able to make the right decisions. Therefore, to recognize their patients’ vulnerability, healthcare workers have a responsibility to recognize their own vulnerability in front of suffering and death.\textsuperscript{233} Physicians have to recognize that their patients are prone to certain decisions not only due to external coercive figures, which is mended through genuine informed consent. But, other factors related to the specific situation may have a say, such as the patient’s fear of death, cultural beliefs, or sadness because of family abandonment.\textsuperscript{234} However, to recognize these factors, physicians have to acknowledge their own humanness and vulnerability.\textsuperscript{235} Some physicians (and all humans in general) tend to hide behind professionalism to limit their contact with suffering and vulnerability.\textsuperscript{236} They may have not come to terms with their own vulnerability. Also, facing death may stir their own fear of death, thus leading to a cold seemingly-rational professionalism.\textsuperscript{237} In the same vein, to genuinely care for their ailed patients, physicians have to be aware of the irrationality that sometimes controls their medical decision making.\textsuperscript{238} Therefore, anthropocentric medical education is warranted around the globe.
B. The role of compassion in medical education:

In facing death, both patients and physicians may become distressed. To help the former, physicians need to become familiar with mortality and approach their patients with compassion to overcome their fears.\textsuperscript{239} Compassion is understood to be the virtue that every caregiver should have to alleviate patients suffering, especially at the end of life. Compassionate physician is she who feels with her patients and is moved to heal her whole person not only her afflicted body.\textsuperscript{240} However, it is arguable that medical education may compromise innate ability to be compassionate toward suffering patients for many reasons.\textsuperscript{241} For instance, anatomy lab experiences, as a global initiation rite into the profession, brings medical students, into a state of detachment from dead bodies and future dying patients after an internal moral battle. The early cold-blooded handling of cadavers shapes novice students even when encountering dying people in their future careers.\textsuperscript{242} In a like manner, some residents feel incompetent dealing with patients at the end of their lives. Few of them choose to round in palliative care units to improve their competency.\textsuperscript{243} In a few words, medical education, at the global level, needs to highlight the humane dimension of medicine and to train new physicians to acknowledge their own and their patients’ vulnerability and mortality.\textsuperscript{244} Thus, compassion may become a central theme in medical training around which all scientific competencies should evolve. In so doing, compassionate medical practice can bring healing to the entire human person rather than only curing the body, if at all possible.

IV. Hospitality and End of Life Care in Global Bioethics

This final section will bring the different threads of this dissertation into a conclusion. It will discuss the different approaches to end of life care and argue for an early adoption of
palliative care in medical practice. The discussion will use the advocated content-full global bioethics to emphasize a different but inclusive way of approaching end of life care.

A. The Hospitality Case against Euthanasia and Physician-Assisted Suicide

As hinted at previously, dying patients may be suffering immensely because of their physical pain or existential worries. Confronting this suffering in contemporary society takes two venues, either by helping the patients to take their lives through euthanasia or physician-assisted suicide (PAS), or by caring for them in hospice facilities to alleviate their suffering and offer them a peaceful death. Defenders of both options argue that their goal is to preserve the dignity of dying patients. By using euthanasia/PAS, it is thought that patients may avoid the undignifying pain and suffering that come with sickness. However, palliative care advocates rightly insist on the human side of these patients and their existential need for compassionate care and the need of their families to healthily grieve their beloved one. Although both sides use human dignity as an excuse for their position, it is clear that they are using dignity in different meanings to lead to contradictory positions. Therefore, the problem with euthanasia and PAS is not the commendable desire to preserve patients’ dignity; it is rather because of the reduction of human beings to their autonomous and independent selves, and thus falling short from a square anthropology that embraces the entire person. A wounded autonomy does not make the human being a less-than human person. Further, dependency on others is innate to human nature and is not demeaning in itself. Dynamic human life passes through variable phases of dependency and independency that should not be considered a factor in deciding human dignity. The simplest example in this regard is the case of children who are totally dependent on society but receive the ultimate care possible by it (this may be paradoxically understood as if they have more “worth” than other social groups!).
B. The Hospitality Case for Hospice Care

It is clear so far that recognizing the mutual vulnerability and weaknesses of all humans brings each one into a closer relationship with others and unites physicians and patients with authentic solidarity (standing in for the other). In this context, hospitality shows itself to be the genuine Christian answer to the suffering of those who are at the end of their lives. The Church in this case is playing a double role: she is the host who cares for strangers, but she is a guest of God from Whom she learns to be more caring and compassionate. Hospice care at the end of life, therefore, capitulates a Christian hospitality that cares for the whole being. Inasmuch as death is inevitable, it is central to comprehend life and its goals. That is why preparation for death should not be left till the very end of life when death is imminent; rather, preparation should be a lifelong process embedded in the dynamic anthropology of the Orthodox Church.

Chapter Seven: Conclusion

Through this dissertation, anthropology has been argued as a possible ground for consensus in bioethical discourse. However, from an Orthodox Christian hermeneutics, anthropology necessarily derives from Christology; and it is therefore able to draw various perspectives to a middle ground using a unique hermeneutics of the human condition. On this ground, human beings are understood to be existentially social beings embedded in reciprocal relations that affect their self- and other-perception. They have also innate and equal dignity, though at the same time, are inevitably vulnerable because of their mortality. When dignity and vulnerability were explored, their social dimension was clear: humans preserve their dignity in a caring society, and they become vulnerable when they are deprived of social protection or belonging. Therefore, in medical practice, when patients experience their vulnerability at its extreme because of suffering and imminent death, medical practitioners should be graciously aware of
these anthropological dimensions, equally in themselves and in their patients. Furthermore, hospitality, as the love for strangers, appears to be the global alleviation of rife vulnerability. Hospitality brings the global community of patients and physicians into genuine solidarity as human beings who mutually appreciate their common dignity and compassionately care for the vulnerability of each other.


44. Yannaras, *Freedom of Morality*; Payne, “The ‘Relational Ontology’ of Christos Yannaras”.


63 Lossky, The Mystical Theology, 156-173.


66 Harakas, Living the Faith, 344-392.


70 Harakas, Living the Faith, 344-392.


75 Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.


81 Jonsen, The Birth of Bioethics, 34-64, 65-89.


84 Rothman, Strangers at the Bedside, 30-69.


88 Beauchamp and Childress, Principles of biomedical ethics.


91 Gert, Common morality.


95 Jonsen, *The Birth of Bioethics*, 34-64.
110 Also in Harrison, *God’s Many-Splendored Image*, 147-168.
113 Theokritoff, “Creator and Creation,” 63-77.

117 Vigen Guroian, Life’s Living Toward Dying: A Theological and Medical-Ethical Study (Grand Rapids, MI: W.B. Eerdmans, 1996), xiii-xvii; Soelle, Suffering, 151-178.


119 Harrison, God’s Many-Splendored Image, 169-184.


123 Harrison, God’s Many-Splendored Image, 1-8.


139 Kateb, Human Dignity, ix-xiii, 28-112; Soelle, Suffering, 61-86; Marcel, The Existential Background, 136-153.


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Lossky, The Mystical Theology, 196-216.


Pentiu, Jesus the Messiah, 139-185.

174 Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.
177 Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.
178 Philippe Ariès, Western Attitudes toward Death: From the Middle Ages to the Present (Johns Hopkins University Press, 2010), esp. 85-107.
181 Hilfiker, “Unconscious on a Corner,” 3155; Zaner, “Illness and the Other,” 185-201; Martinsen, Care and Vulnerability, 71-121.
182 Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.
184 Soelle, Suffering, 33-59, 61-86.
193 Cassell, Nature of Suffering, 81-213.
195 Zaner, “Illness and the Other,” 185-201.
198 Cassell, Nature of Suffering, 30-65.


230 Martinsen, *Care and Vulnerability*, 122-181.


CHAPTER TWO: THE HERMENEUTICS OF ORTHODOX THEOLOGY

This chapter will discuss the hermeneutics on which Orthodox theology can actively engage in bioethical issues at the global level. Although hermeneutics as a discipline has started in Reformation circles, Orthodox theologians must adopt this discipline in order to develop a phronema that is patristic in essence and is relevant to the current life of the faithful.¹ To be patristic is to be relevant; and to be relevant, Orthodox theologians should be able to use the patristic phronema to pastorally minister to those who live in the here and now. This chapter explores the theological foundations on which the Orthodox Church should engage the current debate in global bioethics. Building on an inclusive anthropology, the Orthodox Church should bear the responsibility to find a common ground with other groups (regardless of how different they may seem in their ethos) so that the church may be consistent with her eschatological-eucharistic identity and mission.

I. Theological Foundations in Orthodox Theology

Under this section, the theological foundations of an Orthodox Christian bioethics will be discussed in two dimensions. The first examines the encounter between Orthodoxy and modern and post-modern ideas that have shaped the current understanding of health and the practice of medicine in the West. The second dimension specifically discusses the central theological basis for the involvement of the Orthodox Church in global bioethical discourse.
I.A. Orthodox Christianity at New Frontiers

I.A.1. Orthodoxy in Western Countries

Orthodox Christianity has only established its presence in Western countries close to the end of the second millennia. Contemporary Orthodox parishes in western Europe and North America comprise of immigrants who moved at various times from Orthodoxy’s homeland east of the Adriatic along with a couple of generations of their offspring. In many places, however, Orthodoxy has flourished among native westerns of various religious backgrounds who embraced Orthodoxy after serious searching for a more traditional version of Christianity compared to their previous tradition. Since the end of the nineteenth century, the immigration of lay Orthodox faithful to the West created a need for clergymen to move from the old countries to minister to their compatriots. By the passage of years, monasteries and seminaries were established to effectively address the growing needs of these emigrants and their families. In a new culture with a different religious ethos, Orthodox believers needed a special help to re-conciliate the ethos within which they grew in their old countries (or within their households in a new homeland) with the new environment. At the same time, Orthodox theologians who immigrated to different western countries, especially to Paris and New York, were actively involved in academic circles and ecumenical meetings which shaped their relation to modern (and then post-modern) society and challenged their understanding of the Orthodox tradition.

This dissertation situates the Orthodox Christian encounter with modern and post-modern society within the tradition of those pioneer Orthodox theologians who actively engaged in an enriching discourse with their peers of various religious backgrounds. The premise of this enterprise is that Orthodox Christian theology is able to provide a fresh but traditional perspective to a post-Christian society that is disturbed by many bioethical dilemmas, not only in
the west but also around the world. An authentic Orthodox Christian involvement in global bioethical discourse builds on the traditional and catholic (universal) mission lived over the past two millennia in different contexts where Orthodox believers have lived their faith.³

As a first step in building the Orthodox perspective advocated in this dissertation, it is warranted to give a brief historical illustration of the experience of Orthodox believers over the past two millennia. This illustration will use a very broad brush to extract a phronema (an authentic Orthodox hermeneutics of the world; a mindset) to actively address emerging global bioethical dilemmas.

I.A.2. A Brief History⁴

Orthodox Christians have lived for two millennia on the land of the Eastern side of the Roman Empire (also known as Byzantium) comprised of the Southern and Eastern shores of the Mediterranean. Other ethnic groups embraced Christianity and belonged to the Orthodox tradition outside the geographical boundaries of Byzantium, especially the Slaves of Eastern Europe. Despite the geographical distance that separated the faithful who lived in either side of the Roman Empire or outside its boundaries, the exchange of ideas (including theological ones) continued throughout the history of Christianity, though not without confusion or misunderstanding at times because of linguistic differences. It is arguable that even the contemporary exchange of ideas between the East and the West is partly shaped by the past historical patterns of this exchange. Although western societies have become post-modern and in many aspects far removed from Christendom and its ethos, the contemporary exchange between Orthodox Christianity and the West is still shaped by the past theological encounters between the two cultures. In studying the current exchange of ideas between Orthodox Christianity and western culture, it is important to keep in mind that easterners have not experienced the
Protestant Reformation and the Enlightenment movement first hand. Easterners have migrated to western countries after those movements have resulted in a compartmentalization of religion outside the “secular” public life. Such a stark separation between the church (religion) and the state (while preserving due respect to the followers of the former) is unknown in Orthodoxy’s heartland, as will be explained in what follows.

Therefore, although the following brief historical illustration may not be directly related to the discussion of this dissertation it is reasonable to keep it in mind because of the importance of history in shaping Orthodox Christian identity and ethos. For example, when celebrating feast days, Orthodox hymnology frequently uses the adverb “Today...” to describe when the commemorated event takes place. Thus, events in history are not just shadows of a bygone era; they are mystically part of the here and now, shaping the present and the Orthodox worldview.

**I.A.3. Byzantium**

During the first three centuries of Christianity, scores of the faithful were persecuted and many executed for being members of the nascent religion. They were especially perceived as a threat to the Roman Empire because of their adamant refusal to submit to the assumed divine authority of the Roman Emperor and the Pantheon. Despite this persecution, many people joined the emerging community Christians and missionary work bore the good news of the gospel to many communities outside the Empire. However, the promulgation of the Edict of Milan in A.D. 313 changed the church’s relationship to the political authorities and guaranteed a peaceful environment for the believers to live their faith and spread the word. Under the auspices of the emperors, all the ecumenical councils that defined the Orthodox faith in dogmatic formulations took place. Notwithstanding the benefits that the faithful has accrued within a peaceful and supportive political system, the conversion of the Roman Emperor, Constantine, and the
adoption of Christianity as the official religion of the Empire was not without negative consequences toward the new faith. For example, many people nominally converted in order to climb the political and social ladder. Furthermore, some of the theological and dogmatic controversies involved political meddling (justifiably or not) by the authorities with (sometimes) a goal not to discern the truth but rather to keep the unity of the empire. As a reaction to corrupting political life, the monastic movement, known as the white martyrdom (unlike the red one involving blood), flourished among the faithful. Monks fled imperial urban centers to live a simple life of spiritual strife in order to attain holiness. This same movement is arguably what preserved the authentic Christian life and its genuine daily encounter with God.  

Because of the symphony between the church and the state, many Christian communities in the East were left outside of mainstream Christianity. Some of these communities were outside the physical borders of Byzantium, such as the Armenians and the Church of the East-the Nestorian. Others were excluded partly because of the political support for certain linguistic dogmatic formulae in Greek rather than the languages of these communities (such as the Assyrian (Jacobite) Church and the Coptic Church). The division among these communities (and others, including the Melkites who emerged after 1724 because of western missionaries to the East) continues to this day although it is usually downplayed in public discourse due to a minority status of these communities within their current political-social milieu.

**I.A.4. Western Christianity**

Unlike the eastern side of the Roman Empire, the western side did not experience similar divisions within the Christian community during the first millennia. The church under the authority of the bishop of Rome (traditionally known as the Pope of Rome, similar to the pope of Alexandria) participated in and endorsed the results of all the seven ecumenical councils
convened in Byzantium and elaborated on the dogmatic questions of the time. However, a few factors divided the western church away from its eastern counterpart during the first millennia which culminated in the mutual excommunications of 1054. These factors include: the language differences between the Latin west and the Greek east; the Germanic control of Rome after A.D. 476; the growing authority of the Pope of Rome (dissociated from the traditional conciliarity of bishops still practiced in the East); the addition of the “filioque” (and of the Son) to the Nicaea-Constantinople creed; the ban on the marriage of clergy; the missionary work outside the Christian empire (especially among the Slavs); the adoption of the doctrine of the purgatory; and the use of unleavened bread in celebrating the Eucharist. 9

I.A.5. Encounters between the East and the West

Although the excommunications were directed against the church hierarchies of Constantinople and Rome, the events that followed grew the faithful themselves apart; they linger to this day in the collective memory of the Orthodox faithful (and most Christians) of the east. Many historical reasons, economic and theological, fostered among westerners a desire to free the Holy Land (Jerusalem and the surrounding area which witnessed the incarnation, crucifixion and resurrection of Jesus Christ) from the control of the rising Islamic Empire. However, this seemingly noble mission has, since then, negatively affected those Christian communities who lived under the rule of Islam; Eastern Christians have since perceived with distrust the motivations of western intervention in their lives. 10

European crusaders and their leaders dethroned many of the Orthodox bishops in eastern cities and uncanonically enthroned Latin bishops [within Latin states in Antioch and Jerusalem for instance]. Moreover, Muslims in the Middle East (today’s Greater Syria) distrusted their Christian compatriots whom they saw as co-religionists of the European invaders (an issue that
lingers to this day in international relations). Even worse, the crusaders of the fourth campaign arrived at Constantinople in 1204 (which was not under the Islamic rule at the time) and desecrated its churches in a way that was not seen when the city later fell to the Muslim Turks.

Easterners distrust of the west reached its apex around the time when Constantinople was about to fall to the Turks in 1453. The shrinking territory of Byzantium under the attacks of the Turkish troops compelled the rulers to ask for help from the Christian West. However, the envoys to Rome were mistreated, and were asked to submit to the papal authority and to sign unitary agreements in exchange for military help that never arrived (during the meetings convened in Florence and Ferrara in 1438-9). In the end, Constantinople fell to the Turks and most of the geographical territory of the once Byzantine Empire became under the control of Muslim rulers. Four of the five historical patriarchates (Constantinople, Antioch, Jerusalem, Alexandria, -the fifth being Rome) became under the rule of the Muslim Turks. During the next four centuries, Christian communities lived among their Muslim compatriots as second-class citizens (under the Millet system) and many were forced to convert to Islam.11

The Turkish yolk was finally lifted over the former Byzantine empire at various times and in various ways. Unlike the experience in Greece and the Balkans where Orthodox Christians were the majority, for the Arab Middle East it was the rise of nationalist secular states that brought the hope of equal citizenship to Christians. Thus, Christians, at home and in the diaspora, actively participated in the Arab renaissance and nationalistic movement to establish secular Arab states to guarantee their equal citizenship.12 What lingers among most of the Orthodox Christians who descend from this part of the world is a theologically unjustifiable but collectively experienced nostalgia toward the glory of Byzantium. Such a collective memory has a similar parallel among those Christians who descend from ‘Holy’ Russia and look back to the
glorious time of Orthodoxy before the Bolshevik revolution and subsequent atheistic communism.

**I.A.6. Orthodoxy in Russia**

The experience of those who belonged to Orthodox Christianity within Russian territory was different from those mentioned above. A mass conversion of the Russian Empire took place in 988 after the delegates of the Prince Vladimir of Kiev experienced the majesty of the liturgical gathering in Agia Sophia of Constantinople (an event that holds a special place in the hearts of many Orthodox faithful). Russian Emperors imitated the Byzantine symphony between church and state in organizing the political and public life. This symphony tickled the imagination of some Russian authorities and theologians to consider Moscow the Third Rome of the emerging Christian Empire of Russia. However, the involvement of political authorities in church life bore unfavorable consequences at times. For instance, Tsar Peter the Great starting in 1689 enforced a ‘modernizing’ paradigm on the Russian Church that accorded with western Reformed Churches. Peter’s paradigm of church reformation highlights the still-relevant dilemma of encountering modern and post-modern social reality without betraying the apostolic heritage of the Orthodox Church. A contrast may be felt between those who wish to literally preserve the holy tradition and those who understand this tradition as a dynamic way of life. The latter approach may have given more freedom to the faithful to stay loyal to the spirit of the tradition as will be explained shortly.

**I.A.7. Encountering Modernity: Two Schools of Thought**

Two schools of thought have emerged among Orthodox theologians, mainly of Russian descent, to address the encounter of the Orthodox tradition with modern and post-modern society. These two schools, Russian philosophical and neo-Patristic, parallel the historical-
institutional and philosophical-ontological responses to modernity, respectively. What was special about the encounter that happened early in the twentieth century is that those thinkers had to move to the west and live in modern societies that were drastically different from the ethos of their Orthodox home communities. While previous encounters between the east and the west was limited to the exchange of ideas between the two parties, by migrating to the west, the Russian intelligentsia were challenged (probably for the first time) by an entire culture. They needed to adapt to a new society which was far removed from its Christian roots, at least in the public sphere. Therefore, for the first time, Orthodox theologians had to not only debate western ideas from afar but to live in a society that is shaped by those ideas. Their theological work has not only influenced the way Orthodox diaspora adapted to their new home but also fostered a theological and spiritual renaissance in Orthodoxy’s heartland when communities there were ready.

The two schools of Orthodox Christian thought in discourse with modernity are the Russian philosophical and the neo-patristic schools. Both schools were led by Russian theologians who experienced a spiritual, monastic renaissance that dates back to the nineteenth century. Although Mount Athos, a community of twenty monasteries on a peninsula in contemporary Greece, has had monastic living since the tenth century, its influence on public spirituality before modernity was limited partly because of the burden of the Ottoman occupation. In 1782, St. Makarios of Corinth and St Nikodimos of the Holy Mountain compiled and published a collection of different writings from church fathers about spirituality and constant prayer under the title of Philokalia (the love of beauty). This book was translated into Slavonic and was influential in reviving monastic life in Russia, especially in the Optina monastery near Kiev around the beginnings of the nineteenth century. It was arguably more
influential among the Slavs than around the Mediterranean at that time. Although Orthodox theologians of the two schools of thought may have not used direct quotation from monastic resources of their time, the flourishing monasticism has definitely shaped their worldview and mindset (*phronema*); a mindset that actively engaged the world despite the differences in the two schools’ methodologies.\(^{20}\)

One anecdotal example that have recently attracted a great deal of study among western academicians is the work of Fyodor Dostoevsky and the spirituality embedded in his novels. In many works of ethics, by Orthodox theologians and by others, *The Brothers Karamazov* is frequently quoted to highlight aspects of Christian morality as lived in Russia at the time. The story of the Starz (elder Zosima) in this novel actually depicts one of the spiritual elders of Optina; this highlights how far reaching their influence was on public conscience and spirituality.\(^{21}\) The flourishing of monasticism in Russia came to a halt after the revolution in 1917 and many figures of the Russian intelligentsia had to leave the country, including the theologians of the Russian philosophical and neo-patristic schools. In Paris, those theologians found a home at the St Serge Institute of Orthodox Theology (established in 1926) where their interaction and exchange have been crucial for Orthodox Christian renaissance in modern times, among the diaspora and in Orthodoxy’s heartland.\(^{22}\)

**I.A.8. The Russian Philosophical School**

Theologians who advanced the Russian school of thought approached modernity using a Christian philosophy. Many of those thinkers lived early in the nineteenth century and speculated on the relationship between Orthodoxy and modernity. Sergei Bulgakov (1871-1944), Nikolai Berdyaev (1874-1948), and Pavel Florensky (1882-1937) among others explored a “theology of engagement with the secular world” of modernity.\(^{23}\) They used a philosophical language to
engage the prevalent approaches in and toward modernity. They criticized secular humanism inasmuch as they shunned ‘traditional’ sectarian theological thought because they both denied the active presence of God in the world. Secular humanism has rationally excluded God from the created world; and similarly, ‘traditional’ theology was sectarian in denying the presence of God outside the church boundaries. After the condemnation of Bulgakov’s sophiology as heretical in the 1930s, (despite its importance in shaping modern Orthodox theology), it is thought that the Russian school has withered leaving it to the neo-patristic school to flourish in Orthodox circles. However, it seems that its spirit has actually lived in the persons of many active theologians in Europe. Those theologians took the social mission of the church very seriously, as it was called by Bulgakov “Christian socialism”, and lived a life of service toward the marginalized. Those figures included Paul Evdokimov (1900-1970), Lev Gillet (1893-1980), Mother Maria Skobtsova (1891-1945), Elizabeth Behr-Sigel (1907-2005), and Olivier Clement (1921-2009). Through their life and theological contribution, they gave face and flesh to the so-called “the sacrament of the brother [and sister]” (taken from St John Chrysostom) that shaped the Orthodox renaissance in Europe and even in the Middle East.

I.A.9. The Neo-Patristic School

On the contrary of the Russian school’s approach to modernity, the protagonists of the neo-patristic school avoided using a philosophical language to engage modernity. George Florovsky (1893-1979) and Vladimir Lossky (1903-1958), who started their work in Paris then moved to New York, advocated searching for a patristic phronema to find a unique Orthodox language for modernity. They noted that citing patristic resources was not enough for them to make a modern theology patristic. They benefitted from a growing interest in patristics among academicians of Roman Catholic and Protestant backgrounds who gathered in Oxford every four
years since 1951 during the International Conference on Patristics.\textsuperscript{30} Although Florovsky pioneered the neo-patristic synthesis to address modernity, he did not draw a clear path to achieve this synthesis. Moreover, he unjustifiably condemned the approach of the Russian school as being captive to western scholastic methodologies, especially the sophiology of Bulgakov,\textsuperscript{31} while his own approach was limited in its scope to be able to address the wide range of issues raised by modernity.\textsuperscript{32} However, neo-patristic theologians frequently emphasized that the patristic heritage of the Orthodox Church is embedded in dynamic and lively texts that are heterogeneous. This leaves a space to differentiate between personal theological opinions-
\textit{theologomena} (of each specific church author) and unnegotiable doctrinal formulations that are widely accepted among them.\textsuperscript{33}

In a few words, while the theologians of the Russian school actively engaged secular humanism using contemporaneous religious philosophy to elaborate a “Christian Humanism”, neo-patristic theologians delved into patristic resources to extract the essence of their thoughts and to craft an authentic Christian answer to modernist dilemmas. While both schools did not promote estrangement from the world, they engaged the world on different grounds.\textsuperscript{34}

Although these schools may seem to have salient contrast in their methodologies, generations of theologians since those first founders have used fundamental elements from both schools to foster an Orthodox Spiritual and theological Renaissance among the diaspora and back in Orthodoxy’s homeland, such as in Antioch.\textsuperscript{35} Most important, many of contemporary theologians distanced themselves from polemical dogmatic discourse and attempted to uncover the uniqueness of Orthodox theology and its relevance to present-day Christians wherever they live. One of the major achievements in this regard is the elaboration of an authentic Orthodox ecclesiology that has influenced many other Christian communities regardless of their
background. One field of study in Orthodox theology that is still evolving is anthropology. Orthodox theologians have not shied away from using all available scientific or humanist disciplines to articulate an Orthodox perspective on anthropological dilemmas of postmodernity. Questions raised by the emerging globalization, environmental crisis, and bioethical dilemmas have fueled the interest in unveiling an Orthodox perspective on anthropology.

It is because of the same kind of questions that this dissertation advocates an active involvement of the Orthodox Church in global bioethical discourse building on its inclusive and philanthropic mission to save the humankind.

**I.B. Theological Themes for Contemporary Discussions**

Since this dissertation is advocating a certain *phronema* to actively engage in global bioethical discourse, it is warranted to briefly explore the theological themes on which this *phronema* has to be founded. This *phronema* may be understood to be the hermeneutics of the divine salvific providence; It is the mindset through which Orthodox Christians establish their worldview, the role of God in the world and in their own lives, and the way in which they have to engage the world to continue the divine redemptive plan as the body of Christ, his church (Colossians 1:24).

**I.B.1. An Orthodox Phronema beyond Doctrines**

This *phronema* is not limited to the dogmatic tenets formulated by the Orthodox Church along the centuries; it is inclusive of the ethos within which the faithful strive to encounter the divine persons and stay in constant communion with God and the entire creation. Therefore, doctrinal formulations are valued inasmuch as they facilitate that communion with God rather than as being literally-interpreted ideological formulae. They aim to heal humanity from its fallenness through re-establishing an authentic communion with God. Therefore, in an authentic
Orthodox Christian *phronema*, the mystical-spiritual experience and the theological formulations are inseparable, unlike the western scholastic approach to theology that compartmentalized doctrines away from spirituality (although Orthodox theology has been influenced by scholasticism at times).⁴³ One of the oft-cited sayings by Evagrius Ponticus (c. 346-399) recapitulates this organic relationship between spirituality and dogmatic theology: “If you are a theologian, you will pray truly, and if you pray truly you will be a theologian.”⁴⁴ In the same vein, many church fathers have emphasized that the holiness of church saints does not depend on their accurate (impeccable) theological treatises inasmuch as their holiness manifests in a godly life (St Photius the Great, 820-893). In a few words, there is a place for *theologomena* (theological opinions) inside the church which highlights that church fathers are not monolithic in their theological writings; rather, they are all motivated by one genuine desire to be united in God.⁴⁵

In a book that is dedicated to the discussion of health and medicine in the Orthodox Church, Fr Stanley Harakas depicts a brief exposition of the Orthodox *phronema* that transcends ethnic, social, and historical backgrounds of various Orthodox communities.⁴⁶ He illustrates this *phronema* through a dynamic antinomy (paradox) between the two realms of the divine and created realities (as will be further explained later in this section). At the edge between the divine and the created realms, Orthodox Christians cherish *a sense of the holy* that embraces, without confusion, the transcendent and the immanent at the same time.⁴⁷ They also experience *a sense of the incarnation* which unites the spiritual and the material and excludes any Cartesian duality in encountering the world. Further, they encounter the world with *a transfigurational sense*, a sense that balances between the permanence of the tradition as inherited from the Apostles and its necessary change to address the evolving life of humankind. The same transfigurational
sensibility refers to the eschatological transfiguration of the entire created reality to something that is beyond human imagination, “a new heaven and a new earth” mentioned in the book of Revelation (21:1).48

This Orthodox phronema is realistic in that it recognizes the evil and sin committed by humanity. However, within this phronema, human fallenness is not perceived within a legalistic framework; rather it perceives human fallenness as a state that affects human beings and has repercussions on the entire creation.49 Notwithstanding this fallenness, an Orthodox phronema highlights the ultimate victory of Christ over death that is not only celebrated during Pascha (Easter) but every Sunday (Kyriaki, the Lord’s Day) around the year. This sense of victory is epitomized in the paschal hymn of resurrection (“Christ is risen from the dead, trampling down death by death, and unto those in the tombs bestowing life”) which arguably shapes the entire liturgical life of the Church. Therefore, in acquiring this phronema, Orthodox Christians recognize that the salvific divine providence does not need Christ’s sacrifice as a legalistic ransom to human misdemeanor but as a philanthropic act of compassion by the persons of the trinity. In the end, what saves humanity from its estrangement away from God is God’s love for humankind (philanthropy); a theme that is frequently mentioned in Orthodox hymnology.50

**I.B.2. Relevant Theological Themes**

After illustrating the phronema with which Orthodox Christians encounter the world, it is warranted to briefly explore the theological themes that stand behind this worldview. Unlike the scholastic way of doing theology, Orthodox theological reflection avoids compartmentalizing those themes. Besides, to establish an Orthodox anthropology that is able to tackle the dilemmas of post-modernity, a brief exposition of the fundamental tenets of Trinitarian, Christological-Soteriological, and Ecclesiological theology(ies) is warranted.
I.B.3. The Holy Trinity

God was revealed to humanity in the three persons (prosopon-prosopa, hypostasis) of the Holy Trinity who share the same divine essence-nature (ousia-physis) but each has one’s own personal will and attributes.\(^{51}\) Since the divine revelation was through and in the persons of the Holy Trinity, personhood plays a central role in Orthodox theology despite some controversy around applying modern thoughts to the reading of old patristic treatises.\(^{52}\) Moreover, Orthodox Christian experience of the divinity occurs only through those persons, rather than through any amorphous divine essence. Those persons are known to be God the Father who is the origin of the other two persons before all times; God the Son who incarnated in the person of Jesus Christ from the Virgin Mary and bridged the gap which separates God from the created world; and God the Holy Spirit who proceeds from the Father only (John 15:26) (unlike the later addition in the west of the filioque -and [from] the son- to the Creed) and who sustains the church in its worldly mission until the second coming.\(^{53}\)

Despite the transcendence of God, God is still actively present in the created world.\(^{54}\) It is thought among most of Orthodox theologians, building on early (such early as Clement of Alexandria (150-215), the Cappadocians (4th century) and Athanasius (296-373))\(^{55}\) and recent church fathers (including Gregory Palamas, 14th century), that there is a difference between the divine essence-nature and the divine uncreated energies (powers, energeia).\(^{56}\) Divine essence is not accessible to human speculation; however, God’s energies are actively present in and sustaining the created world and are open to theological reflection. This differentiation highlights that God is not known in who he is but in all the divine attributes which interact with the creation. This dynamic between what is accessible and what is not in the divine persons opens the way to two different but intertwined ways of doing theology in the Orthodox Church,
namely, cataphatic and apophatic theology.\textsuperscript{57} Even further, this unknowable/knowable dynamic has implications for all other theological themes, especially anthropology (as will be explained shortly).

When talking in terms of \textit{cataphatic theology} it is meant to address the various aspects of divinity that are known to the world through energies. Truths about God can be put in positive expressions, such as God is merciful and loving. However, \textit{apophatic theology} is used to describe the ineffable and mystical (mystical as related to the church sacraments, and as being unfathomable since it is related to the Godhead)\textsuperscript{58} experience with the personal God (paradoxical as this may sound). It means to address those attributes of God as one may experience in a prayerful mystical encounter with God. In the end, the only tool that remains to express those attributes is a negative language. Thus, for the previous example of God being merciful and loving, a mystical personal experience of God’s mercy and love will be beyond any human description; in such an experience, the mercy and love in God will be affirmed but will also be emphasized as being beyond any human understanding of those attributes.\textsuperscript{59} In a few words, any human linguistic expression is an imperfect attempt to articulate the human encounter with God.\textsuperscript{60}

Theological explorations using \textit{cataphatic} and \textit{apophatic} terms may look paradoxical (antinomical) from the outside; however, this does not bother Orthodox theologians because, for them, it is not rationality that leads theological enterprise but the mystical experience with God.\textsuperscript{61} The antinomy is most clear in the person of Jesus Christ, as a God and man at the same time. In his person, the realms of divinity and humanity come to unity that is very difficult to comprehend within a rational frame of mind which has led to the rise of many controversies and heresies. For instance, the crucifixion of Jesus Christ unveils the contradiction between his
omnipotence as one of the divine trinity and his ultimate vulnerability by his submission to death for the sake of the entire world (John 3:17).

Similarly, while God is omnipotent and has created the entire world from nothingness (ex nihilo), God is not willing to violate human freedom and enforce on humans to believe in the divine authority. God would rather leave it to individual human beings to freely seek the lost communion with the godhead as a way to give to humans a true sense of what freedom means.62

I.B.4. Human Fall, Christology, and Soteriology

The same dynamic relationship between cataphatic and apophatic Trinitarian theology applies to other themes in Orthodox theological study, namely Christology (the theological tenets related to the person of Jesus Christ) and Soteriology (the salvific work of God). However, to understand what Christ did to save humanity, it is warranted to start by illustrating how the church fathers understand the fall and the ancestral sin committed by Adam and Eve. What the ancestors of the humankind did was far from being a sin in the legal sense of an offense or crime. Adam and Eve were created to be in communion with God in Paradise; however, they were still in training when they disobeyed God. The human condition in paradise, as the church fathers understood it to be, was far from being perfect; paradise was rather meant to be a place for the humankind to become God-like (achieve theosis, divinization, deification) through constant communion with God.63

Therefore, what Adam and Eve did was disobeying God’s commandment and breaking their communion with the divine persons; even worse, they aspired to become gods on their own by following the serpent’s advice (through eating from “the tree of the knowing of good and evil” (Genesis 2:17; 3:25). The result of breaking communion with God was a separation from the only source of life which allowed corruption and death to afflict the entire universe.64
few words, the result of breaking the divine rule was not a punishment commensurable to the offense but was a natural (though actually unnatural per the divine plan) result of breaking away from God. Death, the new ontological reality, did not only affect humanity but it also afflicted the entire created world since then.\textsuperscript{65}

As a divine answer to address the new universal reality of death, the second person of the Holy trinity had to acquire whatever is human in his person and re-establish the lost communion between the Creator and the creation. Gregory of Nazianzus (329-389) put it this way: “That which is unassumed [by Christ] is unhealed.” His salvific (soteriological) intervention in human history was not understood by many church fathers to be a bloody ransom paid to assuage an angry Godhead; rather, it was an atonement (at-one-ment) that re-established the lost communion between God and humankind.\textsuperscript{66} The triumphant resurrection of Christ from among the dead annulled death and strapped it from its authority over humans. Christ has since then highlighted the true meaning of death as breaching the communion with God (so it is spiritual and physical death), and that the only antidote for its inevitability is communion with God and others following the Trinitarian paradigm of communion.\textsuperscript{67}

This soteriological mission of Christ has been expressed in the writings of church fathers in various ways that overlap and emphasize \textit{theosis} as the ultimate goal for humanity through communion with God.\textsuperscript{68} For the sake of this dissertation, a threefold vocation model of Christ’s mission is illustrated to explore a similar threefold vocation for humanity to address the emerging ethical dilemmas at the global level. In early Church fathers work (as early as Eusabius of Caesarea (263-339) and drawing on earlier Jewish writings) and among modern theologians (including John Calvin 1509-1564), Christ is believed to assume three callings in regards to his soteriological economy: he is the King, the Prophet, and the Priest.\textsuperscript{69} These callings will be
explained here in regards to Christ but will be given a nudge to use them as a model for Orthodox Christian (and entire humanity’s) encounter with post-Christendom world and its ethical dilemmas.

**I.B.5. Christ the King**

Christ the king manifests in his consubstantial unity with God the Father. He is a divine person who has the same divine essence of God the Father and God the Holy Spirit. He was thought of, allegorically, as being one of the two hands (the Holy Spirit being the other one) with which God the Father has created the entire universe. Many church fathers have thought that the divine image according to which Adam and Eve were created was Christ himself. That is why Byzantine icons of Adam and Eve before the fall show their facial similarity to Christ. When incarnated from the Virgin Mary, God the Son assumed the human nature. He assumed all that was human to make it possible for humans to acquire that which is God’s. In other words, Jesus Christ was fully God and fully human, so that humanity may be able to grow in its likeness to God and become God-like. He re-established the possibility of communion with God emphasizing the original dignity with which the first humans were created.

**I.B.6. Christ the Prophet**

Christ the prophet has manifested in two stages and is related to the knowledge of God and of the created reality. In the Old Testament, many prophets were chosen by God to announce the divine word to the chosen people. Announcing the word of God did not mean by any means foretelling the future; it rather centered on situating the daily experiences of the faithful, whether positive or negative, within the divine economy. Prophecy in the Old Testament repeatedly reminded the chosen people how they were called by God to be saved and
how without God’s philanthropy (love toward humankind) they would perish; without the only giver of life, the chosen people will wither away.

Similarly, through the incarnation of Christ, himself being the Word of God (John 1), the word of God was fully announced in his person. This announcement reiterated the message of the prophets of the Old Testament emphasizing the mortality of the human kind. Christ announced through acquiring the human nature, that humanity is condemned to death unless a divine savior intervenes to change the status quo. Through his philanthropic death, Christ has shown the vulnerability of God, because he loved the world to the extent of dying on the cross. Nonetheless, Christ’s love is what saves humanity from death; by his death, he trampled down death and strapped the existential human enemy of its thorn. In a few words, what shows as vulnerability in submitting to death on the cross becomes a way to defeat human mortality through God’s philanthropy. True love defeats death.72

I.B.7. Christ the Priest

The priesthood of Christ is epitomized in his universal mission to restore the communion between God and the entire creation. Through his incarnation, he acquires a created body and unites divinity and humanity in his person; thus, he offers a bridge to bring the created world back into communion with God. He is unambiguously the one who offers and who is being offered in the liturgy for the salvation of the world (The prayer of the Cherubic hymn in the Orthodox Liturgy).73 Put another way, through the incarnation, Christ revives the originally assigned mission to humankind of being the microcosm who bridges the existential gap between the creator and the created world (as understood in the work of St Maximus the confessor, 580-662).
These three callings substantiated in the person of Jesus Christ will shape the mission of humanity in general and of those faithful believers who belong to the One Apostolic Church. However, before illustrating the mission of the church in today’s world, it is warranted to explore how the church fathers and Orthodox theology have understood the creation of humankind and its mission in the world. This will help to situate the Orthodox Church’s mission in the world. Two issues are to stay in mind following the above discussion. First, God is still working in the created world outside the boundaries of the church through his own mystical (but not mysterious) methods. Second, in the Church, God has fully revealed the divine economy, in words and in deeds, thus putting more responsibility on the shoulders of the faithful when engaging the world outside the church.74

II. Anthropological Implication of Orthodox Theology

Building on the above theological foundations, this section will discuss the ramifications of Orthodox theology at the practical-human experience in today’s globalized world. The discussion will include the anthropological tenets that shape humanity’s mission in the world, especially the central mission to address the human condition. Anthropology here will be understood as a reflection on who the human being is and how this fits into the divine salvific providence. It should bring practical insights to the study of global bioethics.

II.A. The Divine Image and Likeness in Humans

In this section, the discussion will center on the anthropological ramifications of the above discussed theological tenets and *phronema*. One central idea that will be illustrated here is a multi-dimensional understanding of the human being which is contrary to a modernist narrow emphasis on rational human faculties.75 Building on this Orthodox anthropology and
acknowledging its differences from a modernist or postmodern worldview, this dissertation will advocate a common ground with other value systems to address global bioethical dilemmas.

II.A.1. Genesis as a Source for Anthropology

In the first three chapters of the book of Genesis, many contemporary Orthodox theologians find a major resource to reflect on anthropology. They follow the conclusions of many church fathers who worked on the exegesis of the text and how it reflects a certain worldview (cosmology) that revolves around God. The creation narrative clearly states that Adam, the first human being, was created in the image and according to the likeness of God (Gen 1:26). This model of creation has shaped Orthodox anthropology for centuries. Therefore, it is important to highlight a few points in the narrative which will be central to the unfolding of this dissertation’s argument.

The first lesson from the creation story is the origin of humanity which occupies a special place in God’s creation. “Adam” is not actually a name but rather derives from “adama” in Semitic languages which refers to the dust of the ground (Gen 2:7). As the ancestor of the entire humanity, Adam’s name underscores the common origin of human beings which is only dust. However lowly this origin may be, the creation narrative, as church fathers emphasized, illustrates the special way in which God has made the humankind compared to other species and materials. God has, allegorically, used the divine hands to form the first human being and has breathed into his nostrils to give him life (Gen 2:7). The uniquely created humankind will occupy a special place in God’s creation through the dominion given to Adam and Eve over the rest of the created world (Gen 1:26). Many church fathers understood the authority assigned to humanity by God as a stewardship, a responsibility toward God through caring for the universe rather than as a reckless selfish exploitation of its resources.
The second lesson is the relationship between man and woman, and how that affects human relationship with God. The creation narrative comes in two versions. In the earlier narrative it is noted man and woman are created “in his image” (Gen 1:27). The second of which mentions the creation of Eve from the side of Adam (Gen 2:21). In symphony, these verses emphasize the common origin of all humans, men and women, created from the dust of the ground (adama), rather than alluding to any difference in dignity between Adam and Eve.

This was further emphasized after the incarnation of Jesus Christ, who himself was referred to as the New Adam (Galatians 3:28). In many church hymns, the Virgin Mary is described to be the New Eve, thus emphasizing the central role of women (capitulated in the person of Mary) in the divine salvific providence; without the “yes” uttered by Mary on the day of the Annunciation, the incarnation would not have taken place.80

Equally important is the reason behind the creation of Eve: “It is not good that man should be alone; I will make him a helper comparable to him” (Gen 2:18). The divine rationale was creating an equal to Adam to be in communion. While Adam was in the company of all the other created animals, God meant to create Eve as a soulmate, a peer to Adam, to keep his company. This rationale highlights how God has consecrated human unity within a diversity among them (manifested in the physical difference between man and woman without necessarily excluding other kinds of differences among humans).81 However, this blessed diversity was meant to be experienced in communion rather than as a self-centered, individualistic diversity (that is necessarily superficial because it departs from the divine will).

The third lesson from the creation story is that after Adam and Eve broke their communion with God through disobedience, they themselves lost their communion as peers. The advice by the serpent resulted in what is in accordance with the nature of the devil itself, dia-
bolos (dia: separate, bolos: opinion; the divider). The devil’s advice led Adam and Eve away from God breaking the communion that they enjoyed before their disobedience. Similarly, but not surprisingly, the breaking away from their communion with God cracked their own communion and they started to blame each other and the serpent for their disobedience toward God (Gen 3:12-13). Humans, since they found out about their nakedness (Gen 3:7), entered into a new state of estrangement/alienation with (and away from) God and each other.

Finally, one of the most visited themes in the creation narrative is the plural used by God according to whose image humans are created. It was stated that Adam and Eve were created “in our image, according to our likeness” (Gen 1:27). The plurality of persons in God attracted the attention of many church fathers who highlighted the early indication to the Trinitarian personhood in God. For many church fathers and theologians, the Trinitarian communion illuminates the aspired communion among human beings to overcome the state of estrangement in which they find themselves since the fall.

**II.A.2. In the Divine Image, According to the Divine Likeness**

In turning to what the image of and likeness to God mean, many opinions may be found among church fathers and theologians; however, they all highlight the dynamism embedded in any understanding of the divine image and likeness. Notwithstanding the possibility of mere literary emphasis through saying the same thing twice (which also happens in Arabic, another Semitic language), church fathers have speculated on the differences between the two concepts, image and likeness.

**II.A.3. Divine Image**

“In the image” (kat’eikona) of God (Gen 1:27) refers to a static human makeup that shares many attributes with God. It is a multidimensional makeup endowed on every human
being and analogous (to some extent) to certain divine attributes. However, none of these attributes, on its own, may recapitulate and limit the divine image in any given human being. Some of the similarities between God and humans include: freedom and responsibility, spiritual perception (\textit{nous}) and relationship with God and other humans (communion), excellence of character and holiness (virtues), royal dignity, creativity and rationality manifesting in human arts and sciences along with various cultural products (humans being co-creators). Among all these attributes, modern culture emphasizes human rationality and freedom. However, church fathers and Orthodox theologians have emphasized that these two attributes are open to misuse (as was clear in the story of the fall), especially if they are not understood within the entire mission of humanity.

In patristic understanding of rationality, human reasoning springs from a higher intellectual faculty, the \textit{nous}, which is considered the “focal point of the divine image.” As a faculty, it does not arise from logical-reasonable mental processes; however, it emerges from a spiritual perception (“spiritual”, that is according to the Holy Spirit, as understood in Orthodox Christian spirituality. More explanation will follow). A perception that is according to the Holy Spirit is a perception that goes beyond the tangible and visible so that it has access to the innermost realities of that which is perceived.

For example, the noetic perception gives the beholder an access to see the spiritual realities embedded in the icons. An icon of Jesus Christ opens the spiritual eye (\textit{nous}) of the faithful beholder to see and experience the divine realities depicted on the icon. The beholder is invited not only to stand in front of the icon as a passive-objective spectator but to actively participate in those divine realities that are depicted on the icon. However, to be able to actively engage in this iconic presence, the noetic eye of the beholder needs to be trained to do so;
inasmuch as the noetic eye actively engages that presence, the human being comes closer to the aspired God-like status (to which the discussion will turn next).

This same noetic perception is quintessential to perceive the divine image in other human beings, regardless of where they stand in their spiritual journey. The responsibility is therefore the beholder’s to see the image (eikona-icon) of God imprinted in every other human being. In the liturgical practices of the Orthodox Church, attendants of any service are censed with reverence by the deacon (or the priest) in a similar way to censing the icons that adorn the church building. This emphasizes that the iconic realities of every person who is in attendance (whether they belong to the community or they happen to be just visiting) derive from the divine realities that stand behind the creation of those same persons.

II.A.4. Divine Likeness

“According to our likeness” (Gen 1:27) refers to a dynamic aspiration toward which the humankind should strive. The God-likeness is usually referred to as theosis (deification, divinization) of the human person through the divine grace. A much-cited phrase from St Athanasius (296-373) recapitulates the divine economy in this regard: “he became human that we might be made divine.” Moreover, since Christ, the Son of God, has revealed himself to be the true image of God (Colossians 1:15), human beings, many church fathers believe, are made according to Christ’s image and aspire to become Christ-like. While the progeny of Adam and Eve has long suffered from its estrangement away from God (in corruption and death), the New Adam, Christ, materializes in his person the prototype that humanity should follow. Therefore, whatever vocations Christ has assumed to fulfill the redemptive economy, humankind should adopt to continue that economy under the auspices of the Holy Spirit. This entails to strive
toward bridging the existential gap between God and the creation and to re-establish the loving reign of God on earth (cited in the “Our Father” prayer).

**II.A.5. Human Fallenness**

Notwithstanding the creation of humanity in the image and after the likeness of God, the ancestral disobedience has changed the human condition since then. As discussed above, church fathers have perceived this change within a communal mindset that dissociates from a legalistic understanding of the ancestral sin. The new fallen state of humanity did not efface the divine image imprinted in every human being; it rather disrupted their ability to achieve the God-likeness. More particular, Adam and Eve became able to know the good and evil (because they ate of the fruit of that tree) but while sustaining a state of alienation from God because of their disobedience. Thus, whatever divine-like attributes humans enjoyed before the fall were not retracted because of the fall. Rather, the noetic eye became fogged leaving human beings deprived of a clear perspective to achieve their God-likeness. This lost perspective warped their inclination toward communion with God and instead human beings created other gods (including themselves) toward which they directed their existence.

Although they lost the clarity of their spiritual perception, human beings preserved their genuine predisposition toward communion with God, regardless of their belonging to any religious or philosophical belief. They have also preserved their ability to be co-creators like God through their cultural and aesthetic creativity, although they have sometimes used their creativity in evil manners. In a few words, the image of God was preserved in humanity but veiled because of human fallenness; thus, the incarnation of Christ was necessary to re-introduce the divine perspective and re-establish the lost communion between God and the creation.
In bringing this section to a conclusion, it is important to emphasize those aspects of the advocated Orthodox Christian anthropology which will have ramifications on the argument of this dissertation. Although human beings are rational and free creatures, their rationality and freedom cannot be perceived outside a holistic understanding of the divine image imprinted in every person. Human beings cannot be reduced to their rational and free choices which, if deprived of the spiritual noetic perception, are open to corruption. Their spiritual perception, although clouded because of their fallenness, continues to direct humans’ innermost desires toward an authentic communion with God regardless of their religion or belief system.

Therefore, an authentic anthropocentric Christian engagement with secular and post-modern humanism should highlight the failure of the latter’s anthropology(ies) to realistically address the [fallen] human condition. Both impersonal collective communism and individualistic capitalism are built on distorted anthropologies that condemn them to fail in serving human beings and to fail in satisfying human’s innermost desire to unite with each other and with God.

Accordingly, as a way to establish an authentic anthropology for post-modernity, it is warranted to reiterate humanity’s mission as assigned by God since its creation and to explore how Orthodox Christian theology has drawn the way to achieve it.

II.B. Humanity’s Mission

II.B.1. Theosis, Spirituality, Asceticism

The ultimate mission of humanity, alluded to above, is to achieve theosis (deification), to become God-like. This can only be achieved through communion with God and the entire universe. Although human ancestors were in communion with God before their fall, their status in Paradise was a project-in-the-making to achieve the aspired theosis. When humans become God-like, the resulting transfiguration (change to a better status) does not only affect humanity
itself, but also manifests in a transfigured universe (contrary to what happened because of the disobedience of Adam and Eve).

Practically speaking, becoming God-like entails a divine-human synergy (synergeia, cooperation/co-working). This is a necessarily two-directional relationship that extends the redemptive work of God into the daily lives of the faithful. On the side of God, divine grace or, as previously explained, divine uncreated energies nurture and support human effort to become God-like. However, on the side of humans, asceticism-mysticism are central to this effort according to an authentic understanding of Orthodox Christian spirituality. Orthodox Christian spirituality is understood through its relationship to the Holy Spirit rather than being a vague spiritual experience or elusive pietism.

Central to this understanding of spirituality, Orthodox Christian resources highlight the fundamental importance of asceticism (askesis) to any genuine spiritual experience. Ascetic practices in Orthodox Christian spirituality do not aim at the mortification of the human body, simply because the body is part of the divine image imprinted in humans. Similarly, asceticism does not deny the material needs of human persons, such as food or drink. Rather, denying oneself pleasures or necessities of life is a tool for transforming the practitioner’s spiritual mindset. Ascetical practices change the meaning of those same pleasures and needs and as a result the persons who are involved are gradually transfigured to a God-like status.

II.B.2. Asceticism as a Way to Transfiguration

When the entire universe, including human beings, are transfigured through communion with God, the divine meaning (logos) of the universe will be revealed; a meaning that was meant by God since the very beginning. Furthermore, the meanings (logoi) of every created thing/person will find its ultimate fulfillment in the Logos, the Word of God (John 1), the second
person of the Holy Trinity, the Logos of the entire creation. This dialect between the *logoi* (pl. of *logos*, meanings or principles) of every created thing/person and the Logos who unites them in himself refers to Stoic philosophy.

St Maximus the confessor (580-662) has Christianized these philosophical tenets to emphasize the unity of all created reality in the person of Christ. That’s what made St Maximus perceive the human being as a microcosm in whose person the created and uncreated worlds come to interact. Humans are the only species who have the necessary noetic-spiritual perception to recognize the spiritual realities and *logoi* of every created reality.

Dumitru Stăniloae (1903-1993), one of the leading theologians of the twentieth century, developed St Maximus’ ideas to emphasize that it is not only humans are microcosms but also that the cosmos is “*macranthropos*”, the human writ-large. Stăniloae highlights in this concept the human responsibility toward the cosmos. Furthermore, to have access to the *logoi* of every created reality, and to perceive it as embedded in the Logos, means in some sense having access to the eschatological realities of the creation. In other words, through a trained spiritual-noetic eye, humans may have access to understand the eschatological meaning of the entire creation as it was willed by God since the very beginning. (More on the importance of eschatology in perceiving the world and how to properly engage it will follow).

**II.B.3. Monasticism Leading Spirituality; Death, Vulnerability, and Compassion**

On a practical level, asceticism-mysticism should be the practice of every devout Orthodox Christian. Although ascetic-mystical practices are usually linked to monastic communities through their life of constant prayer and fasting, the mystical experience of God through *askesis* is open to clergy and laity who live in the world (i.e. outside monasteries).
One of the important aspects of any spiritual exercise as practiced in Orthodox spirituality is a silent remembrance of death.

The first part of this exercise is silence (*Hesychasm*). This practice in monastic life aims at self-knowledge, specifically a knowledge of the human need for the other. One does not only rely on others to provide the material needs for everyday life, but more importantly, one needs others to know one’s own self. In a monastic community, every person (monk or nun) needs the brethren and a spiritual mentor (father or mother) to achieve *theosis*.

The second part of this exercise, constant remembrance of death, is quite important. Arguably, all other monastic ascetical practices revolve around this one theme: the recognition of one’s own mortality. Although this might sound like a morbid fixation on death, it has been practiced in Orthodox monasticism (and perhaps other ascetic traditions, Christian or not) as a joyful venture embedded in a frequent celebration of the triumphant resurrection of Jesus Christ in weekly and yearly liturgical cycles.\(^{109}\) In short, monastics live what they believe is the model to confront human mortality; it is through embracing one’s own vulnerability and inevitable mortality that one is able to recognize the fragility of every human life and thus be able to embrace those who are suffering with sincere compassion and solidarity.\(^{110}\) Humanity’s mission may then be modeled using the kind of knowledge experienced in monastic communities. When human beings become comfortable with their own vulnerable and mortal existence, they will be able to authentically (though not effortlessly) recognize that which unites them as human beings. It is the recognition of the frailty of their mortal existence that brings human beings together rather than an impeccable rational consensus.

Moreover, Orthodox monasticism emphasizes one more important thing about human vulnerability. Human beings are not just physically vulnerable in confronting disease and death;
they are weak in facing their sinful spiritual passions. Passions in English may have a positive connotation such as when saying: “I have a passion for painting”. However, in Orthodox monastic literature, passion translates *pathos*, which bears a negative connotation referring to distorted/sinful use of human emotions, such as anger, selfishness, and lust for power. These passions are meant to serve a lofty goal, specifically to unveil the innermost “passion-ate” love toward God and “com-passion” for the entire creation.\(^{111}\) These passions are best summarized in the work of St John Climacus (of the ladder), a monk from the seventh century. He described the spiritual journey toward God as climbing a ladder while transforming every human passion to virtues at every rung toward heaven.\(^{112}\) Therefore, a sincere recognition of one’s own vulnerability would nurture a Christ-like desire to assume the vulnerabilities of others and to strive to bear with them the burdens of their lives (Gal 6:2) as a stipulation to grow spiritually. In other words, standing by other humans in solidarity is cardinal to know oneself and one’s own vulnerability, and is unavoidable to grow spiritually and to become God-like.\(^ {113}\)

In the same vein, embracing one’s own vulnerability highlights a meaning in repentance that is usually cherished in Orthodox spirituality. Repentance translates *metanoia* in Greek which means “*meta-*” change, and “*noia*” from *nous*: mind. As the central call of St John the Baptist in the beginning of the Synoptic gospels (Matthew 3:2; Mark 1:4; Luke 3:3), repentance invites the people of God to have a new mindset. The faithful today are also invited to acquire the same new mindset through constant repentance. Hence, repentance in Orthodox spirituality is not only about confessing one’s sins (as if they were legal offences to be absolved); rather, it is about changing one’s mindset in regards to her own existence to be re-integrated into the community of believers, against whose communion sins are committed.\(^{114}\) Perhaps, the reconciliatory-restorative understanding of repentance can be pushed a bit further to highlight re-integration...
into the divine salvific economy toward the entire human community. In other words, spiritual
growth may be achieved when one acquires a mindset that re-conciliates the person’s life into the
universal divine mission to save humankind. Repentance is reconciliatory in essence, not only
toward the community of believers as a sect, but also toward the entire human community for
whose salvation God has sent his only begotten Son (1 John 4:14).

To summarize, Orthodox spirituality thrives on asceticism not as an individualist and
escapist disciplining of one’s fallen desires; nor does it flourish on idealist and angelic paradigms
that ignore the fallen human condition. Rather, Orthodox spirituality is perceived and practiced
as a social discipline that is lived within a community of believers inside the church but that is
open to the entire world.\textsuperscript{115} Moreover, ascetical spiritual disciplining aims at a mystical
encounter with God not through the mortification of the human body but through the
transfiguration of the person, the community, and ultimately the entire universe.

Transfiguration starts from an avowal of one’s own vulnerability and mortality as a step
toward embracing the vulnerability and mortality of other human beings. By so doing, one
acquires a new unifying mindset however different humans may seem in their philosophical
beliefs and reasoning; they all are vulnerable and mortal and thus worthy of sincere Christ-like
philanthropic compassion.\textsuperscript{116} A Christ-like mission toward the entire universe entails a \textit{metanoic}
perspective that is inclusive and centered on bearing the burdens of others with compassion and
solidarity regardless of the other’s religious convictions.\textsuperscript{117} Lastly, the Orthodox Church, to
which the discussion will turn now, can only fulfill her mission to divinize humanity inasmuch as
she follows the example of Christ “the only philanthropist”, as liturgical hymnology frequently
describes him.
III. Eschatology as the Interpretive Lens for Orthodox Theology and Anthropology

This section will discuss how the advocated *phronema* should shape the Orthodox Church’s responsibility toward the world on a daily basis. The liturgical experience of the *eschata* (the last things) defines the Orthodox Church and thus opens the door to a dynamic understanding of her mission in the world. This mission aspires the economy of the Holy Spirit which continues the salvific mission of Jesus Christ toward the entire creation.

III.A. A Holistic Eschatological Mindset

The Eucharist is central to the mission of the Orthodox Church in the world. It is the manifestation of the pneumatological (related to the Holy Spirit) economy which continues the Christological-Soteriological mission. Moreover, the Church’s ecclesiology (her self-perception as an institution and a community of believers) is necessarily shaped within incarnational and Trinitarian theology. In the Eucharist, the church becomes aware of her own identity, not as an entity in opposition to an inimical world, but as a missionary that works in the world to bring the entire creation back to God. It is the liturgy, the work of the people, which substantiates this mission on a daily basis.

III.A.1. Economy of the Holy Spirit

The salvific mission of Jesus Christ continues to this day in the mission of the Holy Spirit, not only inside the church, but also outside her boundaries. The Spirit sustains the church through the many talents and blessings bestowed upon the believers; the Spirit also sustains the world and mystically works in the world to bring it back to God. To understand the mission of the Holy Spirit in the world and inside the church, it is important to explore what happened on the Pentecost day as was understood by church fathers and many recent theologians. Many theologians justifiably believed that the church has started her mission on the day of the
Pentecost, although dating her start to Paradise is not unreasonable if the church’s mission (as a community of believers not only as an institution) is understood as communion between God and humanity.

The descent of the Holy Spirit (Acts 2:4-11), thus understood the Church fathers, was meant to reverse the sin of those who built Babel’s tower (Genesis 11). This was best expressed in the Byzantine hymnology of the feast of the Pentecost. A similar use of Byzantine hymnology as a source of theology is frequently encountered in Orthodox theological writings.120 The Kontakion of the feast reads as follows:

“When the Most High came down and confounded tongues of men at Babel, He divided the nations. When He dispensed the tongues of fire, He called all to unity, and with one voice we glorify the Most Holy Spirit.”

The sin of the Babylonians is not different from that of Adam and Eve. They wanted to reach heaven, or become gods, on their own by building a tower using man-made material. Because of that not only their communion with God was broken (similar to what happened with Adam and Eve) but also the communication (comm-uni-cation, comm-uni-on) among themselves was severed. Because of that sin, various nations (ethnic groups) emerged which spoke different languages. Not surprisingly, the result of breaking the communion with God was a breaking in the communion among human beings. In contrast to Babel’s splintering of the nations, at Pentecost, language barriers were overcome by the powers of the Holy Spirit. Very importantly this restored the possibility of communion despite language differences. To reverse the sin of Babel, the divine events of Pentecost did not erase history and ‘go back’ to a one language that was before the building of the tower (if at all that language existed). Nor was post-Pentecostal communication only in the language that the apostles spoke (whether Greek or Syriac-Aramaic). Rather, the Holy Spirit made the apostles and other disciples miraculously
speak the myriad of languages of the various ethnic groups which were in attendance, thus symbolically reversing the language division among human beings.\textsuperscript{121}

At the practical level, this event shaped (and should always shape) the mission of the church among those who do not belong to the community of believers. It shifts the responsibility of communication-communion toward the apostles and disciples of Christ in at least two ways.\textsuperscript{122} The first, obvious way is in translating the Gospel’s message into the languages of every group who received a church missionary. One fundamental example of this missionary work is the evangelization of the Slavs in the ninth century. The Slavonic language at the time was only a spoken language that did not have a written alphabet. Sts Cyril and Methodius had to invent the Glagolitic alphabet as a step to translate the Gospel for these nations to read. The second way in which the believers bear the responsibility for communicating the gospel to the entire humanity is through striving to find a semantic style that others can understand. In other words, it is the church’s responsibility to create venues of communication-communion with those who are outside her boundaries rather than demanding those who are outside to come into communion with the church.

\textit{III.A.2. The Eucharist; The Ultimate Economy of the Spirit}

The ultimate pneumatological economy that is constantly experienced inside the church is the Divine Liturgy, the Eucharist, the sacrament of thanksgiving. Most recently, theologians have recognized the Eucharist as the defining activity of the Orthodox Church rather than her dogmatic heritage. This Eucharistic Ecclesiology was named by its pioneer theologian, Nicolas Afanasiev (1893-1966) but is strongly supported in the writings of many church fathers.\textsuperscript{123}

Such ecclesiology highlights two related issues. First, liturgy translates \textit{leitourgeia}: the work of the people highlighting the practical, lively side of prayer. Second, regardless of the
differences among theologians about the details of this ecclesiology, the centrality of the mystical experience of God in Orthodox self-awareness is paramount. This practical experiential dimension of the Orthodox self-awareness puts the dogmatic heritage of the church in perspective. Even the Nicaean-Constantinople (NC) Creed, the Orthodox confessional documents *par excellence*, is integrated into the liturgy. Although the Creed reads “I believe…” in the very beginning, in accordance with the most authentic text, it can only be correctly understood within the prayerful context of the entire community of believers.\footnote{124}

Ultimately, the Eucharist opens the door to the *eschaton* through ‘taking communion’ in the Body and Blood of Jesus Christ at the end of it. However, it is not merely through communion that eschatological realities are fore-tasted within the limits of time and space;\footnote{125} other elements unfold the in-time experience of the *eschata*. One element is the celebration of the Divine Liturgy on Sunday as a weekly celebration and active re-living of Christ’s salvific providence. Many historical reasons compelled early Christian communities to move the celebration of the Lord’s Day from Saturday (Sabbath) to Sunday. Primarily, these communities considered Sunday to be the Eighth day of the week. On the eighth, humanity encounters the Resurrected Christ and the end times (*eschata*) present themselves to the temporal reality of the world. Therefore, when the Eucharistic offerings are consecrated, the priest loudly chants: “on behalf of all and for all” including the entire humanity for which Christ was crucified and has resurrected.\footnote{126} And by the work of the Holy Spirit, the entire created world may be transformed to be in communion *with* and *in* Christ as well.\footnote{127}

Not only is the timing of liturgy important so is the place. The liturgy itself is usually celebrated in a church building which is full of icons (some buildings have more sophisticated collection of icons than others). The presence of icons in their assigned places (a very detailed
issue that goes beyond the scope of this dissertation) opens “windows” toward the divine realities. In the Orthodox theology of icons, it is emphasized that icons are not just an artistic depiction of the persons or events to invoke passive reminiscence among beholders. More deeply, icons present an active personal presence that invites beholders to grow in communion with the eschatological realities depicted on them pushing beyond human complexions or time-bound events.\(^{128}\)

On a general note, the liturgy starts by invoking the presence of the Holy Spirit through praying “O Heavenly King, the Spirit of Truth… come and dwell” and situating the entire liturgy within “a time for the Lord to act” (as the deacon –if present- exchanges with the priest right after that). However, at no point close to the end of the liturgy the celebrating clergy or the chanters announce the conclusion of the Lord’s action. Rather, the priest announces at the dismissal saying: “let us go forth in peace” leaving it to the faithful to take what they experienced during the Eucharist and extend it toward the entire world in their daily lives. This epitomizes what is known in Orthodox circles as “the liturgy after the liturgy.”\(^{129}\) The centrality of the Eucharist in defining the church community and its mission toward the world shapes the way the believers should engage in the world.

Since the church is not defined in contrast to the world, but rather is defined in what is her mission toward the world (saving the world in bringing it back to communion with God), it is the responsibility of the church to define the world from its vantage point, its theology and mystical experience with God.\(^{130}\) In other words, the world outside the church may seem hostile toward and drastically different from the church and her beliefs simply because it is governed by the fallenness of humanity and its consequent alienation from the good and beautiful. While the world is a place where the Holy Spirit has been constantly working to bring back the lost
humanity to God, it is the faithful’s responsibility to communicate the love of God to the entire world. The world, for the church, is not a foe but rather the place where the divine love toward humankind (philanthropy) should reign.\textsuperscript{131}

**III.A.3. Counter Eucharistic phronema; the World as a Foe**

Contrary to this perspective, many thinkers propagate a sense of enmity toward the world because of the contrast they see between the worldly ethos and that of the church. However, what they miss is the responsibility/mission of the church toward those who are on the outside of its boundaries. Some of the arguments by Tristram Engelhardt for instance (which will be discussed in further detail in the following chapters) are only dressed in Orthodox Christian theology and patristic language. Some of the premises underneath his arguments include a “black box” anthropological approach to ethics which discounts any possibility of moral communication among human beings. However, he takes this premise even further to implement “moral strangeness” as a valid boundary between different ‘moral’ communities. Hence, he overlooks the state of alienation among human beings because of their fallenness (even within the same religious community), and concentrates only on their moral differences. Furthermore, he adopts a sectarian ecclesiology that (condescendingly) defines the Orthodox community of believers as different from other religious communities because it “owns” the true doctrinal heritage. In such a sectarian perspective, church doctrinal heritage becomes another defining ideology vis-à-vis other ideologies in the market of ideas to win more followers. Engelhardt’s perspective is in clear contrast to the ecclesiology that has been illustrated above.\textsuperscript{132}

**III.B. A Eucharistic Mission in a Globalized World**

This section will now turn to discussing “the liturgy after the liturgy”. In other words, it will explore how the church community should encounter the globalized world that has an ethos
(or a variety of ethos) which is different from Christianity’s. Yet, the difference between the Christian ethos illustrated so far and a post-Christian post-modern world is not an excuse to absolve the church from her responsibility.

**III.B.1. Unity of the Creation**

One aspect of the advocated *phronema* that needs to stay in mind is that there is no separation between the Creator and the creation; by creation, it is meant to include all the material, irrational, and rational beings, whether they belong to the Orthodox Church or not. The Church fathers believed that the creation of the entire universe from nothingness (*ex nihilo*) (Gen 1) is not meant to offer a scientific theory of the creation of the world. Rather, the narrative in Genesis is meant to highlight the creation’s fundamental relationship with God and its fragility when separated from the only source of life (even before the fall of Adam and Eve).¹³³

This fundamental relationship between the creation and its Creator underscores another aspect that is central to the unfolding of the argument of this dissertation, namely the unity of the created world. Regardless of the fragility of the created world, it is still sustained by the divine energies and therefore the harmony inside creation is still tangible. Further, the unity of the created world, though was disrupted because of humanity’s fall, is rooted in its createdness. Being created by God, the entire creation is in unceasing and collective seeking of the life-giving God, regardless of any perceptible discordance. This approach toward the universe has been central to develop the study of environmental ethics by contemporary Orthodox scholars. It is usually referred to as “ecclesial cosmology”, “sacramental cosmology”, “Eucharistic cosmology”, or “cosmic liturgy”.¹³⁴

To take the mindset of Orthodox environmental ethics further, a Eucharistic recognition of the unity of the entire universe rooted in createdness emphasizes that rationality is not the only
faculty that is important to foretaste the aspired eschatological unity; in this case, even irrational beings stand in solidarity (in unity) seeking God. In the same vein, this dissertation builds on that same recognition of possible unity among irrational beings to advocate the possibility of similar unity (solidarity, even if only as an achievable project) among human beings. This unity is built on the very nature of humanity: a holistic and inclusive anthropology vis-à-vis a reductionistic anthropology that is fixated on rationality. In other words, it is the unifying eschatological reign of God (where God becomes “all in all” (1 Corinthians 15:28)) that should aspire Orthodox believers to seek genuinely unifying elements derived from a holistic anthropology.

***B.2. A Eucharistic phronema in a Pluralistic World***

Furthermore, taking the eschatological-Eucharistic identity of the Orthodox Church seriously is important to illuminate her mission in a globalized world that is effacing all traditional boundaries and is embedded in a web of very complicated relations. One of the signs of complexity is the migration of people of different ethnic backgrounds and the evolvement of pluralistic societies in different parts of the world. However, one of the dangers facing this plurality is globalism: when every cultural identity melts into a one global identity that is unavoidably dysmorphic and superficial. This contrasts a globalization that celebrates various identities as a sign of rich and enriching human cultures.

Therefore, in such a globalized milieu, it is not possible for Orthodox Christians to fixate on the desire to re-build a Christian Empire or achieve the lost harmony (*symphonia*) between church and state under Byzantium; it was arguably a failing experiment. Pluralism is the reality of the post-modern world and Orthodox Christians have to accept it, live within it, and work to transfigure it (in the special sense that was discussed previously). Trying to build Byzantium again is ultimately betraying the universal (catholic) mission of the church.
III.B.3. Pastoral, Missionary, and Prophetic

Over the years, many Orthodox theologians have reflected on the tasks of Orthodox theology and communities in modern times. Alexander Schmemann (1921-1983), a respected figure in Orthodox Renaissance in the West,\textsuperscript{141} believes that Orthodox Christian theology has three fundamental tasks in the US, which are also warranted elsewhere. To be relevant, Orthodox theology should be pastoral, missionary and prophetic in the way it approaches the human condition in post-modernity. Although these are the tasks of theological reflection, they are understood as integral to the daily life of every believer - and thus as the tasks of the entire Christian community at large.\textsuperscript{142} As has been stated frequently, Schmemann emphasizes that the ultimate goal of the church is the salvation of the entire world through establishing the lost communion with God. Therefore, theologians cannot elaborate on their theologies in a cultural vacuum; they have to be relevant to every believer wherever and whenever they live.

At the time of writing his article, Schmemann contends that Orthodox theologians have been disconnected from the daily needs of the faithful because of their unnecessary fixation on academic and dogmatic discourse with peers of other backgrounds. It is important, for Schmemann, to gear theological reflection toward the new global realities of (post)modernism that are affecting Orthodox believers, in Orthodoxy’s homeland and in the West. For many reasons including those discussed in the very beginning of this chapter, (post)modern social milieu is foreign to the Orthodox ethos and worldview and necessitates an active engagement to unfold the uniqueness of Orthodoxy within this new reality. Moreover, Schmemann believes that Orthodox theology has to take the Church’s catholicity (universality, as confessed in the NC creed) seriously through a genuine involvement in missionary and ecumenical endeavors (as did many of the pioneers of modern Orthodox renaissance).\textsuperscript{143} For him, and unlike those who
criticize ecumenism, ecumenical and missionary involvement does not (and should not narrowly) target those who are outside of Orthodoxy to proselytize. Rather, this involvement should also aim at broadening the perspective of Orthodox believers themselves to overcome the ethnic and provincial division among them (especially in the US) which contradicts the catholicity of the Orthodox Church. Furthermore, a missionary work among those outside of Orthodoxy should evolve around a sacrificial and self-giving encounter. This encounter should always center on the person of Christ as the Truth (John 14:6) while at the same time being critically open to all the ideas and values of others as possibly bearing witness to the hidden seed of the Logos in them (as St Irenaeos of Lyons (130-202) advocated and Met Khodr did following his example).

The example of Antiochian Orthodoxy in the Middle East is illuminating in this regard. In the person of Metropolitan George Khodr and many of the faithful who follow his example, an open relationship with Islam is fostered. Through a diligent, open-minded, and non-apologetic discourse with Muslim leaders in the area, Met. Khodr was able to garner the respect of Muslims and to open the eyes of Christians to the strong presence of Christ inside Islamic ethos. Similar example of openness to the world arose in Russia through the person and work of Fr Alexander Men (1935-1990) who believed that Christ was present in contemporary culture inasmuch as he was two millennia ago in the towns of Palestine. Lastly, Schmemann believes that the church’s voice in (post)modern society should be prophetic in reminding humanity of its authentic mission, which is theosis (as explained previously), through adopting a divine sacrificial love toward all humanity (philanthropy).

**III.B.4. Self-Critical and Inclusive**

Similar to Schmemann, other Orthodox theologians reflected on the tasks of Orthodox theology aspiring the patristic heritage that was pastoral and salvific par excellence. It is believed
that Orthodox theological reflection should be self-critical and less defensive in encountering the world outside of the Church.¹⁴⁸ One example of such an encounter is that of St Photius the Great. He was critical from within the Orthodox tradition without seriously risking an authentic encounter of God.¹⁴⁹ In the same vein, the post-modern trends of questioning authority (religious and non-religious alike) should be a positive opportunity for theologians and the faithful to search for their historical share of responsibility in shaping these trends. In other words, religious communities should actively engage in a metanoic (repentant) self-searching to unveil the reasons behind a general social trend of leaving theistic faiths.

At a deeper level, Orthodox theologians and communities should emphasize the mystagogical (mystical) dimension of Orthodoxy as a way to encounter the divine persons rather than fixating on a literal (ideological) preservation and preaching of Orthodox doctrines.¹⁵⁰ Such a mystical encounter with the divine persons aspires a similar encounter with other human beings regardless of their religious background; thus unveiling the ecclesiastical dimension of social life that is known among some Orthodox theologians to be “the mystery of the brother [and sister]”.¹⁵¹ In openly embracing the world, Orthodox Christians become true martyrs (witnesses) for the unwavering presence of the transcendent within the immanent world. They also become martyrs for the spirituality of active social involvement to serve the most vulnerable. As witnesses of the ever-present God, they are not only preachers of this reality in words; they are also encouraged (or expected) to willingly accept martyrdom of blood.¹⁵² Emphatically, being witnesses of the catholicity of the Orthodox Church, believers should be steadfast non-sectarian proclaimers (evangelicals) of the Orthodox faith in the midst of post-modern uncertainties.¹⁵³
IV. Conclusion

In a few words, building on the advocated hermeneutics of the Orthodox theological themes and their anthropological repercussions, it is necessary to adopt an inclusive yet critical mindset (phronema) that fosters an active witness to the world. This witness is not through preaching the dogmatic truths of Orthodoxy, but through self-sacrificing martyrdom, in deeds and even in blood. These deeds proclaim the personal truth of a philanthropist God and living Logos louder and more profoundly than any words.

Central to this witness are ascetic and mystical practices to help the church reformulate her biblical, patristic and liturgical heritage to address the pastoral needs of the entire humanity (rather than narrowly caring for her own faithful). This is represented in a church typology that is derived from contemporary sociology but still relevant to Orthodox ethos. Harakas believes that the personal (mystical) relationship with God in prayer is necessarily embedded in the Orthodox Church within the communal prayer of the Eucharist. However, he emphasizes that the church’s mission is not limited to those who participate in the Eucharistic Chalice but is extended to the entire world in a non-sectarian openness toward humanity.\textsuperscript{154} Acquiring this inclusive and redemptive phronema extends the three-fold vocation of Christ, being the king, the prophet, and the priest of the entire universe, to the church, his body on earth (Colossians 1:24).\textsuperscript{155}

Ultimately, a liturgical life that aspires eschatological realities and defines the church herself adamantly justifies a search for the commonalities among all human beings, regardless of where they exist or what they believe.\textsuperscript{156} Because of her genuine understanding of humanity, it is the responsibility of the Orthodox Church to be at the forefront to confront with the entire humanity, in steadfast hope in Christ and divine philanthropy, the uncertainties and injustices of
post-modernity.\textsuperscript{157} It is from this foundation and within this \textit{phronema} that the argument made in this dissertation materializes.

\begin{flushleft}
\begin{enumerate}
  \item Cunningham and Theokritoff, “Who Are the Orthodox Christians?”, 1-18.
  \item Cunningham and Theokritoff, “Who Are the Orthodox Christians?”, 1-18.
  \item Abou Mrad, “The Witness,” 246-260.
  \item Cunningham and Theokritoff, “Who Are the Orthodox Christians?”, 1-18.
  \item Harakas, \textit{Health and Medicine}, 3-11.
  \item Alexander Schmemann, “The Task of Orthodox Theology in America Today,” \textit{St Vladimir’s Theological Quarterly} 10 (1966): 180–188.
  \item Cunningham and Theokritoff, “Who Are the Orthodox Christians?”, 1-18.
  \item Cunningham and Theokritoff, “Who Are the Orthodox Christians?”, 1-18.
  \item Cunningham and Theokritoff, “Who Are the Orthodox Christians?”, 1-18.
  \item Cunningham and Theokritoff, “Who Are the Orthodox Christians?”, 1-18.
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32 Ware, “Orthodox Theology Today,” 105–121.
36 Ware, “Orthodox Theology Today,” 105–121.
44 As quoted in Casiday, “Church Fathers,” 173.
46 Harakas, Health and Medicine, 12-21.
51 Louth, Introducing, 16-32.
56 Lossky, Mystical Theology, 44-66, 67-90.
57 Lossky, Mystical Theology, 23-43.
60 Assaad E. Kattan, Shiraa’ Fi Uyoun Mustadira; Dirasat Fi Fikr Almutran George Khodr ‘A Sail in Round Eyes; Studies in the Thought of Metropolitan George Khodr (Beirut, Lebanon: An-nour COOP, 2012), 43-56; Sylvie
61 Ware, “Orthodox Theology Today,” 105–121.
71 Schmemann, “Task of Orthodox Theology,” 180–188.
75 Ware, “Orthodox Theology Today,” 105–121; Louth, *Introducing*, 82-95.
76 Pentiuic, *Jesus the Messiah*, 5-24.
77 Harrison, “Human Person,” 78–92.
78 Harrison, “Human Person,” 78–92.
84 Lossky, *Mystical Theology*, 114-134.
92 Louth, *Introducing*, 82-95.
97 Louth, *Introducing*, 82-95.


CHAPTER THREE: THE INTERPRETIVE CONTEXT OF PLURALISM IN BIOETHICS

In this chapter, the discussion will concentrate on the *status quo* of bioethical discourse within the globalized context that is complex and pluralistic par excellence. The discussion will highlight the trends that developed over the past few decades in secular and religious approaches to bioethics. It will advocate a global bioethical discourse supported by an inclusive iconic *phronema* derived from Orthodox Christian theology.

I. Procedural Pluralism in Secular Bioethics

Under this section, the pluralistic context of contemporary bioethics will be explored advocating an open dialogue among different stakeholders and value systems. Then, a brief historical study of the factors leading to the development of secular bioethics in the US will be discussed. Further, an inclusive bioethical discourse will be advocated as the best approach to handle the demands of new medical technologies in a globalized world.

I.A. Pluralism and Dialogue in Bioethics

I.A.1. Globalization as the Context

Globalization is a new phenomenon that has developed over the past few decades. Many reasons have contributed to its emergence including the development of communication technologies, the opening of national borders for free trade agreements, and the flourishing of powerful networks of multinational corporations and financial institutions. All these developments almost effaced the boundaries among various groups and nations and highlighted the fundamental interdependence among human beings as a basis for them to flourish. However,
the promised benefits of the evolving relations plagued many communities with unprecedented injustices and unjustifiable disparities. In a shrinking world, the complex and dialectical processes of globalization are polarized between the universalization of the local reality and the particularization of the global trends, thus bringing a great deal of ambivalence. Complexity and interdependence are the leitmotifs of contemporary world at many levels, including economic and financial levels, political relationships, ecological realities, and cultural identities. Collateral to the complexity of globalized relations are the moral responsibilities that surface due to these relations, however controversial these responsibilities may be.\textsuperscript{1} The various levels of globalization will be discussed briefly in what follows, especially that these levels have repercussions on bioethical discourse.

\textit{I.A.2. Economic and Financial Globalization}

Economic forces have been the propeller of globalization over the past few decades. The demise of the creative tension between capitalism and socialism opened the way for the neo-liberal ideology to take control over all financial institutions and economic forces around the world. Through de-regulation, it was thought that the free market forces of exchange will bring prosperity to everyone on the planet. Although free market exchanges accelerated economic growth and helped accumulate prosperity around the world, the disparities among various social groups in different countries, and inside many countries (developed or developing), have grown ever since. The subsequent unjustifiable inequalities and dehumanizing inequities raise many moral concerns on the legitimacy of free-market ideology and its claims of trickle-down global prosperity. This also questions the morality of shaping any society in a way to serve the market rather than steering the market to serve the common good of society.\textsuperscript{2}
I.A.3. Political and National Power

As a result of market-centered economics, emerging powerful multinational corporations and financial institutions strap national governments of their ability to guarantee the wellbeing of their citizens. The interests of multinational creditors and international financial institutions are being served, in many examples, at the cost of the wellbeing of the most vulnerable social groups. The emphasis of these powerful players on cutting down governmental expenses on education, healthcare, and basic services, has badly affected entire populations in developing countries. Privatizing drinking water in Bolivia, for instance, was enough to entice social unrest.³

Notwithstanding the downside of weakening political power of certain governments, undeniable advantages have accrued for many in those nations. The emergence of a globalized world put several nation-states under international scrutiny in regard to their records on human rights violations. Instant communications and media coverage from around the world emphasize the responsibility of every nation toward its own people and toward its international partners. Although there is always the unfortunate possibility of double standards in addressing violations due to narrow interests, broad media coverage makes it difficult for such violations to pass without scrutiny. Moreover, after the fall of communism, religious communities emerged as necessary players to fill the moral vacuum created by a self-serving free-market mentality.⁴ Major religious communities started to actively participate in public discourse and to provide a social safety net to support the most vulnerable. Most important was the growing ability of minority religious groups to voice their concerns on a global platform and to emphasize the need for protection against discrimination toward minorities.
I.A.4. Ecological Realities and Consumerist Morale

One of the major results of growing globalization is the exploitation of natural resources at an unprecedented rate for the sake of economic growth. The growing consumerist ethos around the world and the accelerated development of many markets to meet growing consumption have raised many ecological concerns globally. The effects on the ecological system is being felt on a daily basis through pollution in many fast-growing cities, such as Delhi and Shanghai. Similarly, the unsustainable use of fossil fuels and sluggish development of renewable sources of energy are fueling the climate change and is consequently putting the lives of many communities around the world in jeopardy.

Whether the climate change is scientifically legitimate or not (especially for those who doubt it), consumerist trends are not environmentally sustainable. The current level of consumption negates a humane stewardship toward natural resources. It also jeopardizes the health and wellbeing of the most vulnerable and voiceless of the world, especially future generations. Moreover, consumerism puts those who produce what others insatiably consume in inhumane circumstances. Many events highlighted the double safety standards in producing clothes and electronics for western retailers. Similarly, farmers in developing countries are producing fewer crops to meet the demands of a global and season-less market of produce at the expense of their nutritional wellbeing. While fair trading practices are gaining momentum recently (such as with coffee trade), many farmers have been hurt by the global exchange of crops even in developed countries (strikes by French farmers, for instance). Morally troubling as well is the recent invasion of genetically-modified crops to Africa under the cover of agricultural development. However beneficial to African farmers this may seem at first glance, many of these
crops will be protected under shackling patent laws at the detriment of the farmers who grow them.⁹

1.A.5. Pluralism and the “Clash of Civilizations”?

The dynamics of globalization have brought many people of various cultural backgrounds into direct contact, whether within a specific geographical space or through virtual reality. American society has witnessed the active presence of many communities of different backgrounds in many parts of the country. Similar cohabitation of religious and ethnic groups has been known in different parts of the world and has exponentially grown due to the migration of people in search for better opportunities abroad. The new reality is usually referred to as pluralism with people of different backgrounds interacting with each other. These various backgrounds substantiate in diverse religious, ethnic, or cultural identities exchanging ideas consciously or unconsciously, intentionally or unintentionally, through numerous venues.

There is a great deal of misconception regarding the nature of pluralism. Pluralism is not another word for diversity where various groups of people may coexist in any given space; the interaction among these groups is essential for a fruitful pluralism. Therefore, pluralism is better perceived as a project that is in the making rather than as a given reality. Similarly, pluralism is not a passive tolerance of the different other who happens to exist in proximity; the engagement with the other is necessary to know her in her difference. Thus, pluralism is built on a sense of equality and equal dignity regardless of identity differences. On the contrary, tolerance is necessarily condescending in that it is hinged on a position of strength to tolerate those who are different. Finally, pluralism is not simple relativism where one’s own commitments are relativized for the sake of universalizing trends. True pluralism rather celebrates the encounter of commitments because it shuns a lukewarm adherence to beliefs. In a few words, pluralism is a
genuine, dynamic engagement of varying serious commitments to equally-dignified identities. Religious commitments, more specifically, do not need to be marginalized for the sake of finding their common anthropological ground nor for the sake of building a peaceful coexistence of different identities.\textsuperscript{10}

Notwithstanding the advantages of a genuine pluralistic engagement among various communities, the reality of contemporary world unveils sometimes-violent conflict of identities among different communities, even among those who lived together for many centuries. This conflict of identities has been recently associated with a global “clash of civilizations” in an article by Samuel Huntington.\textsuperscript{11} However, the superficial analysis of this clash and the ignorance of the author needs to be exposed through a better understanding of human culture and various identities.\textsuperscript{12} This is important for this dissertation because of the uncritical adoption by Tristram Engelhardt of its root ideology of “culture wars” as advanced by James D. Hunter.\textsuperscript{13}

\textit{I.A.6. Cultural Identities and Pluralism}

Fr Emmanuel Clapsis adopts an operative understanding of culture that is very helpful to the discussion of identities in a pluralistic world. He maintains that

“a culture provides the system and the framework of meaning which serve both to interpret the world and to provide guidance for living in the world. A culture embodies beliefs, values, attitudes and rules of behavior. It includes the rituals, the artifacts and the symbolization that bind people to communities and enable them collectively to embody and express their histories and values.”\textsuperscript{14}

Using such dynamic understanding of human culture, a few elements should be highlighted for the purpose of this dissertation. First, it is not only cultures that are dynamic and constantly evolving but also associated identities and communities. Identities are not a divine given even for religious communities. Identities are social constructs that develop within the
community’s internal and external contexts.\textsuperscript{15} This makes drawing nonporous boundaries between different communities an ambitious mission if at all possible.

Second, community’s “values, attitudes and rules of behavior”, or its ethos, are also dynamic products of its historical development as a community within a specific context. Therefore, the morality of any community, even a religious one, has elements that are related to its historical context along with other elements that are divinely (or metaphysically) inspired. All these elements are embedded in a worldview, a mission and/or a \textit{phronema} that are dynamic in nature and open to change. This dynamic understanding of cultural ethos has kept, for instance, Christian communities in a healthy tension between what is authentic to the Christian faith and mission and what is a relative social construct that is adaptable to changing historical, geographical and cultural contexts. The translation of sacred texts to different languages, as mentioned in the previous chapter, is a sign of this adaptability to different contexts.\textsuperscript{16} Contrary to this dynamic understanding of community values and morality, Engelhardt ascribes to a Christian bioethics that is “non-developmental in the sense of affirming the same moral commitments and insights that directed the Church of the first thousand years: it understands that all that has been essential for the appropriate moral life has been available since the time of the Apostles.”\textsuperscript{17}

Third, the definition adopted by Clapsis highlights that moral values are not a ready (dictated) ideological core which unites the members of a certain community. Rather, “the rituals, the artifacts and the symbolization” are the source of unity in a community. In other words, what unites a community is the narration which shapes its members and the meanings assigned to various events and symbols, rather than being united because of a dictated set of meanings and beliefs. As a result, strangeness and neighbor-ness are derivatives of the ethos of
the community; the community itself decides who is a neighbor or who is a stranger depending on its worldview and mission. In the Good Samaritan parable, the Samaritan decidedly approached the wounded man as a neighbor; he chose to be a neighbor, rather than assigning to a dictated definition of neighbor-ness. Christians are ordered to do like that (Luke 10:25-37).

For the sake of this dissertation then, the category of “moral strangeness” applied by Engelhardt to different communities falls short of sound genealogy of meaning, morality, and community-uniting matrix. For Engelhardt, different communities assign nonconcurring different meanings even to the same events or linguist expressions. He clearly misconceives identity crises and the clashes between different identities as being related to a clash between civilizations. However, it is necessary to understand the role of rapid cultural changes in bringing these conflicts to the surface. Because of the processes of globalization and the ensuing cultural change, human identities may develop in three different ways. An identity may become either “legitimizing” in passively blending into the changing environment. Or, it may become a “resistant” identity that either stays in the past or militantly opposes the changing environment. The third possibility for human identity in encountering cultural shifts is to develop a “project” identity which critically engages the shifting environment, cooperatively attempts to invoke a positive change, and genuinely derives meanings consistent with its worldview.

Therefore, a religious project identity, especially an Orthodox one, is not thwarted by a pluralistic milieu. Rather, it thrives through aspiring an inclusive universalism (catholicity, kathollos: per everything-everybody) and actively engaging in a dialogue which perceives the entire creation as a field of the Lord.
I.A.7. An Orthodox Christian Perspective toward Globalization and Pluralism

The Orthodox Church has been reluctant to engage in the discourse pertinent to globalization and pluralism for many reasons. Orthodox communities find themselves in an ambivalent position while equating between secularity and modernity; from this comes the tendency toward withdrawal and isolation among Orthodox Christians. Further, the experience of various Orthodox communities varies depending on where they exist. In western countries dominated by non-Orthodox Christian communities and secular ethos, Orthodox communities have mixed relationship with their context. On the one hand, they have benefitted from an inclusive social ethos which protects different religions. On the other hand, they are immersed in a religious environment which has been traditionally occupied with the polemical discourse between Roman Catholics and Protestants.

Moreover, Orthodox communities in the west inherit a deep suspicion toward western Christianity, especially related to proselytizing in their home countries. The ambivalence lingers even today within the modern states of Orthodoxy’s heartland. The example of Greece shows the difficulties in democratic governance in a place that traditionally cherished the byzantine symphony between the church and the state. Even when this symphony was lost under the Ottomans, the Millet system preserved the particularity of the Greek people and perhaps uncritically shaped their political identity (along with many other detriments). At the ecclesial level, democratic governance in Greece raises questions pertinent to the relation between church unity and formal uniformity, the dynamics between the clergy and the laity, and the separation between religious identity and national-political identity(ies). In a few words, the experience of Orthodox communities in modern countries with Orthodox majority (and their diaspora) have generally conceived modern pluralism and secularity as a threat.
Nevertheless, a more active and creative engagement with a pluralistic world, whether at home or in the west, may be warranted and more fruitful. For instance, and as alluded to in the previous chapter, minority Orthodox communities in the Middle East (especially in Antioch) had a more positive attitude toward secular governance as a way to flourish in their nation-states. They have steadfastly believed that “the church is the heart of the world.” Christians in those communities, regardless of their denominations, have been actively open to dialogue across their differences and with their Muslim neighbors. They were among the first advocates for the ecumenical movement as a way to witness the inclusive loving mission of Christ who was crucified for the humankind. These Christians are at peace having multiple identities and dealing with different ones at the same time. They have been shaped alongside their Muslim neighbors within an Arabic-Islamic culture which, to thrive, was open to the contributions of numerous minorities. They prayed and read their Bible in Arabic, Syriac and Greek for many centuries without being threatened by sharing Arabic with Muslims. For many centuries, it is the narrative and “creative osmosis” that shaped similar identities among Christians and Muslims of the Levant, despite their different religions. Unintuitive as it may sound, Orthodox Christians in Antioch were more threatened and harmed by the crusades and colonial mentalities of western Christians rather than by their Muslim neighbors. Even in the diaspora, Antiochian Orthodox churches were among the first churches to welcome converts who embraced Orthodoxy (Engelhardt included) because of their inclusiveness and hospitality.

Therefore, in the face of global pluralism, Orthodox communities should affirm the universality of the divine mission to save the humankind while emphasizing the uniqueness of every particular human community. Any desire to withdraw from a pluralistic public space to preserve religious purity is a betrayal of the church’s mission toward humanity. Ultimately, an
authentic Orthodox spirituality is not separable from a global activism which aims at healing the world; Orthodox spirituality is activist spirituality par excellence. In a genuine spiritual journey to encounter God in this world, Orthodox Christians should strive to reconcile their way of understanding the world and the different other and that of God.\textsuperscript{25}

Consequently, Orthodox Christians should be at the forefront of a “spiritual ecumenism” that is shaped by the church’s mission. The goal of this ecumenism is not to establish an institutional unity among different Christian denominations; rather the goal is to establish a dialogical platform.\textsuperscript{26} It is a spiritual ecumenism that takes seriously the church’s eschatological identity and its long-established teachings about silence and detachment to create a space for the voiceless, the marginalized, and the alienated.\textsuperscript{27} An ecumenism that is meet to a globalized world should foster a “globalization of solidarity,” as the ecumenical patriarch Bartholomew put it, where every one of the faithful strives to countermand the injustices of globalization. A dynamic ecumenism is a movement searching for what it means to be a human being in a globalized world rather than only attempting to change the structural injustices in today’s world.\textsuperscript{28}

\textit{I.A.8. WCC and a Fruitful Dialogue in Bioethics}

In the spirit of a “spiritual ecumenism,” the ecumenical movement (using the World Council of Churches WCC as its platform) may be the best available venue for dialogue among various Christian communities; it can also be a starting point for inter-religious dialogue with other religions. The benefit of dialogue is unequivocal for the flourishing of human civilizations throughout the recorded history. Civilizations withered when they lived in isolation from each other; however, enculturation between different civilizations, in war and in peace, preserved their unique cultural heritage for many generations. Conversely, cultural elitism and imperialism infest contemporary world and foster a sense of (sometimes-violent) disdain toward different
cultural identities. For Orthodox Christians, cultural elitism and imperialism are not justifiable. Therefore, it is arguable that engaging in dialogue within the ecumenical movement, or with any other religious or non-religious tradition, is warranted, if not necessary, to overcome religious violence and hatred. Even if other cultural identities seem challenging to one’s own beliefs, there will always be a space to meet the different other in the Orthodox church.\textsuperscript{29}

The experience of the ecumenical movement is informative and formative in this context. Despite the disdain of the ecumenical dialogue by some self-proclaimed Orthodox traditionalists, this dialogue was essential for shaping a Christian theology for modern and postmodern time. The ecumenical dialogue was equally important for the Orthodox inasmuch as it was for other denominations. Many of the leading figures of Orthodox theology in the west were among the pioneers of the ecumenical movement such as George Florovsky. Also, Vladimir Lossky was educated in the west and has engaged for many years in theological discourse with his western theologian-peers. The dialogue between Orthodox theologians and theologians from other denominations helped shape the Orthodox renaissance of the twentieth century. Because of the dialogue, Orthodox theologians recognize that the Orthodox Church is not a confessional church but an incarnate community of believers. A church that evolves around the incarnation of Christ incarnates people rather than ideas and dogmas. Therefore, even atheism is important for authentic self-searching and repentance among the Orthodox.\textsuperscript{30}

Comparatively, the participation of Orthodox Christians in the ecumenical dialogue has also shaped contemporary theological reflection by other Christian communities. Orthodoxy brings to the table challenging and original perspectives about traditionally divisive theological issues among westerners. It emphasizes theological concepts ranging from divine \textit{kenosis}, the
role of theosis and apophatic theology,\textsuperscript{31} martyrdom and icons. It also highlights the organic relation between theology, liturgy and spirituality as relevant to every believer.\textsuperscript{32}

It is arguable therefore that the participation of the Orthodox Church in a global dialogue to address the rising bioethical dilemmas is an extension of her participation in the ecumenical movement.\textsuperscript{33} Orthodox theology will learn a great deal from being open to the global discourse on bioethics. Moreover, Orthodox theology has many valuable resources to bring to the dialogue, especially in regard to anthropology and eschatological identity. The most important contribution to this discourse will be at two levels at least. First, Orthodox theology recognizes the inability of pure ethical-philosophical and rationalistic discourse to dictate a clear normative path in regard to bioethical dilemmas. Second, the core of the advocated dialogue should be anthropological. Any global discourse to address human suffering, especially related to health and medical access, should be inspired by an authentic understanding of the human condition and its potential. Extracting anthropological foundations for global bioethics may be more accessible and less controversial than philosophically-based and dogmatically-entrenched moral principles.\textsuperscript{34}

However, to unearth these anthropological foundations, it is necessary to briefly explore how the field of bioethics has developed over the past few decades.

\textbf{I.B. Historical Background of Current Trends in Secular Bioethics}

\textit{I.B.1. Medical Ethics: Concentrating on Physicians’ Virtues}

Medicine has always been perceived as an art and a science. As an art, medicine is centered on caring for patients. As a science, it attempts to use available medical knowledge to ameliorate patients’ suffering. Historically, almost all civilizations and cultures cherished their physicians and guaranteed them social privileges in exchange for their services. Therefore, most of the writings addressing medical practices in various civilizations emphasize three dimensions
of the physician’s virtues. These dimensions are personal decorum (the outward actions which reflect internal virtues), deontology (the duties and obligations of physicians toward their patients), and politic ethics (especially related to justice and duties toward the entire community). Although the practice of these physicians was not built on scientific principles comparable to contemporary medicine, the care they offered was paramount and much appreciated. In his short survey of the history of medical ethics, Albert Jonsen notices that there were many similarities among different civilizations pertinent to their perception of medicine. He notes that this may be indicative of an “inherent and universal moral atmosphere that surrounds the work of caring for the sick and pervades that work, regardless of culturally diverse moral systems.”


By the end of the nineteenth century, the development of scientific medicine facilitated the evolvement of medical ethics to a professional ethics. While medical ethics has emphasized the virtues of those practitioners, professional ethics has developed mainly to protect the monopoly of mainstream physicians. The development aimed at the exclusion of hoax practitioners to guarantee a certain level of training in scientific medicine. Thomas Percival (1740-1804) discussed in his book the main responsibilities of the profession toward society in exchange for privilege. His book was far more influential in the US compared to his home country in England. He inspired the American Medical Association (AMA) to develop its own code of ethics and to present to society the physicians guild as a professional entity with high standards of medical practice. On the other side of the Atlantic however, the discourse regarding medicine as a profession took another route. There, medical deontology developed around the duties of physicians toward themselves and science, toward their patients, and toward the entire society. Although European societies at the time were far removed from their religious roots,
their social discourse on the place and duties of medicine was more substantive compared to that in the US.

**I.B.3. Questioning Professional Ethics**

After World War II, the monopoly of medical professionals became under scrutiny for many reasons. First, the exploitation of patients by physicians was revealed after the war. In the name of developing scientific knowledge, Nazi physicians exploited many captives and sacrificed their lives without respecting their human dignity. Their scandalous research was behind the Nuremberg trials in 1946 and the incrimination of many Nazi physicians. Similarly, physicians in other nations committed similar atrocities. More scandalous though were the unethical researches conducted in the US and surfaced around the same time, such as the studies unveiled by Henry Beecher in 1966 and the uncovering of the Tuskegee Syphilis research in 1974 among other research scandals.

Second, medical and scientific developments after the war brought a great deal of excitement and fear to society. Many aspects of human life were medicalized during this period leading to a dramatic change in life and its meaning. Fascination in scientific research drew many physicians away from compassionate clinical care toward research to push the limits of medical knowledge. The development of technologies related to procreation, contraception and organ transplantation raised many concerns related to where to draw the lines when intervening in human life. Other difficult questions were pertinent to the availability of certain scarce resources and procedures such as dialysis (available since 1960), heart transplantation (first performed in 1967), and life support machines. Underneath these concerns was a mounting suspicion toward the ever-growing physicians’ control over life and death.
Third, social and cultural factors enticed serious scrutiny toward authorities in general. Internationally, a cold war was simmering after WWII with a looming nuclear extinction of humankind. Locally, the rise of the civil rights movement in the US brought to the public attention the dehumanizing influence of unchecked traditional social structures. Medical professionals were among these traditional authorities which were brought into public attention demanding for patients an active role in their medical care and health choices.

On the other hand, changes in medical knowledge and practice gave rise to a new understanding of health and the role of physicians. First, changes in medical practice highlighted the role of other team members in caring for patients, such as nurses, and the importance of other specialized caregivers to command the growing body of scientific knowledge. In the same vein, growing specialization in medicine promoted the need for inclusive dialogue among all relevant caregivers, thus weakening the monopoly of one specialty in caring for patients. Furthermore, a growing awareness of the role of public health interventions in improving the health of communities highlighted the social determinants of health other than access to medical care, such as nutrition, housing, hygiene and lifestyle choices. More deeply, broad medicalization of many aspects of life brought to the surface a public scrutiny to the role of medicine in shaping the meaning of life, suffering and death. These themes are traditionally discussed within other reflective disciplines, such as theology and philosophy; however, medicine, in its pure scientific version and on its own, was not capable of depicting a satisfying picture of the human condition.

In a few words, professional ethics was not effective in providing satisfactory self-regulation to prevent exploitation. Also, it was not able to comprehensively address the challenges related to scientific development, nuanced concerns related to technology and
meaning, and the demand for more patient involvement in their care. These challenges warranted a new approach to moral issues in healthcare under the label of bioethics.

**I.B.4. Biomedical Ethics: Mainstream Bioethics in the US**

Following the developments during the late 1960s, a new academic venture to address moral concerns in healthcare practice materialized under the label of bioethics. It is thought that the word was coined in the US in 1970 by two advocates for the new discipline, Van Rensselaer Potter and Andre Hallagers. However, an earlier German author, Fritz Jahr, had used “bioethics” in an article that dates back to 1927. Various motives were behind the study of moral issues under bioethics umbrella. For Jahr, bioethics should be an integrative discipline which emphasizes the role of human being as stewards of the entire creation. From a Christian perspective, he advocated a dignified and comprehensive consideration for the phenomenon of life itself.

Potter, on the other hand, was a scientist who studied cancer. His search at the University of Wisconsin for a cancer treatment was frustrating; he tangibly recognized the complexity of cancer and the numerous factors possibly linked to its surge. Potter therefore advocated a multidisciplinary approach to science that reunites the art and science in medicine through a biology-informed ethical discourse. The new discourse should use the evolutionary information accumulated in biology to advance a cultural evolution that strives for the betterment of humankind. To face the plights that threaten humanity, a cultural revolution is necessary for the survival of humanity. Humans should acquire a new wisdom: knowledge of how to use available knowledge. Further, a new culture shall emerge that bridges the gaps between the present and the future, between science and values, between nature and culture, and between man and nature.
Although Hallagers had a global motivation similar to that of Potter, he was part of the mainstream bioethics in the US. By mainstream bioethics, it is meant to refer to the discourse held under the auspice of the Kennedy Institute of Ethics at Georgetown University and benefited from governmental and public support (through the work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research between 1974-1978, for instance, and the promulgation of the Belmont Report in 1979). Although the principles adopted within the mainstream discourse were meant to address the ethics of medical research, their popularity brought them to the clinical settings and they became the standard ethical principles for clinical practice. Beauchamp and Childress, two of the engineers of the Belmont Report, published an elaborate discussion of these principles in many editions of their Principles of Biomedical Ethics since 1979. The popularity of these principles derive from their neutral normative tone which avoided ideological and dogmatic disputes. However, the principles flourished in an individualistic environment, thus shaping mainstream bioethics within the same parochial and individualistic mindset.

The agenda for mainstream bioethics as developed under the auspice of the Kennedy Institute reflected the cultural and political context within which its pioneers discussed rising moral issues. First, when encountering moral dilemmas because of developing medical technologies, physicians justifiably invited theologians and philosophers to reflect on best practices. However well-versed these theologians and philosophers were in moral discourse, they used their own old methods to reflect on new issues. This approach may have meant that ethics discourse and methodology are not open to development or moral imagination especially when new knowledge is available. In the work of Beauchamp and Childress, for instance, rather than
analyzing the clinical encounter itself to unveil its particularities, they sought to connect ethical
theory and clinical practice through four mid-level biomedical principles.53

Second, because of an individualistic ethos, minimalist ethics shaped the mainstream
bioethics.54 Within this bioethical discourse, participants clarify various moral concepts, analyze
and build coherent arguments, explore alternative approaches, and advise a best possible action
(Albert Jonsen, for instance, seems to accept this role for bioethics).55 Consequently, members of
society cannot engage in value-judging actions as long as these actions follow the cardinal moral
principle of respecting the liberty of others and their “free” choices. Therefore, when starting
from an individualistic ethos, it is unavoidable to arrive at an anthropology of “black-boxes” and
moral strangers. There are two meanings for moral strangeness as accepted by many bioethicists.
The first is that morality is a private issue that is only decided through a personal ‘free’ choice so
it cannot be objectively judged. The second is more fundamental in that moral convictions
cannot be communicated and are not accessible by others, to which Engelhardt subscribes.56

Third, minimally revolving around the individual, bioethical discourse in the US focused
on the short term moral issues especially those related to the physician-patient relationship. Such
focus perceives the clinical encounter as if it happens in an economic, political, cultural and
environmental vacuum; it regrettably overlooks the complexity of many factors that affect health
and decision making.57 Furthermore, many of the pioneers of bioethics were employed by
medical schools to teach the new discipline. This prevented many from questioning the ultimate
goals of medicine, its perception of death as enemy,58 and the role of healthcare institutions in
mending the rife systemic injustices related to health in the US.59 Along with failing to question
the goals of medicine, Daniel Callahan regrets that mainstream bioethics did not engage in
searching for the meaning of health and the nature and meaning of human life; the three main
issues that bioethics should have addressed. More generally, in a world that is dominated by Western medicine, the Western meaning of health, illness, and morality frames the global discussion of bioethics while overlooking their numerous meanings in different cultures.

Fourth, mainstream bioethics in the US is controlled by an oligarchy of disciplines, specifically by philosophy, medicine and law and has a limited space for theology and other social sciences. Callahan laments that mainstream bioethics has excluded theology and religion from its discourse since the mid-1970s. He believes that by excluding religion from bioethics, and the self-censoring by theologian-bioethicists, a rigorous source to understand the human condition and values is sacrificed for the sake of a less substantive discourse.

In a few words, Potter and Callahan both regretted the development of bioethics within an individualistic ethos which ignores the complexity of social relations and biological interdependence among various species. Potter was interested in a long-term survival of the human race in face of various threats. He therefore revised his suggested bioethics in a new book called *Global Bioethics* to account for the multiple dimensions needed to be included. Callahan, on the other hand, was more interested in a communitarian discourse where interlocutors may be engaged in a multi-disciplinary search for the common (substantive) good of their society. This dissertation aligns with Potter’s global ambitions for bioethics and responds to Callahan’s invitation for a more theological and inter-disciplinary involvement in bioethical discourse.


Because of his disappointment following the individualistic development of bioethics, Potter renamed the discipline he advocated as “global bioethics.” He understood global in this context as both world-wide or international, and as comprehensive and inclusive. In his work, he advocated a scientifically-inspired wisdom for the sake of human survival and for a better
future. However, the new discipline had to develop at various levels and in different contexts to achieve its global horizon. The processes of globalization highlighted the need for a new global discipline and helped garner the momentum for it to go through multiple stages. These stages demanded acquiring a broader scope beyond the individualism of mainstream bioethics. (1) The rising of new global issues related to health and its social determinants highlighted, in the next stage, (2) the importance of international cooperation to address these issues, such as organ trade and offshore research. Along with the various processes of globalization, (3) a growing cultural and philosophical discourse seriously engaged multi-culturalism, diversity and pluralism leading the third stage in developing a global bioethics. (4) The final stage witnessed the agreement on a global ethical framework which, while universal, genuinely respects the particularity of local contexts. The adoption of the UNESCO *Universal Declaration on Bioethics and Human Rights* in 2005 brought these stages into fruition as the first global bioethical framework to address emerging issues.

At the theoretical level, many versions of global bioethics have emerged to reconcile its global scope with its local application; they were thin, thick or intermediate in regard to their ethical substance. Some of these versions are thin in that they are inclusive of new topics, have a broader scope of discussion, invite more methodologies to address ethical dilemmas, or are built around a dialogical environment without enforcing a specific moral theory. On the other hand, thick versions are more substantive and evolve around suggested global values and responsibilities derived from cosmopolitanism, utilitarianism, human rights theories, or theories of building human capabilities. These versions argue for an established moral framework and claim to heuristically find answers for global issues.
However, unlike thick versions, intermediate versions recognize that finding a substantive ethical theory may not be easily attainable; therefore, intermediate versions accept that such framework is a dynamic project in the making rather than an established one.

Intermediate versions of global bioethics, nonetheless, recognize the importance of concepts advocated in thick versions, such as cosmopolitanism, human rights and the centrality of human capability building. Especially important for intermediate versions, is cosmopolitanism: a sense of belonging to a global community across traditional boundaries. However, these versions recognize the need to apply any global ethical framework to diverse cultural contexts. This raises a moral dilemma related to where a line should be drawn between acceptable and unacceptable cultural practices. A representing example of such dilemma is female genital mutilation in certain cultures; the ethical dilemma within a global framework is whether such practice should be accepted as a particular cultural element or is unacceptable due to its detrimental health consequences (or a myriad of other reasons).

By and large, since global bioethics has evolved to address growing ethical dilemmas related to globalization, it is still a project in the making. In the very beginning, the need for bioethics derived from the development of science and the growing power of medicine. On the contrary, global bioethics recognizes that contemporary moral dilemmas of health are aggravated because of neo-liberal ideology and powerful global financial entities. Thus, because of globalization, ethical problems are not only globalized, but they have a different nature than those traditionally discussed in mainstream bioethics. Underlying problems cannot be addressed without a concerted global effort within an inclusive ethical framework that appreciates cultural diversity around the world.
I.B.6. Counter Global Bioethics

Expectedly, global bioethics in its various versions garnered a great deal of criticism.\textsuperscript{68} Mainly, it is criticized by those who perceive ethical discourse solely within a market framework; thus, ethical convictions, for them, are conceived as players in a market of ideas fiercely competing for followers. The neo-liberal ideology, which is not a full ethical theory rather a collection of premises, has regretfully invaded bioethical discourse.\textsuperscript{69} Neo-liberalism made it difficult to adopt a moral imagination that is open to dialogue across moral diversity. If the market should control everything, competition becomes the only social “virtue” and there will be no place for dialogue. Engelhardt ascribes to this ideology,\textsuperscript{70} and as mentioned before, defends an anthropology of “black boxes” and “moral strangers.” It seems that his position derives from the neo-liberal ideology rather than an established moral theory, although he tries unsuccessfully to dress it up in Orthodox theological garment.

Another criticism to global bioethics is related to the fear of moral imperialism especially if the advocated global framework is shaped by a certain cultural makeup. As alluded to previously, this fear may be valid when judging certain cultural elements such as female genital mutilation. However, an intermediate version of global bioethics advocates a framework that is in flux; thus, it is unjustifiable to exclude all forms of dialogue for fear of cultural hegemony. Similarly, pioneer bio ethicists had a fear from authoritarianism and unjustifiable influence on individual choices. Although such fear may be legitimate, bio ethicists should always take into consideration all other social factors that affect the freedom of choices not only governmental authority.\textsuperscript{71}

Therefore, rather than unwarranted emphasis on competing individuals in the ethics market place, global bioethics as a project expands the horizon of bioethics through
anthropocentric dialogue. The ultimate product of the global bioethics discourse was the adoption of the UNESCO *Universal Declaration on Bioethics and Human Rights* in 2005. Although this declaration emerges from an international effort which aspires human rights and is mainly a product of political negotiation among nation states, its importance is related to a few elements. First, the Declaration opens the door for effective global dialogue and cooperation to address the root causes of inequality, exploitation and vulnerability. More importantly, the declaration builds on a different kind of principles compared to the individualistic versions of bioethics. These principles are anthropological in that they derive from the recognition that individuals are not merely consumers competing in the marketplace of ideas to prove the legitimacy of their moral convictions; rather, human persons thrive in communities where cooperation and solidarity are paramount. Such anthropological basis can perhaps overcome the philosophical impasse in bioethics by highlighting the moral common ground among all humans regardless of their value systems.

Through this brief survey of secular bioethics, it is clear that the promised rational consensus among bioethicists is not attainable; humans may still belong to conflicting secular value-systems. Therefore, it seems that other approaches toward bioethics, which espouse rationality among other human faculties, are necessary to enrich the moral discourse. Theological anthropology in this context may have a constructive contribution. Moreover, the argument of this dissertation is consistent with an intermediate version of global bioethics in that it advocates a bioethical framework that is anthropocentric (through emphasizing the respect of human dignity and vulnerability and their relationship with hospitality) rather than being purely rational-philosophical. Further, this dissertation emphasizes the need for a global framework where ethics
is not only about reflection but about activism. Because of the current global health affairs, a serious and inclusive dialogue among all communities to reverse rife injustices is necessary.

II. Ethical Normativity in Religious Bioethics

This section will discuss two different trends in religious approaches to bioethics. The trends are especially pertinent in regard to the propelling mindset behind them.

II.A. Religious Bioethics: Different Ideology, Same Mindset

II.A.1. The Role of Religious Bioethics Today

It was clear in the previous section that theologians were among the pioneers of bioethics because of their long experience in addressing ethical issues related to life, suffering and death. After remarkable contributions by many theologians, Callahan regrets, new generations of theologians were ‘seemingly’ marginalized for a while from public discourse because of the role of “secular” forces in shaping bioethics. Some of the theologian-bioethicists were forced to adapt a washed-down non-religious language to garner public support to their ideas. This made them look more like moral philosophers than theologians. Nonetheless, many other religious bioethicists, building on their particular dogmatic and spiritual heritage, tried to mend the shortcomings of secular bioethics especially in regard to the teleological ends of medical practice and research. It has been rightly argued that without religion’s input, medicine may lose its compass and social service, and perhaps some of its values.

However, the reason behind the marginalization of theologians in bioethics may be related to internal tension in theological thinking between religious identity and the pursuit of general moral consensus. In other words, while theologians were genuinely trying to preserve their religious identity when discussing emerging bioethical dilemmas, they were forced to adapt to a neutral ‘secular’ language to be able to participate in public discourse and commissioned
debates over policies and regulations. Three theological models emerged as a result: autonomous model, theological continuity model and dialectical and interactive model. Advocates of the autonomous model emphasize that theological thinking is able to provide a certain and stable moral normativity to the faithful. Theological thinking works independently from scientific developments to secure those norms. Thinkers who advance the theological continuity model believe in the similarity between religious and nonreligious views. They are willing to freely derive moral norms from scientific advancements within a natural law mentality. Many theologians, however, adopt a dialectical and interactive model to extract theological bioethics that is relevant to modern society. They contend that their theological innovation to address new bioethical dilemmas is authentic to their historical tradition rather than drastically departing from its premises. Although theologians may fall along the lines of one of these models, most of them today pursue the dialectical and interactive model.

However, because of post-modern social forces, many theologians reasserted their presence after a period of marginalization of religious talk in public debates. In the very beginning, theologians only washed-down their religious phraseology to appeal to the public and other colleagues. Most recently theologians were able to engage in public discourse with a clear expression of their religious identity, not out of an identity crisis but because of their dissatisfaction with the hegemony of absolutist individualistic principlism in bioethics. By and large, theologians who were interested in bioethics were able to engage in public discourse to influence public policy depending on how they understood their religious identity, how they conceived the new developments in science and society, and on how they collaborated with non-theologians to formulate public policy.
The post-modern generation of theologians approached bioethical dilemmas with a prophetic voice. They advocated a theological engagement that provides parameters and directions to the faithful while leaving their application to the particular context and depending on the developments of scientific knowledge and technology. This role of theology leaves a room for humans, being created co-creators, to freely and responsibly make ethical judgments. In regard to the role of theological bioethics in the public space, theologians were divided. Some theologians would have preferred to keep the purity of the faith rather than influence public medical ethics and policy. Others were active participants in governmental commissions even when they had to use a neutral language to influence public bioethical policy. \(^{81}\)

In short, theological bioethics arguably has two-fold mission in society today. First, it has to unveil specific answers and norms from its particular tradition to direct believers on how to live their faith in contemporary society. Further, theological bioethics has a social role to modulate public policy for the betterment of the faithful of its tradition and of the entire society. A specific religious tradition may prefer to adopt a communal (tribal)morality that is isolationist and separate from the general society; however, such a model was deemed by Engelhardt to be dangerous in a pluralistic society (as presented in Cahill). \(^{82}\) On the contrary, more theological bioethicists today emphasize that the community is increasingly international. Therefore, social justice and global solidarity have to play a major role in shaping religious bioethics rather than a morbid emphasis on individualistic liberty and autonomous choices.

It is arguable then that a theological bioethics befitting to contemporary globalized world needs to advocate a new mindset. Some genuine attempts to provide a thick interpretation for medical ethics fall short from this mission. Two examples will be treated briefly here to highlight their shortcomings. The goal of this exposition is not to offer a comprehensive study of the
thought of the given theologian. Rather, it is to highlight where a genuine pursuit of substantive versions of bioethics may fall short from the ideal, simply by adopting the same mindset of mainstream bioethics.

**II.A.2. Robin Gill’s Health Care and Christian Ethics**

In his book, Gill provides a Christian contribution to the public discourse on health care ethics within western pluralistic societies. He believes that a Christian ethics provides a thicker version of bioethics through complementing the four biomedical principles advocated by Beauchamp and Childress with four virtues derived from the healing narratives in the Synoptic Gospels. First, Gill analyzes the current situation of bioethics and adopts a positive stance toward its secular inclinations. While some criticize the principlist account developed by Beauchamp and Childress (the latter being a theologian) for marginalizing the Christian faith, Gill seems to justify their adoption of a secular language in their principles. Gill disapproves the prevalent polarization between secular and religious ethics, and leans toward accepting a neutral rational discourse in bioethics so it can be genuinely inclusive. Anyway, he does not think that public bioethics discourse was exclusive to religious input. He contends that many theologians continuously played a major role in shaping the decisions of various governmental commissions related to healthcare policies.

To advance his proposal, Gill identifies three gaps in secular bioethics in the West which need to be mended. These gaps are: a gap between theoretical and actual moral communities; a gap between personal resonance and a shared understanding of cosmic order; and a gap between moral demands and human propensity to selfishness. He believes that these gaps are generated because of individualistic understanding of morality, where communities cannot provide a horizon of meaning even to those who belong to them. Further, while individuals desire to
pursue moral behavior, secular rational morality may not provide them with a strong motivation to overcome their own selfishness.

To bridge these gaps, Gill contends that public theology in health care ethics has a threelfold critical role: to criticize, deepen and widen the ethical debate. When deepening and widening the ethical debate in the public arena, theologians have to be sensitive to the particularity of other beliefs and the improper adoption of explicit theological language in the debate. His contention derives from a realist paradigm of public theology that perceives only relative difference between Christian and secular thought. This is in contrast to a purist paradigm in which Jerusalem has nothing to do with Athens. Nonetheless, Gill admits that theologians alone cannot bridge these gaps in secular bioethics; they definitely need their secular colleagues to do so.

Ultimately, to offer a thicker account of bioethics he suggests complementing the four secular rational principles of beneficence, non-maleficence, respect of autonomy and justice with four virtues. He believes that Jesus’ healing stories of the Synoptic Gospels have more to do with the virtues they highlight than the miraculous action itself. These virtues are compassion, care, faith or trust, and reticence or humility. These virtues are equally valuable in other religious traditions including Judaism and Islam. Rather than conflicting with the secular principles, these virtues offer a thicker account for health care ethics that neither the principles nor the virtues will be able to offer on their own.

Although Gill genuinely attempts to offer a more substantive account of bioethics, he fails to liberate his account from the individualistic mindset that shapes the secular debate of mainstream bioethics. On the one hand, he indeed offers a deeper discourse in bioethics; he highlights the human experience of health and sickness which demands a virtuous physician to
heal the entire person rather than a narrow emphasis on autonomous decision-making. Moreover, Gill’s religious identity is not threatened by a non-religious discourse in bioethics. He is content with the religious roots of secular principles and is not unrealistically eager to emphasize those roots in explicit religious language as long as they are offered a deeper connotation through complementary personal virtues.

On the other hand, Gill is still trapped in the individualistic mindset which shapes the secular and rational principles of mainstream bioethics. In his criticism of secular bioethics, he does not venture beyond the walls of the clinic. He narrowly concentrates on the individual encounter between physicians and patients rather than on the social and global dimensions of the practice of medicine. Ironically, while he is willing to explore the community’s role in shaping the virtues of practitioners, he fails to notice the social forces that shape the entire venture of medical practice as an institution. Furthermore, Gill’s theological project seems final rather than ongoing. Theology can offer four virtues to complement the four biomedical principles; and it is all that theology can offer at this time. A spiritual activism and a dynamic, unceasing dialogue are not on his agenda.

II.A.3. Dennis Macaleer and The New Testament and Bioethics: Theology and Basic Bioethics Principles

In his dissertation, published later as a book, Macaleer interacts with secular common morality advanced by Beauchamp and Childress within the same mindset that Gill perceives it. Macaleer attempts to enhance the meaning of the three/four biomedical principles using three theological themes derived from the New Testament. He employs an invitation-response hermeneutic to extract the biblical themes of the image of God, the covenant, and the pursuit of healing starting from the twin commandment of loving God and one’s neighbor. Macaleer then
uses these themes to address three of the pressing issues in medical practice in the US: withholding or withdrawing life-sustaining treatment, access to medical care in the US, and the use of palliative care. He is established in his biblical exegesis which he considers to be one of the unique contributions he brings to the discourse. As a theologian and pastor in the Reformed Church, he justifiably attempts to clarify to his parishioners and co-believers what bioethics is about.

However, what is striking about his approach is that he is entrenched in the same individualistic mindset that brought the biomedical principles to light. He seems to favor the rational common morality behind them. Unfortunate is that his genuine search for a deeper meaning of the principles through biblical exegesis does not lead him to question the mindset behind the principles; his theological contribution enhances the meaning but does not change the mind (if necessary).

Macaleer separates himself from other ethicists through his emphasis on a more robust exegetical exploration of the New Testament for an enhanced meaning of the taken-for-granted principles. However, similar to Gill, his approach does not scrutinize the basis on which these principles have dawned, namely the rational individualistic mindset of western societies. His invitation-response hermeneutic raises valid theological themes and highlights that the invitation extended by Christ (to come back to Christ) is toward the entire community of believers and all humanity. However, he takes the individualistic mindset of mainstream bioethics for granted without critically addressing the hermeneutics behind the principles.

In short, both Gill and Macaleer do not go far enough in their theological bioethics. They seem to take the individualistic mindset prevalent in mainstream bioethics for granted without
criticizing the deeper hermeneutical apparatus behind it or providing a more holistic approach toward the human condition (especially when humans are sick in a globalized world).

II.B. Religious Bioethics: Non-Ideological Mindset

On the other side of religious bioethics discourse, theologians have approached rising dilemmas using a different mindset. Rather than ascribing to the prevailing model of bioethics, some theologians used their religious tradition and theological hermeneutics to perceive the evolving reality of medicine in a different light. This section will discuss only two of these examples because they may be representative of their perspective traditions. Allen Verhey and Lisa Sowle Cahill belong to different religious traditions but have many things in common in the way they approach bioethics. Verhey is an Evangelical Protestant theologian and Cahill is a Roman Catholic theologian.

II.B.1. Allen Verhey’s Reading the Bible in the Strange World of Medicine

In his book, Verhey explores a Christian bioethics for the Christian community to which he belongs. He contends that theologians may only express a theological voice in bioethics inasmuch as they are able to talk to their particular community and out of its particular experience, although they may not always be able to speak for it. This humble hermeneutical starting point emphasizes that theological perspectives on bioethics are always in flux; ultimately, it is a communal project that is evolving through the narrative experiences of every person as an individual within the entire community. It is a project for the church and of the church that comes with a “readiness to be formed -and reformed” by the Bible and by God. Thus, theological ethics is not final; it is open to revision depending on the shifting experiences of the community.94
At a practical level, the community of believers should aspire the Bible to voice an authentic theological contribution to bioethical discourse. Within Verhey’s protestant tradition, the bible plays a central role in shaping the identity of the individuals and the entire community.\textsuperscript{95} Surprisingly, but probably expectedly, he is critical of the individualistic protestant ethos and its role in shaping western societies at large, and the bioethical discourse more specifically. Although he is rooted in his own religious tradition, he is critical of that tradition when its heritage uncritically elaborated an anthropology that is foreign to a genuine Christian eschatology.\textsuperscript{96}

Although Verhey starts from his particular community and speaks to them, he does not exclude the entire world outside of that community. He is willing to have a talk about God with whomever is interested in this talk, because this is the only talk that he himself is able to have.\textsuperscript{97} However, such talk of God does not discount the ability to have a meaningful and critical talk with others when taking human suffering seriously. To acquire the wisdom needed to address bioethical dilemmas today, he advocates compassion, not only as a virtue (as Gill did to supplement the biomedical principles) but as cardinal to a theological critique of mainstream bioethical discourse.\textsuperscript{98}

Ultimately, he is critical of the general culture, especially in western countries. He rightly attempts to expose those cultural elements which contradict a genuine anthropology that takes the inevitable human experience of suffering very seriously. One cultural element that he successfully debunks is the prevalent meaning of respect for persons. He agrees that respecting human persons is not possible without protecting their freedom; however, moral life cannot be reduced to merely making free choices without considering the content of those choices. Moreover, reducing moral norms to respecting free choices by patients does not take the social
context within which humans are formed. Verhey rather rightly contends that a genuine respect for persons should respect their embodied and communal selves.99

More generally, Verhey is critical of the medicalized culture that gives technical scientific medicine a broad authority on issues of life and death. He rather emphasizes the role of caring and compassion toward those who are suffering. When those who suffer are treated within the “strange world of medicine,” they are alienated from their communal selves. Clearly, he suggests that the strangeness is not in morality itself, but in the world which surrounds those who suffer. Strangeness is in the world of medicine as practiced today, since it deprives the sick from their supporting community, isolates them in medical edifices, but then is not able to effectively relieve their existential suffering.100

In short, what Verhey has to offer to global bioethics is significant although he does not venture into the international meaning of global. He criticizes the popular culture and the technical culture of medicine especially because of their distorted anthropological bases. He also emphasizes the need to acquire a new mindset to address this culture and to ameliorate the associated suffering. This new mindset can be assimilated through a genuine consideration of compassion in the context of unavoidable human suffering. More deeply, he critically approaches his own religious tradition and suggests modifications when this tradition does not genuinely address human suffering today.

II.B.2. Lisa Sowle Cahill and Participatory Theological Bioethics

The hermeneutic of Lisa Sowle Cahill evolves around distributive justice and social sin. This hermeneutic shapes the way she perceives the role of theological bioethics and religious communities in a social context that is inclined toward a narrow, but still “thick”, version of bioethics.
Cahill contends that theological bioethics should be actively present in bioethical discourse using a participatory mode of engagement within the public arena. Theologians should perceive the public arena not only through the lens of their academic engagement in bioethical discourse nor through a narrow religious influence on official and governmental policy making. She contends that religious participation in public debates, generally and especially in regard to bioethics, is substantiated through a web of social network of activists who are shaping the culture itself far beyond official venues. Therefore, Cahill advocates a transformative engagement by theologians and religious communities in their public surrounding where they can agree with others on moral values and the detrimental effects of social sin. Moreover, she aspires for a time when bioethics discussions address all the social, political, and economical determinants of health as essential to the common good.

Within her Roman Catholic tradition, Cahill emphasizes that distributive justice is the underlying hermeneutic on which she perceives the role of Christian theological bioethics. While justice is prominently present in the healing stories of the New Testament, Cahill builds on the long tradition of Roman Catholic social teachings. For her, theological bioethics cannot only decry injustices through a prophetic stance in contemporary society, but should actively participate in various global networks to bring about change. Furthermore, this global engagement does not need to use explicit religious language to communicate across the differences; rather, theologians need to “translate” their work to expressions that emphasize the common good, inclusion, distributive justice and solidarity.

Therefore, Cahill believes that bioethics in the twenty first century should be a social ethics especially because of the effects of globalization on the current world affairs. This is derived from the need to join action to theoretical talk, along with a realistic recognition that
individual decision making is always contextual. In a world that is shrinking to an ever-growing complex web of relations, individual health decisions are embedded within a prominent social system and they only show as a minuscule step within that system.\textsuperscript{105}

Ultimately, Cahill’s contribution to the public discourse of bioethics is original-prophetic in proposition, activist in practice, and global in scope. Thus, in countering a “thick” version of bioethics that is founded on an ideological acceptance of liberal individualism, unlimited scientific progress, and free market economy, theologians should emphasize a similarly thick and inclusive version of bioethics.\textsuperscript{106} Theological bioethics should prophetically redefine many cultural aspects that are taken for granted and actively pursue a “preferential option for the poor [and the vulnerable]” locally and globally.\textsuperscript{107} For instance, Cahill is critical of a naïve ascription to the rhetorical language of pro-life and pro-choice movements because they both take the worth of the conceived person and the freedom of women’s choices out of the social context of health-related decisions.\textsuperscript{108} Her activism is similar to the spiritual activism that was earlier highlighted within an Orthodox Christian \textit{phronema} which embraces pluralism for the sake of human salvation. It is the premise of this dissertation that elaborating an authentic religious bioethics does not depend on the terminology or literal resources used inasmuch as it hinges on an authentic religious mindset. It will be argued in the following section that this mindset is all-inclusive without glossing over the differences among humans and value systems.

\textbf{III. An Orthodox Bioethical \textit{Phronema} in a Pluralistic World}

This section will further the ideas advocated in the previous one. It will show that an Orthodox \textit{phronema} ultimately endorses an inclusive and global approach to bioethical discourse. The discussion here will concentrate on a number of Orthodox theologians who explored what Orthodox Christianity may offer to bioethical discourse today. The list is not inclusive of every
theologian who has worked on bioethics, and even for those whose thought is explored, it is not meant to comprehensively study all their work. However, the goal is to highlight what has been done so far among Orthodox theologians so that this dissertation may extend their work to meet the demands of globalization and its ethos.

**III.A. An Orthodox Christian Phronema: Inclusive Theocentric Cosmo-Anthropology**

**III.A.1. Creator-Creation Separation**

As it has been highlighted in the previous chapter, there is no ultimate separation between the Creator and creation in Orthodox phronema. It is believed that there is no place where God is not present or constantly working to save the entire humanity. In a synergic cosmology, St Basil of Caesarea (fourth century) established a framework where the divine and the cosmic creatively interact.\(^{109}\) It is through the presence and action of the Holy Spirit that the divine providence is still seeking those who are lost.\(^{110}\) As a result of this mindset, the world reflects God inasmuch as one seeks the divine presence in the created world. Many theologians, therefore, emphasize that a scientific exploration of the world complements theological revelation since both seek the divine truth which was revealed in the person of Christ.\(^{111}\) For many church fathers, ancient and modern, Christ is dormant in the night of world religions waiting to be sought and unveiled; he is the logos of every created thing and he is who bestows meaning onto the created reality.\(^{112}\)

Ultimately, Christ’s incarnation for the sake of the world has revealed him as a person rather than a dogmatic set of tenets. The personal experience of Christ was preserved in the Christian Church (especially in the Orthodox Church for Orthodox theologians) but cannot be limited to the boundaries of the Christian community.\(^{113}\) Even at the time of Christ’s earthly mission, he revealed himself to those who did not belong to the people of God, such as the wise
men from the East in the Nativity account (Matthew 2:1-12), Cornelius the Centurion (Acts 10), the Samaritan woman at the well of Jacob (John 4:1-42) and the Samaritan leper who was healed along with nine others (Luke 11:19).

III.A.2. The Goal of Orthodox Christian Bioethics

The work of Orthodox theologians on bioethics generally addresses the faithful and attempts to answer their concerns within the above-mentioned theocentric cosmology. Applauded as it may be, the work of these theologians does not search for a common bioethical ground with other religions and value systems. Rather, they attempt to shape an Orthodox Christian bioethics that is authentic to the church’s tradition. Many Orthodox bioethicists start from an elaborate Orthodox theology. Engelhardt, to the contrary, is a philosopher in the first place, and his premises and methodology will be critiqued in what follows as departing from an authentic Orthodox phronema.

Orthodox theologians agree on the centrality of the liturgy in shaping Orthodox bioethics.\textsuperscript{114} Not only a liturgical ecclesiology defines the identity of the Orthodox Church; it also opens the door of Orthodox bioethics toward the universal divine providence to save the world and all of humanity. The goal of the entire venture is therefore \textit{theosis} (deification) of humanity similar to the goal of Orthodox theology itself. From the liturgy, John Bekos derives two principles he believes to be essential to Orthodox bioethics.\textsuperscript{115} These principles are not conceived within the prevailing sense of bioethics principlism; instead, they are terms that highlight the role of humanity in the divine salvific economy. He contends that memory and justice play a central role in achieving that goal. Through memory, the faithful are not narrowly invited to remember Christ performing many wonders; rather they are invited to remember His suffering and vulnerability exposed on the cross. He contends that remembering Christ’s
suffering is more important than remembering his wonders, especially that wonders do not heal human vulnerability. For Bekos, it is humanity’s thankfulness to God that heals its innate vulnerability. Justice similarly is related to the divine providence. It is not centered on the power of God; rather it humbly highlights the gravity of the divine sacrifice which is asymmetrical to whatever humanity can offer in return. In other words, divine justice is not about divine power and legalistic rights. Instead, justice emphasizes the incomparable divine sacrifice for the sake of human salvation.

Bishop Nikolaos Hatzinikolaou derives from the liturgical tradition of the Orthodox Church five characteristics that should shape a “spiritual bioethics” for modern times.\(^{116}\)

1. Orthodox Bioethics should protect the sacredness of all human persons.
2. It should discern the will of God through humble recognition of human weakness and the divine desire to save all humans. (3) It should highlight the value of life and foster a respect for death. Despite its enmity, death is the only certain companion to human life. Respecting human mortality underscores that the worth of human life does not derive from a wealth of rights that a person enjoys; rather, humans are worthy of respect inasmuch as society is willing to embrace them when they are most vulnerable. More importantly, (4) Orthodox bioethics should avoid being scholastic in searching for perfect and adequate answers for bioethical dilemmas. It should approach the mystery of human life with humility leaving final decisions to the freedom of those who are involved. Therefore, (5) Orthodox bioethics is not conservative, yet it is cautious. It does not fear errors and is willing to confess mistakes with humility. It is similar to an Orthodox anthropology that revolves around a personal experience of God despite human sins, yet within a repentant (metanoic) way of life.
All these characteristics highlight that an Orthodox bioethics, according to Hatzinikolaou, is a project which does not offer final answers to all bioethical dilemmas. Instead, Orthodox bioethics, within the entire mission of the church, is to nurture a conscience (a mindset) that leaves a space for human freedom and fosters a discourse that reveals the personal and divine truth of Christ. Thus, for Hatzinikolaou, the dogmatic heritage of the Orthodox Church is not enough to reveal normative ethical principles that are legally binding. Bioethics is rather embedded in an ascetic and liberating spirituality that is sensitive to those who are vulnerable and marginalized in any given circumstances.

In a similar vein, Fr John Breck contends that an Orthodox bioethics should be theonomous rather than autonomous. For him, God’s authority is central to shaping a phronema within which no boundaries persist in the constant interaction between God, human persons and the natural world. Under the divine authority, all the created world is the field of God and is invited to the divine kingdom. Orthodox bioethics, for Breck, has one mission, that is to “commend ourselves and each other and all our lives unto Christ our God” (a frequent petition in Orthodox liturgical prayers). He alludes to the responsibility of any Christian community to bring back to God what belongs to him.

Unfortunately, Breck, somehow similar to Macaleer, accepts the four biomedical principles and the principle of double effect as useful to guide practical decisions in healthcare. He grounds them in the authority of God and the sacredness of human life in its pursuit of true communion with God and others. However, while he recognizes that they are foreign to an Orthodox ethos, he searches for a deeper meaning through theological exploration. Yet, he does not critique the narrow scope of topics explored in mainstream bioethics. Other theologians have done the same. When Harakas wrote his entry in the Encyclopedia of Bioethics on Orthodox
bioethics, he explores only the topics discussed in mainstream bioethics and highlights what is special about an Orthodox perspective. Understandably when Harakas wrote that entry in 1995 (reprinted in the 2004 edition), global bioethics as advocated in this dissertation was still in its nascence.\textsuperscript{119}

Notwithstanding the nuanced differences among these theologians in regard to the mission of Orthodox bioethics today, they all criticize the ethos behind mainstream bioethics.\textsuperscript{120} They contend that God is not the point of reference to mainstream bioethics; there is a great deal of emphasis on individual autonomy as if the individual is eternal or her health is of ultimate value. They all point to the distortion in the common perception of scientific medicine. On the one hand, contemporary medicine operates within a consumerist mentality; it claims to aim at improving the health of everyone but actually very few can afford its expensive technology and patented medications. On the other hand, there is a great deal of financial interest in modern medicine what Hatzinikolaou perceives as the “financial captivity and corporate totalitarianism” of human scientific venture.\textsuperscript{121}

Applauded as it may be, the work of these pioneer Orthodox bioethicists does not go as far as the mission of the church should go. None of these bioethicists discusses the global dimension of bioethics, whether international or comprehensive; rather they concentrate more on the mainstream questions in bioethics discourse and how Orthodox bioethics should address them. While they explain to their target audience, the faithful Orthodox, what is special about Orthodox bioethics, they, understandably, refrain from searching for a global common ground in bioethics. In other words, their main interest is to elaborate on what is unique to Orthodox bioethics rather than on where it meets with other bioethics (save for Breck who uses the secular principles within a different mindset). Their perspectives, nonetheless, do not exclude the
possibility of finding this common ground. They all embed their bioethics within the liturgical identity of the Orthodox Church which is necessarily “catholic” or universal in its seeking to save the entire world.¹²²

III.A.3. Engelhardt’s Version of Orthodox Christian Bioethics

To the contrary of this unexplored global mission, Engelhardt’s version of Christian bioethics, intentionally excludes the possibility of finding any “rational” common ground between different religions and value systems. Engelhardt “[In] sometimes whimsical way (though quite seriously) ... made his case for Orthodox Christianity as an alternative response to the chaos of an essentially irrational world.”¹²³ He builds his bioethics on dubious and un-Orthodox cosmological and anthropological foundations. Not least among these foundations is Engelhardt’s ascription to a narrow rational discourse, even when he argues from a particular religious perspective; that is necessarily reductionistic when it comes to issues of life and death and human flourishing.

Before converting to Orthodoxy, Engelhardt ascribed to the Enlightenment project pursuing a rational common ground for ethics among all human beings. He defended rational foundations for bioethics to which every reasonable human being may ascribe.¹²⁴ However, by the dawn of post-modernity and consequent uncertainties, Engelhardt revised his foundations and dropped the Enlightenment project in defense of numerous versions of particular bioethics. He moved to explore the Christian foundations of bioethics through the lens of a traditional (Orthodox) Christian bioethics. He consults a wealth of Church Fathers’ writings and a long-standing liturgical heritage of the Orthodox Church. Although he shares many of the details of his Orthodox bioethics with the above theologians, he constructs a fundamentalist-conservative version,¹²⁵ which is unjustifiably dressed in Orthodox garments and which seriously contradicts,
at least, Orthodox cosmology and anthropology. He heavily quotes Church Fathers of the first millennium and recent ones without comprehensively engaging their mindset and premises. Comparatively, he scarcely engages contemporary theologians as if they do not exist (anecdotal search for the names of some influential theologians reveals this trend. Even when he does engage them, he includes them in his footnotes only, in his *Foundation of Christian Bioethics* for instance).

In a book that should critically discuss the thought of Engelhardt, his theological premises are taken for granted. Fr Stanley Harakas, a proliferative Orthodox ethicist, regrets that this treatise does not invite Orthodox Christian ethicists, nor Jewish Orthodox ethicists (whose tradition Engelhardt consults frequently in his articles). Harakas, rather sarcastically, describes Engelhardt’s version of the Orthodox faith and commitments as being “whimsical (though serious) Texan traditional(ist) Orthodox Christian commitments.” On a general note, Harakas emphasizes in his review, as he does in many of his articles and books, the importance of an ecumenical dialogical spirit in the face of Engelhardt’s “sharp sectarianism.”

Along with Engelhardt’s cosmological and anthropological premises, there are many other reservations on the theological components of his Orthodox bioethics, to which there is not enough space here to discuss in detail. However, to elaborate a critique on his cosmological and anthropological elements, a reference to one of his recent articles will be made, unless otherwise mentioned.

### III.A.4. Abysmal Separation between God and Creation

In his version of Orthodox bioethics, Engelhardt accepts a drastic difference between the divine (uncreated) and the world (created). Although this difference is recognizable in Orthodox theology, the gap between the created and uncreated has finally been bridged in the person of
Christ. Engelhardt maintains, for instance, that “the truth is a Who” and that “this truth is hidden by immanence.”128 This sounds contrary to what has been maintained in Orthodoxy that there is no place to which God does not have access, no place where God is not already present, and no place where God is not actively pursuing the fallen world to save and bring back to His kingdom. A separation between the secular and the sacred is artificial in Orthodox phronema.129 Moreover, while God may have revealed the divine providence through the person of Jesus Christ fully to the Orthodox Church, the Holy Spirit continues to work in the world despite the world’s fallenness.130 It was nicely put in the words of Paul Evdokimov: "Secular humanism denies God, exaggerated asceticism denies the world, pietism overstresses the transcendence of God, but Orthodox ethic balances the earthly and the heavenly."131

Furthermore, Engelhardt is decidedly against any ecumenical encounter depending on marginal Orthodox authors who, despite their sainthood, do not represent the mind of the entire Church. He intentionally uses authors, such as Justin Popovich,132 while ignoring the scores of authors who participated in the ecumenical movement, were nourished within its spirit, and as a result enlivened an Orthodox renaissance around the world (as discussed at the beginning of this chapter and the previous one).133

In the same vein, Engelhardt advocates a procedural approach to bioethics in a pluralistic world. Since rational consensus on moral values is not possible because of his anthropological premises (more to come in the next section), the only way to live in a pluralistic society is to respect value differences as long as differences do not affect the wellbeing of others.134 Such an ideological captivity to liberal individualism, prevents Engelhardt from being open to a social discourse about common good and common values.135 Ironically, while ascribing to liberal individualism, he criticizes modern western (post-Christian) states for being fundamentally
secularist and laicist; both of these attributes result from the same liberal individualistic ideology that he adopts. His opinion divulges two troubling premises.

First, he defends liberal individualism as long as it advantages his particular community (in this case Christian community). However, he claims that a secular state becomes fundamentalist when it systematically tunes down its Christian components. In other words, when a secular state equally treats all groups in a pluralistic society, it is not clear why it becomes fundamentalist, according to Engelhardt, although governance in this case is built on the same liberal individualistic ideology to which he ascribes. Second, when he derogatively describes modern states as laicist, he alludes to (and sometimes clearly expresses) his nostalgia toward a Byzantine model of state-church symphony. This model has been discussed in detail earlier on, and its detrimental consequences on the Orthodox Church are still felt to this day. Similarly, through using “laicist,” he is probably attracted to an outdated (and dangerous) clericalist theocracy. It is not clear how Engelhardt’s theocracy is less fundamentalist than a secular state in contemporary globalized and pluralistic human society. Establishing a purely Christian west after Christendom (with the expansion of “the Empire of Holy Texas”) is as fundamentalist as the secular ideology which excludes the role of religion in shaping the human person.

In his ideological ascription to a Byzantine (theocratic) political system, Engelhardt departs from the above-mentioned theologians in regard to a theocentric bioethics. A theocentric bioethics aims at continuing the divine providence to save the entire world; a theocratic bioethics is interested in political power and enforcing Christian values on pluralistic societies. John Meyendorff contends that the authority of Christ cannot be identified with the political power of
the state and the universality of the Gospel cannot be defined in political terms. The difference between theocentric and theocratic bioethics is drastic.

**III.A.5. Distorted Anthropology**

Several times so far, it was alluded to Engelhardt’s distorted anthropology. The three components of his anthropology can be summarized under the following tenets: “black-box” anthropology, moral strangeness, and culture wars. These three components are co-centered around the individual person and her connection, in matters of morality, to herself, to her surrounding community, and the entire world (and in how any particular community interacts with other communities at large). Engelhardt’s model parallels and contradicts the inclusive church typology within which Harakas perceives the mission of the Orthodox Church in the world (the individual, the liturgical-communal, and the social-universal).

Engelhardt believes that only the individual person, as a “black-box”, is responsible for her own morality and moral choices, the reasons of which are not communicable with the outside world. Moreover, he believes that people are moral strangers across their communities. If a person who belongs to a certain religious community wants to communicate her moral convictions to other people who do not belong to that community, she will not be able to do so. The reason, Engelhardt contends, is that different communities have different meanings to the same morality-related words that these meanings are not bridgeable or explicable. Because of their different worldviews, different moral communities cannot speak the same moral language. However, there is an empirical evidence that religious communities in the US may not be monolithic in regard to many morally-relevant social and economic issues as Engelhardt will wish. Similarly, even among Orthodox Christians there is no unison in regard to bioethical issues such as organ transplantation, and feeding the terminally ill.
Along with ignoring the actual anthropological problem which is alienation from God and the other, it is not clear, theologically speaking, why the strangeness should be only perceived in terms of morality. He uses expressions such as “[r]eason without grace, …, cannot restore the moral unity shattered by sin”; “… united in Christ… can one unite the fragmented elements of morality”; and “[o]nly in a relationship through worship… can fragmented moral practices be made whole” (emphasis added).\textsuperscript{145} However, it has been explained in the previous chapter that, since the fall, human beings became strangers to each other and to God, and they needed reconciliation to bridge that alienation. Hence, it is not theologically justifiable to concentrate on moral strangeness out of the entire human condition, nor warranted to perceive unity only in terms of “moral unity.” Moreover, Engelhardt does not justify the ability to communicate morality within any given community despite human “black-box-ness.” It is not clear how individuals can be morally shaped within their communities if moral reasoning is not communicable. Nor it is clear why individuals can communicate within their moral communities but are not able to do the same outside of it (regardless of the claimed dissociation in meaning of their different moral languages).

An extension of Engelhardt’s abysmal separation between creator and creation is his unbridgeable separation between the religious and secular. Such separation is deemed among many Orthodox theologians to be the first seed of nihilism in modern society.\textsuperscript{146} Moreover, Engelhardt’s attack on any secular mindset suggests that secularism is monolithic or has one established and achievable agenda. However, it is clear that rational-philosophical discourse, in regard to morality at least, has produced so many secular (or more accurately non-religious) varieties that are contradictory in some respects. He claims that secular discourse has “thin” morality and that anything that is done within a secular mindset is meaningless. However, Cahill
has previously highlighted that contemporary secular discourse is as “thick” as its religious counterparts because it builds on a specific anthropology and cosmology especially when it decidedly excludes the importance of religion to human identity. Therefore, secularism that is respectful to religious identities is not as detrimental as Engelhardt would argue.147

This leads to question what makes a discourse in public arena a religious discourse or a secular one. It seems that Engelhardt wants a public discourse that clearly mentions God or emphasizes in explicit words the Judeo-Christian heritage of American society. However, many historical examples (some mentioned in the previous chapter) show that heresies explicitly spoke in the name of Christ, however they distorted his image and their experience of him. The Church at that time emphasized in dogmatic formulae what was her genuine experience of the true Christ. In other words, it is not the phraseology (the use of words like “God,” “Christ,” or “Christian”) that makes a discourse genuinely religious rather than secular; it is the mindset, the phronema.148

More importantly, in a pluralistic and post-Christian world, Orthodox theologians should face non-religious discourse with humble repentance. Olivier Clément advocates a creative secularism and inclusive anthropology that embraces the entire human experience of life to minister to those who thirst for meaning in today’s society.149 Similarly, he admits the mistakes that were committed by religious communities, especially Christians, which probably led to the death of God in contemporary culture. Prevailing atheism and secularism should elicit self-criticism and repentance rather than acrimonious polemical rhetoric.150

At a larger scale, Engelhardt uncritically adopts the politically-charged rhetoric of “culture wars” advanced by James D. Hunter.151 However, there is enough sociological evidence to doubt the premises of Hunter’s worldview and perceived lack of consensus among the general
Further, “[B]y arming ourselves for [a cultural] war we make war more likely.”

Hence, the roots of culture wars can be found in liberal individualism and neo-liberal ideology rather than in the prevailing differences in moral perspectives.

Although “culture wars” has not attracted enough comments from Orthodox theologians, its offspring by Samuel Huntington of the “Clash of Civilization” did, perhaps because of the embedded attack on Orthodoxy-related civilizational heritage. By dividing different peoples according to their religious-civilizational heritage, Huntington does not leave a place for diversity within any given culture, civilization, or religion and he crafts blanket judgements using many inaccurate readings of history. So does Engelhardt. Engelhardt does not explore the long-standing experience of the Orthodox Church in the face of cultural diversity, and does not evaluate the consequences of a culture-wars mentality in the light of the universal (catholic) mission of the Church. An inflamed culture-wars rhetoric diametrically contrasts with an eschatological reality that is pre-tasted in the Orthodox Church; in Christ, and because of Him, there is no difference between Jew and Greek, slave and free, male and female (Romans 10:12; 1Corinthians 12:13; Galatians 3:28; Colossians 3:11).

III.B. An Orthodox Phronema for Modern Dilemmas

III.B.1. An Iconic Phronema

In bringing the threads of this chapter together, it is arguable that an Orthodox Christian bioethics aspires an iconic phronema. This phronema, as will shortly be explained, not only shapes the community’s perceptions toward innovative medical technologies but also clarifies a roadmap for the believers to follow when encountering ethical dilemmas. This iconic phronema should also shape the engagement of the Orthodox Christian community in the global bioethical discourse and help direct believers in ways to advocate for the most disadvantaged within the
human community worldwide. The advocated *phronema* aspires the special status of the icon in Orthodox theology and in the liturgical (and supposedly daily) lives of the believers. Icons are not a piece of art that depict certain religious realities. They rather stand as windows between two different worlds extending an invitation from the one to the other. Icons open the created reality of this world toward the eschatological reality that is depicted on them. This window opens that eschatological reality to the beholder not as a space to be objectively explored (which is still a possibility) but as an inviting reality which targets the mindful beholder. Orthodox icons do not follow the logical reality in that their geometrical depiction centers on the infinite distant; they rather inversely center on the beholder in an inviting gesture to become involved in the divine reality as depicted on the icon. To explore this *phronema* in regard to bioethics, the following dimensions of the icon are most relevant: eschatological, realist, and hospitable.

**III.B.2. The Eschatological Dimension of Icons**

It is because of the incarnation of Jesus Christ, the second person of the Holy Trinity, that the Orthodox Church draws icons as an integral part of her liturgical practice. Icons therefore depict the divine reality that is beyond the human ability to comprehend, especially as a means for those who are illiterate and cannot read the gospel (some call drawing icons an act of writing icons to unveil the good news). However, since icons do not only depict the person of Jesus Christ who was incarnate but also the saints, they highlight the divine destiny of every believer. Icons emphasize that the created reality where humans live is not the only reality; rather, every human is invited to transfigure (trans-form as Christ did on Mount Tabor celebrated on the Transfiguration feast, August 6th).

Therefore, an Orthodox bioethics which aspires an iconic *phronema* is first incarnational in that it perceives ethical dilemmas to be happening with human beings as a whole rather than
as intellectual (rational-dogmatic) minds. Humans who struggle with health and medicine have human faces which demand respecting their dignity with love and compassion; they are not merely autonomous selves who mandate respecting their choices.

Moreover, an Orthodox bioethics is hopeful because icons depict an eschatological reality beyond human comprehension. It gives witness to that which was once written: “Eye has not seen, nor ear heard, nor have entered into the heart of man the things which God has prepared for those who love Him” (1 Corinthians 2:9). Thus, an authentic Orthodox bioethics recognizes that the ultimate goal of humanity is beyond this created world, it is theosis, the deification of humankind, the becoming of humans God-like as Christ himself became human-like in his incarnation. Ultimately, this human goal is what gives meaning to the human experience rather than any imminent and ephemeral set of beliefs or conceptions.

Moreover, the eschatological reality of the icons penetrates and permeates the created world to transfigure it, to change the reality of the beholder. Therefore, it becomes the responsibility of the mind-(nous)-ful beholder (the one whose noetic eye is illumined to behold the invitation depicted on the icon) to bring this eschatological reality into the life of the created world and for the life of the world (John 6:51). This is exactly what is practiced in the liturgy in which the faithful pre-taste the eschatological reality and forcefully bring this reality into their daily lives in the “liturgy after the liturgy.” It is the responsibility of the Church as the body of Christ “to create unity where there is division, to bring forth reconciliation where there is alienation, to heal and restore a sick and deprived human nature, and to free persons from the spiritual and physical violence of evil.”

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III.B.3. The Realist Dimension of Icons

On the other side of the icon stands the beholder and the entire created world. To extend a meaningful invitation to the created world, the theology behind icons recognizes the reality of the world icons invite. On the one hand, icons extend their invitation to the entire world. When Christ himself was incarnated, he did not only take on the human flesh; rather he took the entire created material as his body which brings salvation to the whole world not only the humankind. On the other hand, iconographers use the materials of this world to depict the ineffable divine reality. Thus, icons are made of the corrupt materials of the world to transfigure the world. Some Orthodox theologians have gone even further to contend that the created world (despite its corruption) is an icon for the divine reality; however, it is the responsibility of the faithful beholder to unveil the iconic dimensions of the world. In the same vein, every human being is an icon because he is created in the image of God. It is the liturgical practice of the Orthodox Church to cense those who are attending any liturgical service (whether they were Orthodox or not) similar to censing the icons mounted inside the church building.

Therefore, using an iconic *phronema* in bioethical discourse would necessarily expand the mission of bioethics beyond its current narrow agenda. Bioethics was meant to connect the biological sciences (bio-) to the moral heritage of the humankind (ethics). The ultimate way of bridging these two dimensions is the icon, because only the icon unfolds the ultimate meaning of creation while deeply understanding the current status of the created world. In perceiving the current world through the lens of icons, the Orthodox Church cannot ignore the prevailing iniquities. It is clear that the world is plagued by corruption and death. Suffering and injustice is everywhere. Pluralistic perspectives are the norm, while interdependence among various groups is unavoidable. Strangeness in the world is the result of human fallenness rather than pure
rationalistic disagreement. In a globalized world, human vulnerability is frequently exploited and environmental degradation is threatening the survival of the human race. An iconic *phronema* takes on the responsibility to extend a divine invitation to save the entire created reality. Similarly, an authentic Orthodox bioethics cannot overlook the plight of the human race and the environment and dwell upon the narrow agenda of mainstream bioethics. An iconic *phronema* has to be hospitable.

**III.B.4. The Hospitable Dimension of Icons**

As a window open to the uncreated divine reality, icons are hospitable through a constant openness toward and invitation to the entire world through the conversion of a microcosmic beholder. A converted beholder is a beholder open to changing her mindset through repentance to acquire a new *phronema*-mindset toward the world.

Because of the liturgical place of the icon in Orthodox worship, icons are invitations extended to a community of believers rather than isolated individuals. Further, since icons aspire the community’s experience of the incarnate Lord, iconic *phronema* is dynamic in that it is open to the community’s lively experience of the Lord. As a result, an iconic *phronema* does not seek a dogmatic certainty in formulated tenets; it breaks away from rigid conservative demands and seeks to have a meaningful and dynamic experience of the Lord. An iconic *phronema* is therefore not a dogmatically correct endeavor but a constantly repentant human experience of the *eschata*. Hence, an authentic Orthodox bioethics is not a search for dogmatic certainty in regard to bioethical dilemmas; rather it is a constantly repentant project which invites the created reality to participate in the divine world.

At a practical level, starting from an iconic *phronema*, Orthodox bioethics can only work on one variant, namely the one who is converted in front of the icon. Orthodox bioethics can
only shape the *phronema*, the perspective, and the actions of the faithful person to espouse an iconic agenda, namely saving the entire world. It is only through the converted and mindful beholder of icons that the invitation toward the entire world can be extended. As a microcosm, only the human person can bridge the gap between the created world and the Creator.\textsuperscript{166} Therefore, only through a deep understanding of the human experience, i.e. anthropology, that bioethics can address the dilemmas faced by humanity to overcome the current reductionistic rational impasse.

Starting from a theocentric anthropology, Orthodox bioethics is *theonomic* in that the invitation to save the world is freely extended by God. The invitation is not meant to be theocratic by enforcing certain morality on all humanity; it leaves a space for human freedom as created co-creators. Moreover, the iconic invitation to save the world extends the responsibility of the faithful beholders to reveal the eschatological reality to those who do not know it. Such revelation is not judgmental but occurs through genuine Christ-like love and mercy. In the same vein, a genuine iconic *phronema* is aware of the deepest needs of the human being so it bears the responsibility to unfold the common anthropological ground to address ethical dilemmas.

Gregory of Nyssa (fourth century), for instance, emphasizes the anthropological commonalities between slave-owners and their slaves; an idea that can be extended to contemporary time when differences among humans do not overshadow their commonalities. Gregory contends: “... you who are lord and the one subjected to lordship are to an equal extent dominated by the passions of soul and body: pain and good cheer, joy and sadness, grief and pleasure, anger and fear, sickness and death. Is there any difference in these matters between the slave and the lord?”\textsuperscript{167}

As a result, an authentic Orthodox bioethics should be at the forefront of global bioethical discourse to highlight the common anthropological ground among various experiences of life and
An Orthodox bioethics should also be activist in that it aspires the hospitable iconic *phronema* to tend to the needs of the most vulnerable human beings. It is missiologically prophetic in that it searches to bring the good news to the entire world through redefining the misunderstood concepts of bioethical discourse. On the one hand this mission is propelled by a vulnerable love that is open to dialogue with the different other. On the other hand, it is the responsibility of the royal priests of the community to show the face of Christ in the midst of the politicized bioethical discourse. So rather than perceiving freedom as the freedom of the market, an Orthodox bioethics emphasizes the ascetic freedom of those who perceive the world as an icon. Similarly, rather than perceiving bioethics as a legalistically binding enterprise, an authentic Orthodox bioethics brings the experience of Christ to the world through mercy and compassion. Further, Orthodox theology avoids extreme positions because they imbed distorted premises, such as condemning the idolization of biological life or individual autonomy in the clinical setting. Both cases negate the divine providence to save all humans and eliminates the Orthodox genuine hope in resurrection at deathbed.

**IV. Conclusion**

In short, it is the responsibility of the Orthodox Church to take the above-developed Christ functions, as the king, the prophet and the priest to develop a working plan to effectively engage in the global bioethical discourse. It is argued in this dissertation that Orthodox theology offers a mid-level set of principles that are supported in various value-systems and religions. These interconnected principles derive from the three functions of Christ and are organically connected that any one of them cannot stand alone. Moreover, these principles do not offer final answers to all bioethical dilemmas at a global level; rather they emphasize that a global bioethical discourse is a dynamic project that should highlight, in every debate, the fundamental relationship between
respecting human dignity and vulnerability as they connect to hospitality (philoxenia- the love of the stranger).

3 Henk ten Have, Global Bioethics: An Introduction (London: Routledge, 2016), 123.


41 Rothman, *Strangers at the Bedside*, 190-221, 222-246.


81 Cahill, “Religion and Theology,” 73–90.
82 Cahill, “Religion and Theology,” 76.
96 Verhey, *Reading the Bible*, 68-98.
98 Verhey, *Reading the Bible*, 99-144.
101 An example of activism that was inspired by Cahill’s participatory theological discourse is discussed in: David M. Craig, “Everyone at the Table: Religious Activism and Health Care Reform in Massachusetts,” *Journal of Religious Ethics* 40 (2012): 335–58.
102 Cahill, *Theological Bioethics*, 13-42.
104 Cahill, *Theological Bioethics*, 1-12.
105 Cahill, *Theological Bioethics*, 1-12.
107 Cahill, *Theological Bioethics*, 43-69
122 Breck, Sacred Gift of Life, 11-14, 258.
126 Harakas, “REVIEW of At the Roots of Christian Bioethics,” 376–79; Similar criticism of Engelhardt’s Orthodox bioethics is established in Harakas, “Reflections on Authority in Ethics,” 355–73.
134 Engelhardt, Foundations of Bioethics.
135 Potter, Global Bioethics, 119-121.
139 Engelhardt, Foundations of Christian Bioethics, 393.


166 Harakas, “The Integrity of Creation and Ethics,” 27–42.


168 Hamalis, “Eastern Orthodox Ethics,” 1525-1535.


CHAPTER FOUR: THE MEANING OF HUMAN DIGNITY: A SYSTEMATIC INTERPRETATION

In this chapter, the discussion will concentrate on the first concept advocated for Orthodox Christian bioethics and as a basis for a common ground in global bioethics, namely human dignity. The foundations for human dignity in Orthodox theology and in secular bioethical discourse will be demonstrated. The goal is to promote a content-full and globally-sensitive bioethics that nourishes gratitude in healthcare. Ultimately, gratitude should play a major role in shaping both clinical encounter and medicine as an enterprise.

I. The Theology of Human Dignity in Orthodox Bioethics

This section will briefly reiterate the theological principles reached in the second chapter to defend an Orthodox Christian understanding of human dignity. This should unfold certain principles to constructively engage in a global bioethical discourse.

I.A. A Christocentric Hermeneutics for Human Dignity

This section reiterates the main theological themes to emphasize a prominent place for respecting human dignity in Orthodox Christian theology. The creation of humans in the image and according to the likeness of God is the basis of respecting human dignity. As the prototype for all humanity (an idea that is shared by various Christian denominations), Christ executes a threefold vocation which should shape the mission of humanity, especially an Orthodox bioethics in a globalized world. Respecting human dignity should center on the embodied and
communal experience of sickness and suffering rather than on a misplaced emphasis on autonomous decision making.

### I.A.1. Christ the King

Christ’s kinghood is derived from his being consubstantially united with God the Father and his involvement in the creation of the entire universe before all ages. Adam and Eve were both created in the image of Christ (Genesis) who will later incarnate of the Virgin Mary taking the entire human nature, without the sin, to save humanity. Christ re-establishes the possibility of communion with God that was lost because of the ancestral disobedience. Through his salvific providence, including crucifixion and resurrection, Christ emphasizes the original dignity with which God has created humanity.

### I.A.2. The Creation Narrative

In Chapter two, three lessons were learned from the Orthodox reading of the creation narrative in Genesis 1-3. First, the narrative emphasizes the special place of humanity in God’s economy. Although Adam was made out of the dust of the ground (*adama*), God formed Adam (by an active action, rather than by a simple order) and “breathed into his nostrils the breath of life” (Genesis 2:7) giving him dominion over all other creatures. Adam was intended to be a steward of God’s land, rather than to selfishly exploit it. Further, whereas only kings were divine in ancient religions, divine royalty was bestowed upon all humans in the Old Testament by the virtue of being created in the divine image.

Second, because of the common origin of the entire humanity in the anonymous man, Adam, human unity in his person precedes human diversity. Even the taking of Eve out of the side of Adam demonstrates the inseparable origin of both genders and their equal dignity in the divine perception. Certainly, a Triune God aspires a Trinitarian communion among human
beings who are created in the divine image; it is ultimately the entire humanity that bears the image of God rather than an isolated individual. Hence, to achieve the sought God-likeness, humans need to engage in authentic communal relationships to conform their identities according to that ideal. Third, because of the ancestral disobedience, human communion with God was severed leading to alienation from God and from each other. This alienation epitomizes the root of the current human condition of estrangement and enmity.

I.A.3. In the Divine Image and According to the Divine Likeness

It was noted earlier that the divine image is, innately and inalienably, ingrained in human beings and manifests at several dimensions. Contrary to the narrow modernist emphasis on rational human faculties, Church fathers discuss many attributes that are analogically similar to divine attributes. However, clearly in their writings, none of these attributes exhaustively recapitulate the divine image in all human beings. These qualities include freedom and responsibility, spiritual perception and communion with other humans and God, virtues and royal dignity, along with cultural creativity in the arts and sciences. Whereas modernity emphasizes rationality and freedom of choice as the highest human characteristics worth of respect, church fathers and contemporary Orthodox theologians warn against their misuse. For instance, by trying to become gods without God, Adam and Eve misused their freedom and chose to disobey the divine command (Genesis 3:5). Likewise, contemporary misunderstanding of freedom to mean “market freedom” departs from the ascetical dimension of freedom which hinges on liberation from selfishness, greed and consumerism. Indeed, without a full understanding of the universal divine providence and the human condition, many of the divine-like attributes are open to abuse to the detriment of the entire human race.
Ultimately, many church fathers contend that the \textit{nous} - the spiritual perception (according to the Holy Spirit) or the higher appreciation of the \textit{logoi} of the created world- is the “focal point of the divine image.” Without such noetic perception, one cannot appreciate the divine realities depicted on icons, neither can she perceive the imprinted divine image in every other human being. Therefore, those whose noetic perception is illumined bear a grave responsibility; they must perceive in others the inalienable image of God regardless of how alienated from God those others may seem. They likewise ought to perceive God as the one who continues to be present in the created world, rather than the one who condemns the world for being estranged from God.

Only through an illumined perception that one can see the human condition as a common ground to respect the dignity of other humans. St Gregory of Nyssa (fourth century) demonstrates, in forceful words, the equality of lords and slaves by saying: “… you who are lord and the one subjected to lordship are to an equal extent dominated by the passions of soul and body: pain and good cheer, joy and sadness, grief and pleasure, anger and fear, sickness and death. Is there any difference in these matters between the slave and the lord?” This equality expands beyond lords and slaves to apply to all human beings regardless of their differences and religious backgrounds. Religious communities, therefore, bear the responsibility of nourishing a spiritual ethos that instills a respect for human dignity through genuine personal rapport with those who are different.

Notwithstanding the fallen human condition, a potential to achieve the divine likeness brings hope to humanity. While the inalienable divine image is the basis for respecting dignity, the potential of divine likeness leaves a room for dynamic improvement of the human condition. It is through ascetical practices, though, that humans are able to achieve \textit{theosis},
become Christ-like. With this in mind, inspiring *thesis* should shape the mission of the Orthodox Church in contemporary globalized world,\textsuperscript{17} certainly in regard to bioethical discourse. Being a microcosm, humanity in general, and the Orthodox Church in particular, strives to bridge the existential gap between the created and divine realities; it is through the merciful and loving reign of God that this is possible (as it is succinctly captured in the Lord’s prayer: “Our Father… Thy kingdom come…”).

**I.B. Human Dignity and Humanity’s Mission**

**I.B.1. Pursuing Unity as Microcosm**

The patristic heritage of the Orthodox Church emphasizes that humans are microcosms in that they stand between the divine and created realities trying to bring them together. Although the human ancestors failed to do so because of their disobedience, Christ became man, so he may bridge the existential gap between the two realities. Recent theologians, such as Staniloae, extend the microcosmic mission of humanity. Some theologians emphasize that humanity is a “macrocosm,” a world writ large; others contend that the world is a “macro-anthropos,” to highlight the human responsibility of bringing the entire universe back to God.\textsuperscript{18}

Starting from this ultimate and unique human mission toward the universe, Orthodox theologians maintain that the unity of the created world is rooted in its createdness. Because of the human disobedience, as the book of Genesis narrates, the “goodness” and harmony of the created reality were disrupted; yet, the entire world stands in solidarity seeking God, the only source of life. It is the createdness of the world, including humans and all irrational creatures, that unites them in the presence of God rather than any rational human ability. If the unity of irrational created things is possible standing in the presence of God-despite their lack of rationality- then it is unjustifiable to exclude the possibility of agreement among humans.
Perhaps, it is the unrealistic emphasis on rational common ground that hinders the effort to finding commonality across moral differences.

Therefore, from an Orthodox theological perspective, it is warranted to pursue a common ground with other value systems building on realistic anthropological principles, including the inalienable worth of humans (for being created in the image of God), and the human potential of achieving *theosis* (God-likeness) despite their innate (but not divinely intended) fallenness. In the final analysis, the Orthodox Church should zealously confront, along the side of the entire humanity, the uncertainties and injustices of post-modernity, in steadfast hope in Christ and divine philanthropy.

**I.B.2. Orthodox Bioethics, Principles for a Global Discourse**

Many important theological and anthropological principles have surfaced so far to shape the way in which the Orthodox Church should engage in global bioethical discourse. First, the human embodied experience is fundamental to any genuine discussion of bioethical dilemmas. Human Body is essential to the divine image imprinted in all humans as emphasized in many church fathers,¹⁹ and in Jewish exegesis of the creation narrative.²⁰ In the Orthodox understanding of *theosis*, asceticism does not aim at releasing the human soul from its bodily captivity. Rather, asceticism is encouraged to transform the embodied experience and to sublimate human natural (related to human nature) needs toward its original God-intended purpose.²¹ Above all, following Christ does not imply “becoming other-worldly.”²²

Second, authority and dominion are not the only values that derive from the divine image in humans. Rather, human freedom and dominion over the natural world interweave into a synergic cosmology whereas humans are invited to be co-creators with God. Hence, human dominion comes with a responsibility that derives from a different understanding of God’s
authority and justice. Within the Eucharistic experience of the Orthodox Church, divine authority and justice come with an immeasurable divine sacrifice; a sacrifice that is incomparable to any human sacrifice. Humans should emulate this sacrifice not only claim an unhindered freedom over their lives.\textsuperscript{23} In the face of transhumanist aspirations, for instance, an Orthodox perception derives from authentic anthropological realism. Although a pursuit of God-likeness may aspire medical interventions to improve human technical abilities, these interventions may become available only to a few due to their cost for instance. This raises a serious concern for social justice especially that it may deprive many people from the hope of becoming “God-like” in the limited sense of transhumanism. Moreover, medical transhumanist interventions promise to technically perfect an already mortal human existence rather than to transcend the human nature beyond its limitations.\textsuperscript{24}

Furthermore, Hatzinikolaou advocates a spiritual bioethics which respects the dignity of every human life while at the same time being mindful of the inevitable limitation by death.\textsuperscript{25} He argues that human worth is not rooted in a wealth of rights to protect individualistic desires and necessities. Rather, he unmistakably emphasizes that respecting human worth hinges on the willingness of society to embrace its most vulnerable members when their dignity is at stake. Therefore, the previous chapter emphasized that an authentic bioethical phronema should humbly seek the amelioration of human suffering through active solidarity rather than pursuing perfectionistic rational bioethical principles.

Generally speaking, anthropological experience takes precedence over rationalistic formulations of bioethical principles. On one side of the Orthodox spiritual life, the humble acceptance of no-final answers to all bioethical dilemmas does not disqualify the attempt to find tentative answers from being authentic to the Orthodox tradition. It is enough to remember that
theosis, the ultimate goal of Christian life, necessitates persistent, humble, and repentant strife to achieve God-likeness, rather than a flawless pursuit of perfectionist sainthood. Saints, in the Orthodox Church, are those who are humbly repenting everyday rather than those who are flawless. On the other side, the core of the Orthodox spiritual life is the personal encounter of Christ in the liturgy. Thus, it was contended in the previous chapter that dogmatic formulations cannot recapitulate, on their own, all the possible unique encounters with Christ. Dogmas, important as they are, cannot reveal static normative principles for bioethical dilemmas.

Therefore, to explore meaningful and redeeming bioethical answers in a globalized world, only an ascetic and liberating spirituality which seeks the face of Christ can help. This dynamic project mentality in bioethics is not unique to Orthodox theological deliberation; rather, authors from other religious traditions recognize the importance of a continued deliberation on ethical issues across different religious and non-religious traditions. Building on this important anthropological experience and the Orthodox understanding of human dignity, Orthodox bioethics cannot be procedural and autonomic venture in dealing with dilemmas at the internal ecclesial level or when addressing a broader audience.

In a critique of Engelhardt’s version of Orthodox bioethics in the previous chapter, autonomous decision making is shown to not be the only value in bioethics. Comparatively, John Breck clearly emphasized that an authentic Orthodox bioethics is theonomic in that it centers on God’s authority and will to redeem the entire universe. In a sect-like mentality similar to that adopted by Engelhardt, the inevitable alternative to a theonomic bioethics is a theocratic one in which God is assumed to give clear normative directions in bioethics. In such community of presumably like-minded believers, there is no place for the “glorious liberty of the children of God” (Romans 8:21). Furthermore, Engelhardt’s emphasis on autonomous decision-making
misses the point, from a *theonomic* perspective, in that it subtly presumes an eternal human life or an absolute value for health. Similarly, Engelhardt’s version of Orthodox bioethics builds on two dubious anthropological categories, “moral strangers” and “culture wars.” Both categories are not compatible with an authentic understanding of the human condition and the Church’s mission in a globalized world.

**I.B.3. Eschatological Dimension of Iconic Phronema**

At the end of the previous chapter, it was argued that an authentic Orthodox phronema for global bioethics today should be iconic, in that it aspires the place and meaning of icons in Orthodox theology. In such phronema, the eschatological dimension of icons is relevant to the discussion of human dignity.

By taking human dignity seriously, the eschatological dimension of Orthodox iconography highlights the hopeful message of the Christian faith; their potential to become like God is what keeps humans striving with hope and trust. Hence, what gives meaning to the bioethical discourse is the human strife to achieve *theosis*, rather than an exclusive set of assumed meanings to moral concepts.27

On the one hand, the unifying principle of all humans, in a *theosis*-centered life, is the person of Christ, regardless of the prevailing religious diversity. The createdness of the universe unites all in their innate attraction toward God, the only giver of life. In the person of Christ, further, the created world is drawn toward unity, a unity that preserves the uniqueness of every person but transforms her into a Christ-like status.28

On the other hand, an eschatological dimension of icons permeates the world and shapes the faithful’s mission toward those who bear the same divine image. While an Orthodox *phronema* recognizes the eschatological potential of every human being, it heeds the current
human (and universal) condition of corruption, suffering and death. Thus, an Orthodox bioethics ought not limit its mission to those who belong to the Orthodox Church but should be open to the anthropological reality of a globalized world. The Church’s mission is “to create unity where there is division, to bring forth reconciliation where there is alienation, to heal and restore a sick and deprived human nature, and to free persons from the spiritual and physical violence of evil.”

II. The Anthropological Implications of Human Dignity for Secular Bioethics

In this section, human dignity will be discussed within the prevalent philosophical framework and contemporary secular bioethics. This discussion will establish a non-religious support for the use of the concept of human dignity in bioethical discourse as fundamental to the advocated common ground.

II.A. Human Dignity in a Secular Mindset

To understand the role that human dignity may play in global bioethics, this section will briefly discuss the philosophical relevancy and historical development of the concept of dignity and its most recent use in advocating human rights.

II.A.1. Difficulties of Human Dignity Discourse

The use of the concept of human dignity in moral discussion encounters many difficulties. Regardless of the various meanings connected to dignity, the idea of a special value/worth for human beings, collectively or individually, is problematic. Starting with these difficulties will help sort through the various meanings of dignity and their use in global bioethics discourse.

One of the fundamental problems with human dignity is that humans cannot realistically judge their own worth. It is a delicate issue for humans to objectively decide their worth vis-à-vis
other species, especially when human limitations and ephemeral existence should be considered. Comparatively, exaggerated self-appreciation on the side of humans may lead to arrogance and unhindered exploitation of others (of less worth) and natural resources. Therefore, contenders of the use of human dignity in moral discourse maintain that humankind is not different from other animal species and uphold that human atrocities throughout history disqualify humans from having any special worth. For instance, attributing an equal worth to victims and their victimizers is disheartening. Moreover, if humans were to have a special worth because of their abilities, attributes or achievements, social inequalities and varying innate talents clearly intensify a sense of unequal dignity. If different individuals unequally contribute to human flourishing, it may be tempting to treat them unequally depending on their merit. Hence, it is warranted to balance between a general and equal worth for all humans and the unique value of every individual.

As a value, human dignity encounters other kinds of criticism. On the one hand, some assert that human dignity is not a universal value as its advocates may claim. Different cultures adopt different codes of honor and self-worth. Some cultures may attribute honor to certain behaviors that are abhorred in other ones. This may highlight the difference in cultural understanding of what matters most for a dignified human life. On the other hand, human dignity encounters skepticism regarding its contribution to moral discourse. Critics of dignity contend that it does not add any new to moral discussions; dignity is only a reiteration of other moral arguments. Others uphold that respecting human dignity is not different from respecting the autonomy of the involved individuals. Further, other critics affirm that dignity is a laden concept that is influenced by various external political, economic, social and religious factors; this excludes the possibility of a meaningful use for universal moral discourse. Since dignity
grows out of a religious ethos (especially a Judeo-Christian one), some critics exclude its use in a pluralistic and global society.\textsuperscript{35}

\textbf{II.A.2. Preliminary Considerations of Difficulties}

Although several of these difficulties may seem legitimate, further consideration of them is warranted before exploring in detail the meaning of human dignity and its role in ethical discussions.

On the one hand, one should acknowledge the religious roots of the concept of human dignity. Those roots in Christian theology were discussed in the previous section. Besides, contemporary western understanding of dignity derives from the concept of “sanctity of human life” as understood in Judeo-Christian tradition. Hence, re-integrating those religious dimensions into mainstream ethical discourse would arguably enrich the discussion of human dignity and its application in a pluralistic society.\textsuperscript{36} However, since all established religious traditions attribute special worth to human beings for various metaphysical reasons, there is no justification to limit the religious input to the Judeo-Christian heritage.

On the other hand, the value of human dignity is universal despite any possible controversies regarding its meanings and applications.\textsuperscript{37} Dignity is an umbrella concept similar to freedom, love, justice, and integrity that it is intuitively understood but may not be clearly defined.\textsuperscript{38} Because of that, many communities are emotionally invested in and morally committed to preserving human dignity.\textsuperscript{39} Notwithstanding human atrocities, humanity is ultimately different from all other natural species. Humanity’s stature makes humans stewards of the entire natural universe for being “only partly natural.”\textsuperscript{40} Humans break with the natural world because of their innate ability to take care of it down the generations. Human language and rational abilities are the tools that make this possible through recording, understanding, and
appreciating the natural world with a sense of gratitude for existence.\textsuperscript{41} Such partly natural status of humans resonates with the previously discussed microcosmic mission of humanity as understood in Orthodox theology. Human stature is not only connected to humanity’s relation to nature but is also tangible through human self- and other-awareness. Humans are unique in their ability to process ideas (ideational uniqueness), their ability to shape their individual identity (idiographic uniqueness; unlike animals), in their being existentially unique as persons (existential uniqueness; they are immeasurably different from animals), and in their moral abilities as social creatures (ethical uniqueness). Even if humans may have evolved from other mammals, the genetic difference between them and their closest relatives in the animal kingdom is so drastic that the difference in abilities is immeasurable.\textsuperscript{42}

Furthermore, the uniqueness of humanity as a species is equally applicable to every human being. It is arguable that no one individual can stand for the entire humanity whether she is an average person or an exceptional one. Although humanity in general is endowed with exceptional abilities and individuals do not equally contribute to human achievements, every human being has an innate and irrevocable worth.\textsuperscript{43} George Kateb advocates this differentiation between humanity’s stature and human status within a secular mindset; however, this differentiation resonates with the ideas of an early Christian anthropologist Nemesius of Emesa (fourth century).\textsuperscript{44}

In general, the present-day idea of equal and universal human dignity has developed over a long period of time.\textsuperscript{45} In the west, input from multiple traditions dating back to the Stoics shaped the place and meaning of dignity.\textsuperscript{46} From the Stoics comes the universality of ethics regardless of religious tradition, which puts all humans on equal footing in regard to their moral responsibility. In Judeo-Christian tradition, the creation of humans in the image and likeness of
God highlights the universal and unique mission of humans and their metaphysical equality. Whereas Kant was very influential in shaping modernity’s moral discourse using human dignity, post-modern phenomenology along with universal threats to humanity (because of nuclear and mass destruction weapons, environmental degradation, and genetic manipulation) established human dignity as a basis for identity, solidarity, and compassion.

Notably, Kant was very influential in shaping the discussion of human dignity for modern ethical and philosophical discourse. In moral discussions, Kant is usually used to advocate respecting the autonomy of individuals as a sign of respecting their dignity. However, a deeper exploration of Kant’s philosophical contribution unveils the frequent but unjustifiable abuse of his thought. For one thing, Kant restricted the meaning of dignity to refer only to human dignity, which prompted a general abandonment of other meanings of dignity. Kant also connected dignity to morality making the two words interchangeable in certain contexts. Further, by connecting dignity and morality to autonomy, he opened the door to a secular discourse on morality and dignity.

Unfortunately, the consideration of autonomy as the sole criterion for morality and dignity betrays Kant’s system of thinking and narrowly applies his categorical imperative -that of not treating humans as means to other ends. Kant’s position on suicide highlights this disparity. While defenders of suicide (especially in the context of unbearable suffering) deploy Kantian autonomy as justification, Kant abhors suicide for being dishonorable. Kant does not exclude suicide for existential reasons -in that suicide annihilates the very person whose autonomy is being respected. Rather, permitting suicide expresses a failure to abide by the duty to respect dignity, not only the dignity of those who are committing suicide, but also the dignity of those who permit it. Suicide is dishonorable to humanity; by disrespecting the humanity of others, we
undermine the humanity in ourselves. In short, Kant’s account of respecting human dignity goes beyond the narrow respect of individual autonomy; there is more to human dignity than autonomous decision-making and free choices.

This brings the discussion to the meaning of freedom as a sign of human dignity. Respecting the individual’s freedom as a sign of respecting her dignity bears several meanings. (1) Being free evokes a sense of freedom from interference (negative freedom; to be left alone). (2) Similarly, being free demands a freedom from surveillance by authorities or others. More fundamentally, freedom demands (3) independence from a need for others to sustain one’s life and (4) access to basic necessities while being able to act freely. (5) At the existential level, freedom demands an inalienable ability to shape one’s own life without a reference to outside criteria. In this case, dignity is owed regardless of fulfilling certain outside moral criteria or contributing specific achievements to their communities.

For instance, if a person enhanced certain abilities he has, he will not become a better human being inasmuch as a winning athlete is not a better human being than all the rest. In general, when discussing human dignity and autonomy, the above overlapping meanings of freedom should be always taken seriously. An autonomous and free choice is not only about the ability to choose from among numerous options; Rather, a free choice presupposes an existential freedom to shape one’s own life which necessarily demands having the capabilities (material and aptitudinal) to do so. These capabilities can only be available within a caring community.

II.A.3. Meaning of Human Dignity

Building on the existential meaning of freedom, it is justifiable to think of human dignity as an existential value rather than a moral value. This is because the personal identity of the involved individuals (and at large, every human being) is at stake. When an individual is treated
with disrespect, her uniqueness is compromised, and she is considered, symbolically and actually, only as one more human being.\textsuperscript{52} Here lies the root of many atrocities committed against humanity. This again brings to the front the balance between human stature as a species and the individual achievements of every human being. Whereas personal achievements are central to a sense of dignity (or pride), there is more to being treated with dignity than having a high self-esteem.

To strike this balance between the commonness of dignity and the importance of individual uniqueness, further unfolding of dignity is necessary. Through a meticulous study of the history of the concept, Michael Rosen explains that dignity has been used in different contexts to refer to more than a transcendental and worthy human kernel. He adopts four strands of meaning; His model is different from a classical model of expanding dignity to include more individuals.\textsuperscript{53} Similarly, Daniel Sulmasy studies the different meanings of human dignity and how they apply to bioethical discourse.\textsuperscript{54} Their two models correspond in the following manner. (1) The inherent value of human beings is the most used meaning of dignity. This meaning corresponds to Sulmasy’s category of intrinsic dignity; It refers to the innate value of every individual that is inalienable and irrevocable. (2) Dignity as status for Rosen corresponds with Sulmasy’s category of attributed dignity; It refers to the value conferred on humans by their community for any given cultural reason. (3) Dignity as behavior, character and bearing corresponds with Sulmasy’s category of inflorescent dignity; It refers to the excellence achieved through behaviors, attributes and attitudes which put the person in a respected position compared to others (without making him a better human being).

Sulmasy, furthermore, rightly highlights that, logically and linguistically, the intrinsic meaning of dignity is prior to the attributed and inflorescent meanings. Unless humans recognize
and appreciate the intrinsic value of every human being, it would not be possible to recognize an attributed or inflorescent value in special individuals.\textsuperscript{55} Other scholars recognize the difference between two values: the innate (basic) human value and the flourishing value; the latter is dependent on cultural and social contexts, is achievable, and may be withheld or distinguished.\textsuperscript{56}

While Sulmasy only includes these three categories of meaning, Rosen unfolds another strand that is usually taken for granted in any given human society. One human practice across all cultures, according to Rosen, illumines the understanding of dignity, that is respecting human cadavers. Respecting human cadavers through rituals stirs a moral dilemma in that it does not benefit any one (whether these rituals include cremation or interment). He argues that even the last living human being has a moral duty to respectfully bury the person who has just died. This radical and general idea emphasizes that every person should be treated respectfully.\textsuperscript{57} Rather than respecting human dignity by respecting certain “attributed” rights, Rosen contends that humans have a right to be treated respectfully; dignity requires respectfulness.\textsuperscript{58} In his analysis, Rosen meets Y. Michael Barilan’s emphasis on the universal taboo of homicide. Although Barilan starts from a Biblical (Old Testament) perspective on human dignity, he highlights the universal prohibition of homicide and the general respect for human cadaver regardless of cultural differences.\textsuperscript{59}

Barilan goes even further in discussing what the respect of human dignity means in a pluralistic global community where the language of human rights prevails. Barilan highlights four formal elements of human dignity: (1) universality, (2) equality, (3) primacy (dignity does not need to be condoned by an outside entity), and (4) inalienability and irrevocability.\textsuperscript{60} He acknowledges the shift of moral discourse from being agent-centered (where emphasis was more on the agent’s virtues and duties) to being recipient-centered (where emphasis is more on utility
However, Barilan defends a consideration of human rights as a tool within an ethos that is respectful to human dignity. The advocated ethos is sensitive to expanding circles of needs; meeting these needs is a sign of respecting human dignity. To show respect to any agent’s dignity, meeting (1) vital human needs and providing favorable circumstances (2) to pursue rational human goals and values and (3) to assert one’s own freedom is quintessential. However, beyond the provision of these needs as a sign of respecting human dignity, Barilan discusses what he calls “residual dignity.” He contends that residual dignity is respected in all cultures and is attributed to all humans and only humans. Respecting “residual dignity” is intuitive in many instances and is usually taken for granted, such as by giving names to infants at birth, by ritually burying human bodies (despite the different rituals), and by covering the genitalia and keeping sexual activities private. The intuitive importance of residual dignity in shaping human communities underscores that morality goes beyond narrow respect of individual choices.

II.A.4. Disrespecting Human Dignity

Regardless of the possibility to positively defining dignity, it is much easier to discuss what degrades the dignity of a human being. Although humiliating practices may be delineated differently in various cultures, they all violate human dignity. The most dangerous of humiliation is the one that is practiced in the name of God or any metaphysical authority. In these cases, and because of a self-referring certain acquisition of truth, humiliating others becomes justifiable.

It seems problematic to discuss the possibility of degrading human dignity (through certain actions) while at the same time emphasizing its innate and inalienable nature. However, it is suggested that a dynamic understanding of dignity as necessarily embedded in a social context may be illumining. A dynamic relation exists between dignity as a duty toward people,
on the one hand, and dignity as an expectation of people, on the other. In the same vein, a sense of honor and self-worth is socially determined through relational and comparative valuation of traits and achievements. Such sense of honor and self-worth bridges the gap between what humans owe of respect to other individuals and what they expect of respect from them.\textsuperscript{66}

Therefore, any self-awareness of pride, honor, shame, embarrassment or humiliation is agent-centered. It may be provoked by different culture- or society-specific practices and norms. On the contrary, respecting human dignity is recipient-centered in that it is the responsibility of the beholder and the entire society to treat every member of that society with respect.\textsuperscript{67} In short, to respect human dignity it is necessary to seriously take its relational dimensions within a caring social context rather than exaggerate the role of autonomous choices. It is arguable, hence, that fundamental for any society, \textit{qua society}, is to treat every member with dignity, rather than promulgating a utilitarian and choice-centered understanding of dignity. Every human society sensitizes its members, as they grow up and integrate its values, to certain norms and practices. Likewise, social environment shapes an agent-centered sense of self-worth;\textsuperscript{68} hence, the former necessarily precedes the latter even when some individuals, because of mental disability for instance, are not able to register any meaningful sense of self-worth.

Torture offers an edifying example of disrespect to human dignity. Regardless of the tools and methods used to execute torture, all practices humiliate and violate the dignity of the victim. Therefore, torture is abhorred not only for the associated and unnecessary pain but also for not recognizing the shared humanity between the prosecutor and her victim.\textsuperscript{69} Christianity, for instance, underscores the shared dignity between the torturer and her victim. With enthusiasm, early Christians faced death at the hands of their persecutors without betraying their faith in a biblical hermeneutics of equal human dignity.\textsuperscript{70} Unfortunately, denying the humanity
of victims justified numerous human atrocities throughout recorded history. Genocidal propagandas everywhere center on the less-than-human nature of their victims. Torturers necessarily dehumanize their victims to be able to execute them.\textsuperscript{71} Practically, victims are dehumanized when, for instance, they are prevented from behaving in a dignified way, such as by forcing them to defecate and urinate in their cells or by exposing their private parts (war prisoners frequently fall victims to dehumanizing treatment).\textsuperscript{72} By the same token, torturers tell cold jokes to distract themselves from the brutality of their actions. While innocent humor and acrimonious satire frequently bear dehumanizing aspects, humor in the context of torture has a distracting effect away from brutality.\textsuperscript{73} Humor is closely related to the experience of medical students in the anatomy lab, as will be discussed in the sixth chapter; for medical students, dehumanizing cadavers through humor is necessary to ameliorate the trying experience.

Furthermore, to the global bioethical discourse, two aspects related to torture and human suffering are paramount. First, because of degrading conditions, those who constantly suffer may stop to register the dehumanizing treatment they receive. They may stop to perceive themselves as respected humans because of their persistent state of humiliation.\textsuperscript{74} Second, witnesses of constant human suffering may stop being moved by dehumanizing and brutal treatment of other humans. In both cases, it is the collective responsibility of society to resist all humiliating practices and to mend all circumstances that strain dignity. In this vein, different societies and international entities have adopted the language of human rights as a safeguard to the dignity of every human being.

\textbf{II.A.5. Human Dignity and Human Rights}

It has been clear so far that the discourse of human dignity is ubiquitous and supported in various religious and nonreligious value systems. United Nations’ 1984 Universal Declaration of
Human Rights adapted human dignity as a basis to ensure the validity of rights claims in a pluralistic world.\textsuperscript{75} It was argued that the use of dignity in this and similar international legal documents may play a heuristic role in searching for rights rather than giving a clear-cut set of rights to enforce.\textsuperscript{76}

In this legal context, human dignity may seem merely axiomatic in that to specify a set of fundamental rights and enforce it is what matters in the end.\textsuperscript{77} However, confusion in regard to the meaning and role of human dignity and rights may be attributed to their adoption into many national and international legal documents. Similar to many legal terms, dignity and rights are not clearly defined, are open to interpretation and may solicit disagreement and confusion.\textsuperscript{78} Notwithstanding the importance of dignity and rights in legal discourse, their legalization may be related, as referred earlier, to the shift from an agent-centered (virtue) to a recipient-centered (rights) discourse of ethics. Reversing this trend and re-orienting the global moral discourse may not be possible now.

Nonetheless, it is warranted to perceive the status of dignity discourse and its relations to human rights through positive lens so that it becomes possible to improve the human condition globally. As previously discussed, Barilan defends an ethos respectful of human dignity which deploys human rights as an instrument to show respect. However, he admits that an ethos respectful of human dignity does not address all moral problems and that human rights discourse does not cover all dignity-related issues. At a general level, although the language of human rights is perceived as individual-centered, Barilan rightly emphasizes that rights derive their meaning and authority from the community within which they are applied.\textsuperscript{79} Furthermore, Barilan contends that human rights have a limited mission; they do not aim at achieving justice. Rather, rights should be limited to the provision of basic goods and to the respectful and equal
treatment of every human being. In the final analysis, human rights discourse is not a moral doctrine; rather it is a tool within an ethos which guarantees respecting the dignity of everyone.  

II.A.6. An Orthodox Perspective on Human Rights

This section does not intend to offer a comprehensive discussion of the Orthodox Christian perspective toward human rights discourse. There are many authors who discussed this issue within the national, political, and practical contexts where Orthodox Christians live. However, for this dissertation, it is warranted to highlight a positive Orthodox perspective toward human rights that is built on a robust theological basis.

A contemporary Orthodox theologian, Aristotle Papanikolaou, thoroughly examines the different trends among recent Orthodox theologians and church entities. He ultimately opposes a suggested exclusive relation between modern liberal notion of human rights and an Orthodox theological anthropology. His argument builds on the development of an Orthodox notion of personhood within the realism of divine-human communion.

Papanikolaou admits the contenders of the language of human rights are ambivalent due to its connection to atheistic humanism, its marginalization of Orthodoxy in its heartland, and its grounding in individual, a-relational, and solipsistic anthropology. He rightly debunks some of these presuppositions and emphasizes that the language of rights predates the Enlightenment and modernist humanism. He also gives theologically-based arguments to explain that freedom, even to reject God, should be protected within a traditionally Orthodox country. Fundamentally, he contends that human rights are not individualistic per se, but are social in that they need a social context to be protected.

At a general level, political communities, Papanikolaou believes, are necessary because humans have failed to relate to each other as God relates to each one of them. Political structures
accordingly are inevitable out of the sinful and fallen human condition and out of fear of exploitation and abuse. Therefore, for Papanikolaou, as long as the language of human rights defends the uniqueness and irreducibility of every human being, all Orthodox (and Christians in general) should support it. Although this language falls short from expressing all that humans are meant to become -from a theological perspective- it is still a good start for a pluralistic global community.

In short, the qualified compatibility between the language of human rights and Orthodox anthropology makes it possible, in global bioethical discourse, to find a common ground with other value-systems. By the same token, other Christians find themselves attracted to this language despite its shortcomings. Even if the language of human rights seems secular and is frequently abused, it is no excuse to abandon it; there is always a possibility to find a Christian - or generally speaking, a religious- basis to profoundly respect every human being.⁸⁴

II.B. Human Dignity for Secular Bioethics

II.B.1. The Politicization of Human Dignity in Global Health

The integration of human dignity in many national and international legal documents is used to defend various human rights. Because of the universal experience of illness and clear disparities in health around the world, human dignity was also deployed to defend certain universal rights in regard to health care. In the UNESCO’s 2005 *Universal Declaration on Bioethics and Human Rights* the interplay between human dignity (and vulnerability) and human rights language is very clear. Not only human dignity shapes the global discourse related to health and illness, it also fashions the daily clinical encounter between patients and providers.⁸⁵
II.B.2. Difficulties in Using Dignity in Health

Similar to the discussed difficulties with the general use of the concept of human dignity, this concept encounters several difficulties in the context of health care.\textsuperscript{86} Contenders of its use in the context of health care and bioethics emphasize that dignity does not bring any new to the discourse; it only reiterates the principle of respecting patient’s autonomy.\textsuperscript{87} However, dignity has an important moral meaning that is enriching to the bioethical discussion.\textsuperscript{88} At a minimum - even for someone who criticizes the use of dignity in bioethical discourse- a cautious respect to dignity is warranted. It is necessary to avoid mistreating vulnerable patients; lest a beholder is hardened by witnessing excruciating suffering, emphasizing patients’ dignity is unavoidable.\textsuperscript{89} Moreover, for contenders, dignity is rooted in the religious concept of sanctity of life which makes it unsuitable for pluralistic practice of medicine.\textsuperscript{90} Similarly, because political, social, economic, and religious factors influence its meaning, dignity may be confusing to health care practitioners; there is no clear way to pinpoint what it demands of them.

II.B.3. A Unique Role for Dignity in Medicine

Notwithstanding these difficulties, it is still arguably necessary to pragmatically discuss the concept of dignity to unravel prevailing bioethical controversies,\textsuperscript{91} especially when it is used to justify diametrically different positions, such as for and against euthanasia and physician-assisted suicide. Undoubtedly, respecting human dignity occupies an important place in the unique context of medical care.\textsuperscript{92} In the clinical context, patients do not choose to be sick and to seek medical attention.

Although patients freely choose their provider or hospital (even if their choices are initially restricted depending on their insurance plan), they would prefer not to be ill in the first place. Further, by seeking medical attention to treat their ailment, they implicitly succumb to the
power gradient embedded in medical provision. When a patient meets her doctor, she indirectly acknowledges that he knows more about her body than she knows. More generally, this physician-patient encounter takes place within an institution (or at the fringes of an institution) which is governed by faceless administration and industry. These unknowable (to the patient) institutions decide all sorts of things that may affect the “choices” and health of the patient, such as: what medication is covered by the insurance, which diseases are targeted in pharmaceutical development research, and what incentives are offered to use a certain intervention … etc.

Within this complicated -and hidden- web of relations and interests, the patient seems to be the most disenfranchised player, especially that she did not “freely” choose to enter that web.

More important, different players are embedded within a cultural context that shapes their interactions. When the overarching culture highly values self-independence, control and autonomy, medicine and health care conform in a way to serve those idols rather than their patients. On the side of patients (and every human being), a culture that idolizes health accordingly shapes patients’ self-esteem and their own sense of dignity.

Within the dire context of medical practice, human dignity may be compromised for different reasons, or feel to be so. While the internal worth of the human being cannot be compromised regardless of the context or the affliction, in the context of illness, the ontological vulnerability of the patient and her sense of self-worth are exposed. Being a “patient” is etymologically connected to vulnerability. Besides, a dynamic relation between what the patient demands to feel dignified and what the team offers in respect to her dignity is at play. Thus, a patient will feel undignified when the medical team treats her as one more patient, as another case of heart failure, or as a room number. Although these expressions may be benign
in the hectic settings of a hospital unit, they deprive a patient of her sense of uniqueness as a dignified human being.

Aside from the clinical context, patients bring along their cultural beliefs which may make them feel undignified. When a patient values in life her independence and autonomous decision making, she may feel worthless when she is not in control of simple things like bowel movement or when medications sap her clarity of mind. A patient’s dependence on others may not be blamed for her sense of worthlessness; rather, one should blame the wide-spread cultural perception that autonomy is what makes humans dignified. Caring and compassionate relationships, by family members, medical teams, and the entire society, are what preserve a patient’s dignity.97

These examples and many others show the fundamental relationship between dignity and vulnerability, especially in the context of health care provision.98 As previously discussed, dignity is usually linked to intellectual abilities and free will of humans. However, human dignity goes beyond autonomous decision making, especially when patients are most vulnerable due to the nature of their illness and the institutional context where they seek medical attention.99 The experience of vulnerability underscores the universality of the human condition as ailing and fragile contrary to the mainstream moral relativism in bioethics.100 Humans as dignified but vulnerable beings have more in common because of their affliction than when rationalistically agree on particular moralities.

II.B.4. Human Dignity and Transhumanist Medical Interventions

As previously discussed, the transhumanist aspirations of some thinkers may be related to a certain understanding of religious thoughts to improve the human condition. However, even within a secular mindset, transhumanist aspirations challenge medicine as a tool to fulfill them
and the ensuing impact on human dignity. It is hoped that accumulated medical and scientific knowledge will help improve the human body, its longevity, its immunity against certain diseases (and probably death) and almost all physical and intellectual abilities (such as sport performance and unaided computing abilities). To advance their agenda, transhumanists usually refer to the ubiquitous methods currently in use to improve human abilities such as vaccines, coffee and education… etc. However, when transhumanist interventions meddle with genetic makeup, some of these improvements may become “innate” to the evolving human (or trans-human) beings.

Regardless of the success prospect of these interventions and the arguments used for and against them, one aspect is still relevant to this dissertation; it is the dignity of the human species in its current condition and the dignity of the evolving trans-human species. In academic discussion of transhumanism, scholars are divided between three camps in this regard. Some believe that enhancement threatens human dignity, while others believe that it may contribute to dignity. Others, however, prefer to frame the discussion about transhumanism away from those two possibilities and advocate a cautious acceptance of some enhancement.

As previously discussed, nothing that humans do will affect their innate and inalienable worth. The intrinsic value is equal for a rising athlete, a brilliant scholar, and a mentally-challenged newborn. They all deserve to be treated respectfully as unique human beings regardless of their achievements or the lack thereof. Thus, any projected improvement on the human species through genetic intervention or enhanced interaction with machines (implanted memory chips, for instance) would not yield better-than-human species; the evolving humans have enhanced abilities but not more dignity or worth.
However, because of the social nature of human dignity, as has been highlighted several times, further challenges arise because of the projected transhumanist changes. When transhumanist improvements become available, one challenge to the dignity of many humans will be related to their just distribution and the public perception toward those who are not “enhanced.” Such challenge is similar to when an athlete, for being an athlete, is treated with special care compared to another patient who is ignored for not being a celebrity. The underlying discrimination contradicts the duty of health care professionals to treat every patient with dignity. If a trans-human with super-powers is admitted to the hospital, it is questionable if he will be treated with equal respect compared to other “human” patients. If a culture evolves that idolizes super-powers (its roots are already growing in contemporary culture), it would be expected to perceive more worth in those who have them. In the same vein, if enhancements become available, it is uncertain who will be able to afford them. The already wide gap in access to basic health care between different nations and within the same nation threatens to become even wider. This will add another dilemma to the millennial question of justice in health. Notwithstanding the importance of these questions, one concern remains in regard to the dynamics between medical practice and human dignity to answer the following questions: what is the role of the concept of dignity in shaping medicine? And what is the role of medicine in defending human dignity?

In the next section, a connection between human dignity and gratitude will be established. It will also defend a practical role for gratitude in shaping medicine in a global world.
III. A Systematic Interpretation of Human Dignity for Global Bioethics: The Role of Gratitude

To further the discussion on human dignity, this section will consider the practical dimensions of respecting human dignity through embracing gratitude as a proper virtue for dignified humanity. Gratitude, it is contended, should have a central role in shaping medicine as an enterprise and during the clinical encounter. In a globalized world where human beings of various backgrounds come into contact as never before, national and cultural boundaries are far less significant, especially in medical practice. Human dignity in this context has special importance in shaping ethical deliberation when facing human vulnerability and inevitable death. Two inputs are important for the ethics of medical practice at a global level.

III.A. Gratitude for Entangled Human Lives

III.A.1. Social Construct for Gratitude

Human dignity is necessarily socially constructed. Many social factors and entities, near and far, play a role in respecting the dignity of individuals and in fostering a healthy sense of self-worth. Consequently, dignity can be thought of as a social gift. While dignity is innate to every human, it can only flourish and be recognized within a social context. Recognition here does not mean that dignity needs to be approved by others or that a person needs to have certain qualification to be considered worthy of respect. Rather, for a person to grow a healthy sense of self-worth, a nourishing social context is paramount. Conversely, in isolation, dignity and its respect are meaningless since human linguistic abilities to construct meaning is only possible within a community. If one is born into a community that enslaves her since birth (or treats her with disrespect), this person will grow with a limited understanding of self-worth, yet without being deprived of dignity.
In this manner, every society bestows on (ideally) every member a gift of understanding and respecting dignity. In other words, when a given society respects the dignity of its members, those members are expected to show gratitude toward society and pay forward through respecting the dignity of others. Through a sense of gratitude, every member of the society recognizes her existential dependence on other members. Even a true understanding of personal freedom and autonomy requires a genuine recognition of dependence on others. Being on the recipient side of a gift, especially if the gift is the ability to recognize one’s own worth as a dignified human being, brings along several obligations. These obligations are toward God (who bestowed this innate dignity, if a theistic understanding of dignity is adapted), toward one’s neighbors (in the form of paying forward the generosity of others), and toward one’s own self (in the sense that one has an obligation toward one’s own self to show respect to others).

In the same vein, it has been argued that if gratitude (or any of its derivative virtues: humility, compassion and forgiveness) does not play a role in one’s way of life, she would “lack a quality or capacity of humanly definitive spiritual and moral significance.” Having gratitude toward the surrounding social matrix, one recognizes the importance of gratitude at two levels at least: first, gratitude is essential to know one’s self and limitations; second, without gratitude, one is inclined toward “personal alienation and social isolation.”

III.A.2. Preliminary Definition for Gratitude and its Role

To advance the role of gratitude in shaping bioethical discourse, it is warranted to start with a working definition of gratitude. This definition will be revised and extended to support the argument of this dissertation. However, for the time being, a basic definition will show the fundamental need for gratitude in a deeply entangled human life, especially when it pertains to medicine and health.
Gratitude is defined as a “positive emotional response of a beneficiary directed to a benefactor for benefits provided intentionally to the beneficiary.” This definition is usually broadened to include those cases when a benefactor attempts (or intends) to provide a benefit, whether he was successful or not.\textsuperscript{112} Three conditions are usually adopted: “that gratitude ought to be a response to a benefit (.. or an attempt to..), a benefit given from an appropriate motivation (usually benevolence), and a benefit that was either wanted or accepted by the beneficiary.” These conditions are rightly challenged by Patrick Fitzgerald (see next section).\textsuperscript{113}

Building on this narrow definition only, any community member clearly thrives because of the generosity and kindness of others. One is born into a family whose members provide all material and emotional needs for a healthy and productive citizen to grow.\textsuperscript{114} Without the generosity of a family, one may not have existed in the first place. Further, each member of this family depended while growing up, and continues to depend at any given time, on her interaction with her surrounding to receive her basic needs (such as food products, shelter, and other essentials to sustain life). Without these cooperative, interdependent relationships, any community would not thrive. Thus, while many social interactions may seem contractual at the surface, they are actually embedded in a fundamentally generous ethos; benefits or goods are more existential gifts than contractual exchanges. Within such ethos, a good recipient of social generosity is a generous benefactor to others who adopts gratitude as a way of life. At a deeper level, the dynamic between social generosity and gratitude is vital to society; gratitude helps shape a moral memory without which society will fall apart.\textsuperscript{115}

\textbf{III.A.3. Medicine without Borders}

After briefly illustrating that human life is dependent on the generosity of many others, it is warranted to demonstrate how the practice of medicine is not limited to the institutions or
countries where they are practiced. This section contributes to the rest of this dissertation by establishing the role of gratitude in shaping the practice of medicine, research agenda, and the training of new practitioners. At three levels, health and medical practice are entangled for humans regardless of their geographical location; in many examples, some people are disempowered and undignified under the auspices of medicine.\textsuperscript{116} These levels are as follows: at the level of establishing medical knowledge and research; at the level of medical and health-related practice; and at the level of medicine’s role within the social and environmental contexts.

\textit{III.A.4. At the Level of Establishing Medical Knowledge and Research}

This level includes all the practices intended at acquiring new medical information to advance the practice of medicine and the preservation of health. Numerous examples show medicine is fundamentally connected in a globalized world.

Searching for new drugs overlooks national boundaries.\textsuperscript{117} Western pharmaceutical companies extract new drugs from plants that are indigenous to faraway countries. People of these countries are usually aware of their therapeutic benefits and have been using them for centuries. However, pharmaceutical companies usually patent the derivative medication and market it to their nationals, sometimes without meaningful acknowledgement of the original users. Similarly, researchers sometimes use the genetic material from isolated human communities to gain priceless medical knowledge. Then, pharmaceutical companies patent pieces of these genes or develop interventions building on the acquired knowledge. However far the link between the genes and the developed intervention is, it would be morally dubious to not be grateful toward those who shared their genetic material.\textsuperscript{118}

In the same vein, developing new vaccines that only benefit few people without acknowledging the contribution of others is problematic. In 2007 for instance, Indonesia raised a
valid point by holding off avian flu samples from the World Health Organization because of unequal distribution of burden among various nations. While Indonesia, by gratuitously providing these samples, would help develop effective flu vaccine, the vaccine may only be affordable to western countries where it is developed.\textsuperscript{119}

After new medications are discovered and developed, pharmaceutical investigation of their safety and effectiveness is sent off-shore to developing countries. Although many international and local entities attempt to safeguard the autonomy and well-being of participating research subjects, a great deal of exploitation takes place away from the eyes of international laws and moral principles. Such research benefits from lax regulations in these countries and from prevailing misconceptions about the nature of research in communities that have minimal -if any- access to health care.\textsuperscript{120}

Therefore, gratitude toward those who participated in research, whether autonomously or sometimes coercively, is the responsibility of those who benefit from these drugs daily. Without those faceless subjects, the safety of many drugs could not be established.

\textit{III.A.5. At the Level of Medical and Health-Related Practices}

When practicing medicine in a globalized world, national borders are effaced, and the movement of knowledge, practitioners, and services brings unprecedented realities and challenges. For instance, organ transplantation to needy patients overlooks traditional boundaries between countries and creates a global -illegal- market for organ trade.\textsuperscript{121} In 2007 for instance, it was estimated that 5-10\% of annual kidneys transplanted around the world were provided by commercial living donors through trafficking. By the same token, transplant centers in destination countries attract clients from around the world while fueling the market of medical tourism in their communities.\textsuperscript{122} Similarly, a market for surrogate mothers is tapping into the
meager provision of healthcare in developing countries while -dubiously- promising marginalized women a way out of their misery.\textsuperscript{123}

Clearly, while medical knowledge and technologies are developed in western countries their application travels the world and shapes the lives of many in developing countries. Medical knowledge has even contributed to the exploitation of vulnerable populations around the world. In a similar manner, the migration of health care professionals from developing to developed countries, and within these countries, from rural to urban areas, is detrimental to the health of many communities around the world. Many factors play into the movement of health care workers along these migration routes, especially better compensation and opportunities. However, the detrimental effect of this trend goes beyond any compensatory “pay back.” By recruiting physicians from developing countries, for instance, developed countries can meet the needs of their own populations; however, this comes at the expense of deteriorating health systems in resource countries in a way that money alone cannot pay back.\textsuperscript{124}

Clearly from these examples, the practice of medicine in a globalized world is intertwined across national boundaries. They highlight the interconnectedness of human lives around the world, particularly pertinent to health care and medical practice.

**III.A.6. At the Level of Medicine’s Role Within the Social and Environmental Contexts**

Similar to the previous levels of medical practice, at this universal level, numerous factors related to the environment and social dynamics affect human health.\textsuperscript{125} The existential interdependence among humans is embedded within a broader dependence of humans on the environment at large.

A basic need for food, for instance, underscores the reliance of every human not only on the generosity of those who produce food (through their labor) but also on the environment as a
source for this food (including fertile soil, appropriate weather, and timely seasons). Thus, in face of this generosity, humanity is invited to sacrifice, asceticism and gratitude. Although these requirements are usually discussed within a religious mindset, they are not foreign to what modern science has shown to be necessary. To protect the environment, self-denial and taming consumerist and controlling desires are warranted. In gratefulness for life itself, humans would embrace each other with hospitality and become united in political solidarity as a species and with the entire creation. Consequently, when environmental hazards are detrimental to the health of many, medical practitioners and institutions cannot, conscientiously, stand on the side. Regardless of how much medicine can reverse of sicknesses, it is more responsible and cost-effective to prevent these sicknesses through better public health measures such as providing clean water, sanitary systems, and sufficient nutrition.

At a more focused level, an ethical practice of medicine cannot exclude the social factors that affect health. As have been previously noted, mainstream bioethics in the US ostracized those who criticized social injustices which were detrimental to health. It is arguable that bioethical discourse cannot be sufficiently pursued if restricted to the clinical encounter between physicians and patients. The social and cultural backgrounds of both parties should be seriously considered to fully understand the processes of disease and healing. Hence, an anthropological basis for modern medicine and bioethics is warranted to prevent possible atrocities committed in the name of advancing science. Within a broader anthropological consideration of human illness as embedded in a social and cultural context, medical practice will be more sensitive to the many dimensions of suffering. Furthermore, medical education will take a different route in shaping new practitioners (more to come in Chapter 6).
Notwithstanding the successful attempts to integrate narrative medicine into training, its presence in medical textbooks is still minimal at least in regard to the way of presenting pathological cases. In general, patients are presented as puzzles to solve their intriguing clinical presentation rather than as full-fledged human beings with established histories. In the same vein, if pictures are included, they usually show the relevant lesion without the patient’s face (or while covering her eyes) so that she becomes faceless. While these measures are propagated to defend patients’ privacy, the ensuing sacrifice in medical education is significant. By the same token, Eric Cassell highlights recent changes in preparing human anatomy books. He illustrates how contemporary anatomical illustrations de-humanize the cadaver; they depict a cadaver as only a tool to teach anatomy rather than as the body of a “real” human being. Although these aspects of medical education may seem marginal to the nuts and bolts of treating diseases, they are indeed very important in shaping the ethos of new practitioners. They, along with other factors, are elemental in drafting a hidden curriculum that influences the quality of care future practitioners will provide to their patients (chapter 6 will offer more discussion on these issues).

By and large, because of how entangled human life is, especially when it comes to medicine, it is arguable that gratitude should shape medicine as a profession (and the system that is built around it) and should influence the way medicine is practiced at the clinical level. For one reason, medicine as a profession should acknowledge and show gratitude toward the many generations of patients and research subjects who helped reach the knowledge that is available today, regardless of how far removed, physically and chronologically, these people may seem. For another reason, in the next section a broader understanding of gratitude will be adopted to argue that physicians should show gratitude toward the patients they serve daily.
III.B. Gratitude as a Sign for Dignified Humanity

III.B.1. Gratitude and Morality

Now that the entanglement of human life especially in medical practice is established, it is time to discuss gratitude itself and extend its applicability in shaping medicine (to be discussed in chapter 6). The discussion of gratitude started in the previous section from a narrow working definition. Gratitude was defined as a “positive emotional response of a beneficiary directed to a benefactor for benefits provided intentionally to the beneficiary (or for the intention of providing a benefit).” Beyond this definition, gratitude has three functions that are relevant to moral discussion. (1) Gratitude is a moral barometer in that it is a response to a perception of a benefit. (2) Gratitude is morally motivating in that it encourages the beneficiary to act pro-socially toward the benefactor and others. (3) Gratitude is therefore a moral re-enforcer in that it encourages the benefactor to behave morally in the future. In general, gratitude has a pro-social effect since it encourages those who enter a relationship of gratitude to act benevolently toward others.

Gratitude has a prominent place in discussing morality and moral formation in various disciplines. It is appreciated in several religions, in philosophical discourse, and in positive psychology. One reason for this general appreciation is that gratitude correlates with other positive values (virtues) and human qualities, such as humility, compassion, and altruism. These values and qualities are nourished more because of gratitude than because of a sense of social indebtedness or reciprocity. In other words, gratitude has far reaching implications in morality and moral formation compared to mere indebtedness or reciprocity.
III.B.2. Gratitude in Religion

On the religious side, gratitude is central to any religious mindset. Regardless of the metaphysical system behind the religious tradition, gratitude grows out of the idea that humans are not the source of their existence and that they are indebted to some form of benevolent deity. In Orthodox theology, humanity’s kinghood derives from its being created in the image of God (as previously discussed); hence, out of gratitude, humans are expected to be stewards of the world as a divine gift. This manifests most clearly in the Eucharistic identity of the church. As a community of Eucharistic beings, the church constantly practices the sacrament of thanksgiving (eucharist) bringing back to God, with gratitude, the entire world as a “sacrifice of praise” (from the Anaphora). Not only in the Orthodox Church that gratitude occupies this central role in shaping the community, but also in other religious communities. Sufism adopts gratitude as central to its religious ethos. In empirical research, a clear connection was found between gratitude and religiousness/spirituality. Furthermore, religious communities are not the only ones to foster gratitude in society; psychologists and philosophers have also discussed the important role of gratitude irrespective of religious frameworks. Notwithstanding these various disciplinary interests, a more interdisciplinary work on gratitude is still needed.

III.B.3. Gratitude in Psychology

It was hinted at previously that gratitude has a pro-social function. In the field of positive psychology, ingraining and nourishing gratitude are thought to be possible and desirable because it is associated with more personal agreeableness and less narcissism. Gratitude, moreover, is one of the best predictors of individual well-being and thriving in any given society. At the cultural level, gratitude helps balance the materialism and objectification that are rife in a consumerist society. It goes as far as being essential for the flourishing of democracy.
When individuals have a sense of gratitude that motivates them to improve the well-being of other community members, they indirectly contribute to their own well-being. Hence, for some scholars, the gift is not separable from the opportunity to give, which excludes the need for the language of rights. While a beneficiary receives her due need because of an act of kindness on the side of a benefactor, the latter also benefits from the opportunity to give. Consequently, there should not be a need to use the demanding language of rights, because those who can give have an equal interest in giving compared to those who receive.\textsuperscript{142}

\textbf{III.B.4. Gratitude in Philosophy}

In philosophical discussion, this mutual benefit between the benefactor and beneficiary is taken a step further. Historically, gratitude has a prominent place in philosophy because of its connection to the discussion of gifts.\textsuperscript{143} Philosophers contend that gratitude goes beyond the reciprocal exchange of benefits; gratitude is the “truest approach to life”,\textsuperscript{144} and a proclamation of a certain attitude toward the world.\textsuperscript{145}

However, because of the mutual benefit associated with gifts, challenges to the narrow definition of gratitude emerge. One challenge is related to the dissociation of a narrow understanding of gratitude from the historical discussion of other important moral concepts, such as duty, obligation, and reciprocal indebtedness. Further, when gratitude is narrowly understood as a reaction to a specific benefit, its connection to morality is severed; gratitude is then appreciated for its instrumental value rather than being appreciated for its own value.\textsuperscript{146}

One reason for the dissociation between gratitude and moral discourse is attributed, according to Fitzgerald, to posing the wrong philosophical question. Usually, the discussion seeks to answer the question of when gratitude is owed so that those who were treated with ingratitude may complain. However, Fitzgerald contends that the discussion should rather focus
on seeking moral reasons for being grateful; and there are a plenty of them because of the importance of gratitude for the flourishing of individuals and communities.\textsuperscript{147}

Here lies a seed for change in the ethos of medicine.

\textit{III.B.5. Extending the Narrow Definition}

Therefore, Fitzgerald builds on the Buddhist tradition (but not without support in other religious traditions and even secular mindsets) and contends that gratitude is warranted in at least two cases which fall below the radar of contemporary philosophical discussion. He maintains that gratitude is warranted toward those who harm us and toward those whom one benefits.\textsuperscript{148}

In the first case, having gratitude toward those who harm us may not be directly related to the discussion of this dissertation. Yet, gratitude in this case is not without philosophical justification and significant ramifications, especially when considering the “nonidentity problem.” This problem highlights that without certain persons, state of affairs, and unintended sequences and consequences of historical events a certain individual may not have existed. Therefore, this person has moral reasons to be grateful toward those persons and events, although harm may have been intended in some cases.\textsuperscript{149}

Comparatively, having gratitude toward those whom one benefits is paramount to this discussion, especially in regard to the role of gratitude in shaping medical practice and systems. Gratitude in this case goes a bit further than the case of mutual benefit in gift-giving as discussed previously. Beneficence toward those in need benefits both the benefactor and the beneficiary; hence, beneficence, within this limited sense, is encouraged, mainly on utilitarian grounds. However, the philosophical argument advanced by Fitzgerald is built on finding moral reasons for showing gratitude toward those whom one benefits. He argues that such gratitude is common
in various social contexts and is felt by volunteers, those who do community service, and is warranted even in medical practice.\textsuperscript{150}

Three moral reasons are garnered. (1) Specifically in the Buddhist tradition, compassion is central to the spiritual growth of followers. Thus, when compassion motivates an individual to be beneficent toward others, she should be grateful to them since they offer her the opportunity to feel compassion. (2) The beneficiary is unintentionally benefiting the benefactor; if it was not for the need of the beneficiary, the benefactor would be absorbed in her self-centered interests. (3) Gratitude is warranted to prevent harm. In any one-directional exchange, the beneficiary occupies a disadvantaged position because of her need. Benefactors stand on strong grounds because of their charitable work. However, when benefactors give with gratitude toward their beneficiaries, they prevent the psychological harm that is usually associated with receiving charity.\textsuperscript{151} Fitzgerald most recently extended his argument even further to defend a sense of gratitude toward things, body parts, and other non-rational beings. He rightly insists, in both his arguments, that gratitude toward (being grateful to), rather than mere gratefulness (being grateful for), is the right attitude.\textsuperscript{152} Gratitude opens the door to meet the other in her otherness and to see her (even things) in different lens; gratefulness to the state of affairs or sequence of events remains self-centered in some sense (it is about being grateful for how things worked out for my own benefit, but not ultimately having gratitude toward persons or things).

\textit{III.B.6. Gratitude in Medicine}

These moral reasons are fundamentally relevant to medicine. On the one hand, patients will, expectedly, have gratitude toward their physicians, nurses, and other healthcare workers and institutions. In their case, the narrow understanding of gratitude applies; patients receive a well-
intentioned benefit from their providers, regardless of the financial exchange taking place in the background.

On the other hand, because of the looming existential threat of death (death is concealed in every sickness), patients may approach their benefactors/physicians with a sense of inferiority where their dignity may be at stake. To mend this imbalance, physicians (and other healthcare workers) have many moral reasons to approach their patients with gratitude. (1) Physicians should approach their patients with compassion (as will be discussed in the next chapter) to safeguard their vulnerability. (2) Physicians’ gratitude is necessary to remind them of the goal of their profession -which is serving those who are most vulnerable- rather than mindlessly occupy themselves in advancing science for its own sake (or for any material gain). (3) Without a sense of gratitude, medical practitioners may fall prey to cynicism and become numb to human suffering. (4) Most important is that when physicians approach their patients with gratitude, the human dignity of these patients will be best served and safeguarded. In a similar vein, when gratitude is warranted toward things and body parts, physicians and medical researchers would have moral reasons to show gratitude toward genetic material because of the benefit they may derive from it. Thus, gratitude may even shape how medicine handles human material, body parts, cells, genes, and embryos.

In general, gratitude plays a central role in cultivating moral communities. The interplay between gratitude and history in Buddhism, for instance, orients the emotional lives of believers toward the past to shape a moral community in the present. It is maintained in these communities that without the efforts of previous faithful, contemporary communities would not have a path forward. This idea is not foreign to Orthodox Christianity; the living memory of the divine redemptive work engenders a synergic relationship between humans and God and at large the
church’s mission in/toward the world. It is by the gratitude nourished in Eucharistic celebration that the brokenness of humanity may be mended.  

This applies to the medical community in a similar manner. Without the historical contribution of many generations of practitioners (at some point most of them were quacks according to contemporary criteria) and patients (some of them were really hurt rather than benefited) medicine as known today would not have existed. Therefore, as a community, medical practitioners need gratitude to shape a moral community centered on serving other dignified human beings. Further, at the personal level, clinical practitioners need to approach their patients with a similar gratitude, so that the dignity of those patients is safeguarded.

III.B.7. The Dark Side of Gratitude

Despite the positive impression it may leave, gratitude has a darker side that cannot be ignored. Although some negative aspects of gratitude may not be related to gratitude per se, and some are not directly related to the discussion of this dissertation, it is warranted to briefly mention some of them. Objections to the adopted broad definition of gratitude, that which demands gratitude toward one’s beneficiaries, are expected. Only beneficiaries receive a tangible benefit and they are to be grateful rather than their benefactors. However, as Fitzgerald argues, benefactors have moral reasons to show gratitude rather than having an obligation to gratitude. Furthermore, starting from the narrow definition, some philosophers warn against the possibility of offensive gratitude (when the benefactor is doing what a decent human being is expected to do), misplaced gratitude (when the alleged benefactor, for instance, did not intend any benefit toward the beneficiary), and foolish gratitude (when the beneficiary has gratitude toward an abusive or oppressive “benefactor” because of her low self-esteem and expectations).
Moreover, gratitude, regardless of its definition, may encounter opposition that is not directly related to it. Gratitude is usually opposed in an individualistic culture that idolizes autonomy and self-sufficiency and categorizes gratitude as a humiliating emotion. In such society, a sense of entitlement and a fear of dependency may thwart moral motivation toward gratitude. By the same token, when the language of rights is understood as setting a moral agenda (contrary to the argument of this chapter), one may not feel obliged to have gratitude because what she receives is owed to her as a right. Thus, it is arguable that further empirical studies on general attitudes toward gratitude is necessary to better understand its social role and how to nourish its presence.

IV. Conclusion

Building on an Orthodox bioethical phronema, this chapter discussed the first mid-level principle as a common ground for global bioethics. Respecting human dignity derives from the kinghood of Christ that is transferred to every human being because of their creation in the divine image and should fashion their mission in the world. Respecting human dignity, it was shown, is also supported in secular discourse of bioethics and opens the door to shape an ethos in which the language of human rights is a tool to show respect to every person. At the practical level, establishing a social understanding of human dignity is central to highlight the nature of dignity as a gift and the many moral reasons to foster gratitude in society. In medicine, as an enterprise and as a clinical encounter, gratitude is necessary because of how human life and medicine seem entangled in a globalized world. Therefore, gratitude is argued to be cardinal to illumine the various aspects of medicine (along with compassion and solidarity), such as its research agenda, public policies, and educating new generations of practitioners. These practical aspects will be further discussed in the sixth chapter.
14 As quoted in Harrison, “Gregory of Nyssa,” 338.
28 Harrison, “Gregory of Nyssa,” 333-44.
32 Kateb, Human Dignity, 174-217.
39 Barilan, Human Dignity, 93-147.
40 Kateb, Human Dignity, 1-27.
41 Kateb, Human Dignity, 113-173.
43 Kateb, Human Dignity, 1-27.
45 Rosen, Dignity, 1-62.
47 Kateb, Human Dignity, 1-27.
48 Rosen, Dignity, 1-62; Andorno et al., “Human Dignity.”
49 Rosen, Dignity, 63-128, 129-160.
50 Barilan, Human Dignity, 93-147.
51 Barilan, Human Dignity, 93-147.
52 Kateb, Human Dignity, 1-27.
53 Rosen, Dignity, 1-62.
58 Rosen, Dignity, 1-62.
60 Barilan, Human Dignity, 93-147.
62 Barilan, Human Dignity, 93-147.
64 Patricia S. Churchland, “Human Dignity from a Neurophilosophical Perspective,” In Human Dignity and Bioethics, ed. A. Schulman et al. (Washington, D.C., 2008), 99–121.
65 Rosen, Dignity, 63-128.
66 Barilan, Human Dignity, 1-22.
67 Barilan, Human Dignity, 93-147.
68 Barilan, Human Dignity, 1-22.


Andorno et al., “Human Dignity.”


Rosen, *Dignity*, 63-128.

Similar to Andorno et al., “Human Dignity.”


Andorno et al., “Human Dignity.”


Andorno et al., “Human Dignity.”


103 Turner et al., “Vulnerability, Diversity and Scarcity,” 663–70.


130 Fagley, “Construct of Appreciation,” 70.
133 Emmons, “Is Gratitude Queen,” 141–53.
144 Emmons, “Is Gratitude Queen,” 151.
146 Emmons, “Is Gratitude Queen,” 141–53.
147 Fitzgerald, “Gratitude and Justice,” 119–53.
150 Hilfiker, “Unconscious,” 3155.
CHAPTER FIVE: THE MEANING OF HUMAN VULNERABILITY: A SYSTEMATIC INTERPRETATION

This chapter will elaborate on the second of the three concepts central to the advocated Orthodox Christian bioethics and the common ground for an inclusive global bioethics. The understanding of human vulnerability will be discussed within Orthodox Christian theology and secular bioethical discourse, as it derives from the universal embodied experience of all human beings.¹ The goal is to promote a content-full bioethics that nourishes compassion in healthcare. Ultimately, compassion can play a significant role in shaping medical practice at the clinical level. In combination with gratitude (from the previous chapter), it shall model medical education and systems to meaningfully care for those close to their death.

I. The Theology of Vulnerability in Orthodox Bioethics

This section will explore a theological understanding of human vulnerability within Orthodox Christian hermeneutics and its practical ramifications to ameliorate human suffering.

I.A. A Christocentric Hermeneutics for Human Vulnerability

I.A.1. Christ the Prophet

In the previous chapter, the kinghood of Christ was explored in Orthodox theological *phronema* to connect it to respecting human dignity and its relation to gratitude. In this chapter, the prophecy of Christ is explored as it relates to human vulnerability and compassion. Christ the prophet has revealed himself in two stages, first within the Old Testament and then after his incarnation. His prophecy reveals God to the created world and the divine providence to save it.²
In the time of the Old Testament, God chose numerous prophets to announce the divine word to the chosen people. In their prophecies, those prophets did not fore-tell the future; they rather situated the daily experience of the people of God, favorable or not, within the entire providential economy.\(^3\) One theme runs through the prophecies of the Old Testament; it is a reminder of how God called his people and frequently saved them through philanthropy (love toward humankind). Without the life-giving divine philanthropy, the chosen people would have perished.

When the Son of God incarnated, himself being the Word of God (John 1), the divine revelation was fully proclaimed in the person of Jesus Christ. Throughout his salvific indwelling among humans, Jesus Christ reiterated the prophetic message of the Old Testament by highlighting the mortality of the humankind due to its disconnection from the living God. However, it takes a divine savior to change the *status quo* and to re-establish that relation. Therefore, Jesus Christ acquired the entire human nature (save sin) and submitted himself to the universal human experience of death so that he may redeem all those who were bound to death for ages. In his philanthropic death on the cross, Christ has revealed the Almighty God to be also vulnerable; God has loved the world to the extent that Christ died for the entire world to have everlasting life (John 3:16). Christ’s submission to vulnerable death saves humanity of its ultimate enemy, death, and straps it of its thorn. In short, what shows as vulnerable submission to death out of true love and solidarity leads to resurrection and ever-lasting life. Only true love defeats death.\(^4\)

**I.A.2. Human Fallenness**

Although humans were originally created in the divine image and aspire to become God-like, the disobedience of the human ancestors has changed the human condition since then. As
previously discussed, church fathers perceived this change within a communal mindset rather than a legalistic one. The ancestral sin was more about breaking communion with God through disobedience rather than breaking a legal rule which deserves a proportionate penalty. In freely choosing to disobey God, Adam and Eve separated themselves from the only source of life, thus leaving a room for corruption and death to occur.

Therefore, illness and death are not understood in the Orthodox Church as legal punishment proportionate to the sin. Rather, corruption, illness and death are a “natural” (though originally unintended by God) consequence to the free disobedience of the human ancestors. God did not intend for illness and death to afflict humanity. It is understandable from the creation narratives and many church fathers that humans were originally created incorruptible and immortal as long as they were in communion with God. However, due to their sin, Adam and Eve would exchange their ingrained yearning toward God with a distorted desire to become gods apart from God (Gen 3:5) and to enshrine idols of themselves. What the offspring of Adam and Eve inherit is not their sin, rather the result of that sin, namely corruption and death. Humans since then are under the bondage of death, and because of their existential fear of death, they continue to sin and perpetuate corruption and death. In the words of St Paul: “The sting of death is sin, and the strength of sin is the law “(1 Corinthians 15:56).

Along with human mortality as a source of vulnerability, sinfulness puts humans in vulnerable situations due to distorted desires leading to greed, anger, hatred, and exploitation. Because humans fear the existential threat of death, they compensate by asserting their might (when they can) through using others for their own benefit. Hence, political systems are necessary in any society to protect humans from each other, because humans frequently fail to treat each other with the same dignity with which God treats them. In the same vein, the
weakness of the human will manifests in the universal human inclination to develop strong identity and to emphasize individual autonomy. St Paul shows the human fallen status in saying: “For what I am doing, I do not understand. For what I will to do, that I do not practice; but what I hate, that I do” (Romans 7:15).

In Orthodox Christian monasticism, human fallenness and death are experienced within a disciplined context in search for healing. Authentic spiritual living in a monastery unveils that humans are not only vulnerable because of their mortality, but they are also vulnerable in facing their sinful spiritual passions. While passions (pathos) are originally meant to serve a lofty goal of fueling a “passion-ate” love toward God and “com-passion” toward the entire creation, human fallenness distorted their compass. Therefore, rather than cultivating virtues, passions have nourished vices. To mend this universal vulnerability and grow spiritually, the monastic tradition emphasizes the importance of knowing one’s own vulnerability and assuming the vulnerability of others by bearing with them their burdens (Galatians 6:2). In other words, to grow spiritually closer to God-likeness, one should stand in solidarity with other persons while recognizing the universality of human vulnerability.

I.A.3. Illness, Suffering & Death

As a result of the new human condition, health is only precarious. In a comprehensive study of the theology of illness and suffering, Jean-Claude Larchet, a contemporary Orthodox theologian, contends that “‘health’ is always in some sense ‘illness’ that has simply not appeared as such and/or is not significant enough to be identified as such.” This understanding leaves a room for a positive perception toward illness. On the one hand, illness cannot separate humans from God; it is actually a result of the separation caused by the fall. On the other hand, health
is only good in appearance. Health may give a false sense of self-sufficiency which would perpetuate the human separation from God.\textsuperscript{13}

Therefore, in line with many church fathers, Larchet advocates a positive perception toward illnesses; human illnesses may be “cathartic” in that they foster humility, patience and hope through debunking illusory self-sufficiency and independence.\textsuperscript{14} Moreover, the patristic consensus, Larchet explains, emphasizes that illnesses are not directly related to the personal sins of the afflicted. Nonetheless, a few church fathers contend that personal sins and lifestyle may still directly cause someone to fall prey to certain diseases.\textsuperscript{15} In general, church authors highlight that sickness is a reminder of human mortality where death itself is an “educational experience.”\textsuperscript{16} Sicknesses remind everyone of the vulnerability of the human body and its susceptibility to the corruptible forces of nature. It is because of the looming death and its existential threat that suffering may occur.

Therefore, suffering is an existential experience with holistic spiritual repercussions.\textsuperscript{17} It is an experience which afflicts the entire person, not only her body. In Christian theology, the person exists in a unity of soul and body contrary to the Cartesian dualism which shapes contemporary culture. Hence, when afflicted with a serious illness, one suffers because of the disruption in life conditions and relationships especially because of the growing isolation from self, others and God.\textsuperscript{18}

Perhaps, some of contemporary suffering is rooted in frustrated hopes in idolized medicine. Modern scientific medicine concentrates its efforts on diseases as phenomena isolated from the person who is afflicted which makes it difficult for practitioners to address the concurrent existential anguish. By the same token, when contemporary culture idolizes medicine and enthrones physicians as the new saviors of humanity, it fuels false hopes in those who are
It is ironic that whenever humans claim, in self-aggrandizing hopes, their dominion over human body and diseases, they betray the lurking vulnerability of their existence. Nonetheless, when suffering is perceived against the background of human fallenness and divine providence, those who suffer may have a way to extract a positive outcome. It is through patience, prayer and thankfulness that a faithful afflicted person may get closer to God. By the same token, those who witness the suffering of others are invited to get closer to God through respect and openness toward the afflicted; among those faithful afflicted people may be another Job in the making. By so doing, witnesses will learn a great deal from the afflicted one’s perseverance so that they may grow in their own spiritual life. Moreover, when vulnerability, illness and suffering are embedded within the divine providence to save humanity, death itself acquires a positive meaning. Death for Orthodox theology is a “defining moment, not end but beginning” which should shape the human perception toward life and what deeply matters in the end.

Similar to Orthodox Christianity, all other religious traditions perceive vulnerability as ontological to the human condition, especially because of human mortality. However, religious communities recognize that some people are more vulnerable than others because of their social standing, especially children, women, the disabled and the elderly. This understanding of vulnerability encourages religious communities to pay special attention to the needs of the most vulnerable among them regardless of how different their responses may seem. Further, religious communities recognize that vulnerabilities are not solely related to medical or health issues but are embedded within the social circumstances of each community. Similarly, non-religious perspectives on vulnerability are rooted in the universal and unifying embodied experience of life by every human person regardless of their cultural particularities.
Notwithstanding the care afforded to the vulnerable within their communities, religious, social, and cultural practices may themselves expose the vulnerable to further exploitation because of the fallen nature of humans; natural vulnerabilities are ameliorated on the one side, but interpersonal vulnerabilities may be further exposed on the other.  

I.B. Mending Human Vulnerability

I.B.1. Mending Alienation

As it has been discussed previously, human vulnerability and mortality derive from breaking the communion with God. Therefore, to genuinely address the human condition, the existential gap between God, the only giver of life, and humans should be bridged. Further, after the human ancestors freely followed the Devil’s advice (*ho diabolos*: the divider), their alienation from God, other humans, and within the self, took hold.

Human alienation from each other first manifested itself during the exchange of accusations which took place after breaking the divine command. Adam accused Eve of leading him into sin. Eve, who was until then “bone of my bones and flesh of my flesh” for Adam (Gen 2:23), became “the woman whom you [God] gave me to be with me” (Gen 3:12). Similarly, Eve accused the serpent of tempting her into eating of the tree while evading any responsibility of her actions saying, “the serpent deceived me, and I ate” (Gen 3:13). This alienation continues to this day among humans through greed and selfish exploitation of others for one’s own pleasures and benefits. Therefore, enmity and conflict with others are much more existentially rooted in the human condition than in mere moral strangeness; moral strangeness is the outer layer of a much deeper strangeness among humans.

At the personal level, estrangement similarly afflicts the human will and embodied identity. On the one hand, humans have a weak will because of their fallenness. Thus,
contemporary attempts, in medical context or elsewhere, to emphasize the power of human autonomy or decisiveness overlook the existential weakness of decision-making and internal conflicting desires. On the other hand, personal embodied unity is severed when humans are exposed to the nihilistic threat of diseases and death. Although humans do not recognize this threat until they bluntly face their existential frailty, alienation lurks inside the self and threatens its soul-body unity.27

To mend this ingrained alienation, the Son of God took the human nature in its entirety (save sin), in a “self-risking” initiative,28 in order to bridge the existential gap between the divine and created realities. Through genuine divine and compassionate love that defeats death, he opened the door for humans to re-establish their lost relationship with God.29 Through suffering with humans (compassion), Christ was able to heal humans from their death. Thus, humans have a new way to perceive death: death as a beginning of a renewed itinerary toward God rather than as an end to life and its meaning.30 In the same vein, any attempt by humans to heal the human condition aspires the reconciliatory mission of Christ. Christ opens the door to defeat death without eliminating mortality and corruption. He leaves intact human freedom and gives a different meaning to human attempts to encounter mortality.31 In short, Christ mission to heal vulnerability and mortality reminds humans that the problem is not health or illness, rather its sin and the consequent alienation from God, humanity, and the self.32

I.B.2. Principles to Face Death

When sickness and mortality became ingrained into the human condition after the fall, humans used all available resources to heal their affliction and fend off death. Traditional medicine and its most recent scientific interventions were among the promising havens, though with limited success.
Similar to many religious communities, the Orthodox Church coexisted with medicine for a long strand of its history, from the time when practitioners used herbal and primitive unscientific methods to the time when the art of medical care was interweaved into science. While contemporary Orthodox theologians do not propagate any specific medical diagnostics or prognostications, they express favorable perception toward medicine and its practitioners. In general, this has been the case with Christianity since its very beginning. Christianity was known to many outsiders as the “religion for the sick” because of many believers who took care of outcast and absolute strangers in times of plagues. Similarly, Christian communities in Byzantium modelled the first known hospitals and shaped hospitable care systems for the sick and suffering. Moreover, many Christian saints are still celebrated for their inspiring practice of medicine and the healing they accrued to their patients through spiritual advice and genuine care. These saints are known to be ‘unmercenary’ in that they received no monetary compensation for their care. They modelled genuine care that was the ultimate expression of the virtue of charity.

In general, Orthodox theology emphasized, in action and in theory, that the true healing comes from God since Christ is the true physician of the human body and soul. Even the availability of herbal medicines, the art of extracting them and their beneficial use are meant and inspired by God for the sake of healing humanity.

Therefore, to face human illnesses and death, the Orthodox Church does not reprimand those who seek medical attention to their ailments. Contrary to this general rule, some extreme opinions in the Orthodox Church, though not representative of the entire tradition, understandably prefer not to seek medical treatment. These authors, especially within the monastic tradition (but still not representative of all monastics), encourage a positive welcoming of sickness as a source of healing to the soul rather than seeking medical treatment. The
underpinning idea for these opinions is rather understandable and shared among church fathers, which is that life should be lived only toward God. Therefore, it would be better not to have health back, if after restoring health, those who were afflicted feel self-sufficient and in no need to God (thus alienating themselves from God again). In other words, a healthy life not lived toward God is not an absolute good which should be pursued at all cost. Within such mindset, medical treatment -whether successful or not- should inspire humans to seek the true healing of the human condition rather than a temporary (however long it may be) cure of certain diseases. This is a reminder to be wary of enshrining medicine or its practitioners as the new saviors of humanity.

At a more general level, Orthodox spirituality perceives mending human alienation from God as a two-directional effort. While Christ did his part through incarnation, death and resurrection, Christians have to live their lives spiritually (in accordance with the Holy Spirit, not according to an elusive pietism) so that they may truly heal. In Orthodox monasticism, where spiritual living is constantly sought, asceticism respects the embodied experience of humans and does not deny material needs. Human body is central to the imago dei and is the dwelling place of the Holy Spirit, the focal point of transfiguration and sanctification. Hence, asceticism sublimates the meaning of human needs and redirects them toward God.

One principle is paramount to Orthodox asceticism, for monastics and lay people alike, namely constant and silent (hesychastic) remembrance of death. Through silence (hesychasm), a Christian may be able to know herself, especially her fundamental need for others. A need for others is not only related to the provision of material necessities; rather more importantly, others are necessary to know one’s own self. Furthermore, through remembering death, a Christian is training to recognize the vulnerability of her life and its inevitable mortality. It is through
embracing one’s own vulnerability and inevitable mortality that one is able to recognize the fragility of every human life and to embrace those who are suffering with sincere compassion and solidarity. In other words, it is only through embracing one’s own vulnerability that one is able to recognize what unites her with every other human being, namely their mortal existence. It is the recognition of the frailty of their mortal existence that brings human beings together rather than an impeccable rational consensus.

As a result of avowing one’s mortal life, one can assume the vulnerabilities of others and strive to relieve their burdens (Gal 6:2) as a stipulation to grow spiritually in God-likeness. In Dostoevsky’s *The Brothers Karamazov*, this collective responsibility to mend human vulnerability in particular persons surfaces in the words of Starets (Elder) Zossima when he says: “Each of us is responsible before all, for everyone and for everything.” Therefore, when they have to handle rising bioethical dilemmas, Christians should remember that Christ did not heal human mortality through his miracles but through exposing his loving vulnerability, suffering, death and resurrection. Moreover, in facing death, Orthodox theology values human life inasmuch as it fosters a respect for death, the only certain companion to human life. Within such *phronema*, theologians and ethicists emphasize that human worth is not derived from an enjoyable wealth of rights but rather from universally embracing humans when they are most vulnerable.

In short, to address bioethical dilemmas, Orthodox communities start from an ascetic and liberating spiritual *phronema* that is sensitive to the most vulnerable and marginalized wherever they are. More importantly, out of this *phronema*, Orthodox communities should assume the responsibility to change their circumstances. Especially near death, the responsibility shifts from those who are dying (to autonomously protect their interests) to those
who accompany and care for them. Similar to Christ’s mission, with compassionate care, i.e. suffering with those who suffer, humans are able to ameliorate the vulnerability of those who suffer in all circumstances and especially before their looming death. Ultimately, “compassion is the potentiation of the *imago dei*” in all humans.  

**I.B.3. Realist Dimension of Iconic Phronema**

While on the one side of icons is depicted the eschatological reality of this world, on their other side stands the beholder and the entire created world. To extend a meaningful invitation, the theology of icons recognizes the fallen reality of this world. On the one hand, icons extend an invitation to the entire world. When Christ took a human body, he embraced the entire created (material) reality as his body so he may bring salvation to the whole world not only the humankind. On the other hand, iconographers use the corruptible materials of this world to depict the ineffable divine reality. Some theologians even believe that the world itself (despite its corruptibility) is an icon of the divine reality. However, it is the responsibility of the faithful beholder to unveil the iconic dimension of the world. Similarly, it is the responsibility of the faithful beholder to perceive in every other human being the divine image, regardless of how far from God the latter may seem.

Therefore, using an iconic *phronema* in bioethical discourse would necessarily expand the mission of bioethics beyond its current narrow agenda. Bioethics was meant to connect the biological sciences (*bio*) to the moral heritage of humankind (*ethics*). The ultimate way of bridging these two dimensions is the icon; only the icon unfolds the ultimate meaning of the creation while profoundly understanding its current fallen status. In perceiving the current world through the lens of icons, the Orthodox Church cannot ignore prevailing iniquities. Clearly, the world is plagued by corruption and death. Suffering and injustice are everywhere. Pluralistic
perspectives are the norm, while interdependence among various groups is unavoidable. Strangeness in the world is the result of human fallenness rather than pure rationalistic disagreement or cultural diversity. In a globalized world, human vulnerability is frequently exploited and environmental degradation is threatening the survival of the human race. An iconic phronema takes on the responsibility to extend a divine invitation to save the entire created reality. Similarly, an authentic Orthodox bioethics cannot overlook the plight of the human race and the environment and dwell upon the narrow agenda of mainstream bioethics. An iconic phronema has to be hospitable in that it prophetically reminds the world of its mortality and strives with sacrificial and Christ-like love to overcome human alienation from God and from each other. It is only through highlighting the role of compassion, i.e. suffering with the other, as Christ did, that the world may be saved of its innate mortality.  

As a result, an authentic Orthodox bioethics should be at the forefront of global bioethical discourse to highlight the common anthropological ground among various experiences of life and death. An Orthodox bioethics should also be activist in that it aspires the hospitable iconic phronema to tend to the needs of the most vulnerable human beings. It is missiologically prophetic in that it brings the good news to the entire world through redefining the misunderstood bioethical concepts. On the one hand this mission is propelled by a vulnerable love that is open to dialogue with the different other. On the other hand, it is the responsibility of the royal priests of the community to show the face of Christ in the midst of a politicized bioethics discourse. Hence, rather than perceiving freedom as the freedom of the market, an Orthodox bioethics emphasizes the ascetic freedom of those who perceive the world as an icon. Similarly, rather than perceiving bioethics as a legalistically binding enterprise, an authentic Orthodox bioethics brings the experience of Christ to the world through mercy and
Further, Orthodox theology avoids extreme positions because they imbed distorted premises. Orthodoxy condemns the idolization of biological life and individual autonomy in the clinical setting. Both cases negate the divine providence to save all humans and overshadows the Orthodox genuine hope in resurrection at the deathbed. It is therefore, the responsibility of Orthodoxy and all religious communities to prophetically teach medicine “to be present to those who are weak by accepting our finitude and vulnerability.”

II. The Anthropological Implications of Vulnerability for Secular Bioethics

Under this section, the concept of human vulnerability will be discussed as it relates to the prevalent secular bioethics discourse. As a new concept in bioethics, human vulnerability is supported within a non-religious mindset which would bolster the argument for a meaningful global discourse in bioethics. The premise of this secular discussion is the fundamental connection between vulnerability and dignity as if they were two sides of the same coin; if humans were not invaluable, there would be no need to worry about them when they are vulnerable.

II.A. Human Vulnerability in a Secular Mindset

II.A.1. What is Vulnerability

The word “vulnerability” is related to the Latin verb “vulnerare” which means: wounding and the noun “vulnus” meaning wound. Vulnerability refers to the possibility of being easily hurt, influenced or attacked by others or by natural events. When vulnerability refers to humans, it highlights their fragility and innate finitude. However, being vulnerable in a certain context refers to two related possibilities: a possibility of being harmed and a possibility of being protected from the impending harm, regardless of the nature and severity of the harm itself.
Vulnerability as a concept is usually used in technical contexts to refer to the precariousness of the particular system and the possibility of manipulating or harming it. In medical context, human beings are vulnerable to a certain infection, for instance, because of other comorbidities (susceptibility of their bodies), because of exposure to certain pathogens, and/or because of the fragility of their defense mechanisms. Similarly, but to a lesser extent, military personnel use vulnerability to refer to weaknesses of a certain system which allow for exploitation by the enemies.

To challenge mainstream bioethics, Henk ten Have offers a thorough study of vulnerability and its use over the past few decades. He discusses examples of four groups of vulnerable people to highlight several points on the use of the concept of vulnerability. In any society, (1) seniors and (2) homeless people are vulnerable to exploitation and harm because of their life circumstances especially the unavailability of effective social support systems and necessary protective relations. (3) Some medical research subjects may be vulnerable to harm not only because of their inability to make informed choices but also because of the nature and content of their choices which put their life in jeopardy. At a larger scale, (4) entire countries and cultures may be vulnerable because of geopolitics, global injustices, and environmental degradation to only name a few detrimental factors. Therefore, ten Have argues for a comprehensive exploration of the term because of its broad applicability and possible normative implications.

**II.A.2. Dimensions of Vulnerability**

Contrary to the narrow medical use of vulnerability (susceptibility to certain diseases), the above examples unveil a broader understanding of vulnerability. The following three dimensions of vulnerability are recognizable: (1) Vulnerability is applicable to individuals,
groups of people, communities and countries. At this dimension, although harm manifests at the individual level, vulnerability is not limited to individual persons.\textsuperscript{69} (2) There are many types of vulnerability which can affect people at various levels at the same time. Individuals and communities may be vulnerable to physical, psychological, social, economic, and environmental harmful factors. Therefore, it depends on their ability to cope (on the short term) and adapt (on the long term) with these factors to prevent harm. (3) Internal and external factors also play a role in shaping the vulnerability of different individuals and groups of people. To be exposed to harm, it may not be related to making the wrong choice but rather to certain external factors which influence the number and quality of available choices. These dimensions promote a necessity to understand vulnerability in terms of its dynamics rather than in terms of who qualifies as vulnerable or not.

\textit{II.A.3. Functions of Vulnerability}\textsuperscript{70}

To have a comprehensive and useful understanding of vulnerability, Henk ten Have advocates a functional, rather than a descriptive, definition. By exploring its functional dimensions, one is able to understand the dynamics that put certain people under the threat of harm rather than indiscriminately labelling certain groups.

In general, vulnerability is functionally a result of the following three components together: exposure, sensitivity, and adaptive capacity. (1) In the first place, one should be exposed to some external factor that could harm her. (2) She has to be sensitive to the afflicting factor so that she may be harmed by its effect. And, (3) the afflicting factor is going to be harmful either because she was not able to avoid the looming harm or because she has no ability (or has ineffective ability) to adapt to the changing circumstances.
In general, Henk ten Have explains that vulnerability is understood either from a political or a philosophical perspective. These perspectives differ because they emphasize a certain component of vulnerability rather than the other. A political perspective on vulnerability concentrates on the social context of the vulnerable person and highlights the role of external factors in causing harm. Consequently, to alleviate human vulnerability according to this perspective, society should limit the exposure of its citizens to external threats. However, a philosophical perspective on vulnerability centers on the innate sensitivity of all human beings to be harmed. Therefore, to protect their vulnerability, society should decrease the sensitivity of its members to harmful factors and enhance their adaptability and resilience in the face of possibly harmful changes to their circumstances.

**II.A.4. Globalization & Vulnerability**

The discussion of vulnerability is gaining ground especially because of globalization and its mechanisms which are changing the lives of many people around the world. Globalization is exposing the vulnerability of more people because of its effect on two of the above-mentioned components of vulnerability, exposure and adaptability.

On the one hand, globalization is forcing more people into its exchange dynamics and, in some examples, is limiting the number and quality of their available choices. In the previous chapter, the discussion of human dignity led to the exploration of some of these exchanges under the auspices of medicine, such as surrogate motherhood in India and pharmaceutical research in African countries. In these examples (and many similar ones), not only the dignity of these people is threatened but also their vulnerabilities are exploited because of the numerous faceless relations they are -almost- forced to enter. On the other hand, because of the evolving global economics, more people are seeking better opportunities outside their native communities. Their
new circumstances deprive them of their indigenous support system and alienate them away from their protective communal relationships. These evolving circumstances are detrimental to the adaptability of many individuals leaving them more prone to exploitative relationships and exchanges.

Generally speaking, globalization has unveiled that the vulnerability of many individuals is more fundamentally related to their social matrix than to their perceived ability of making “good” choices. This new global reality establishes new responsibilities for physicians and healthcare workers whose ultimate goal is the amelioration of human suffering. Geographical and political boundaries should not stop physicians from tending to the suffering of humans wherever they are,\(^72\) inasmuch as these physicians are able to help. Many examples of such missionary work by individual physicians are inspiring, such as the work of Dr Paul Farmer.\(^73\) In those same steps, the proliferation of educational programs in global health in developed countries (and limited resource environment) extends the mission of medical care beyond traditional geographical boundaries.\(^74\)

**II.A.5. Intertwined Political & Philosophical Perspectives\(^75\)**

To challenge the narrow agenda of mainstream bioethics in a globalized world, Henk ten Have advocates a dynamic relation between the political and philosophical perspectives on vulnerability. While the social context is gravely important in exposing individuals to various harms (political perspective), human innate vulnerability and resilience are equally important in determining the extent of harm which would befall them (philosophical perspective). Through his analysis, ten Have argues that no one human being is invulnerable, and that it is impossible to eliminate all possible threats. Even science is not able to radically eliminate human vulnerability.\(^76\) Without the innate vulnerability, humans lose their humanity altogether.\(^77\)
Nonetheless, ten Have argues for a deeper positive understanding of human vulnerability rather than its prevailing negative and superficial impression as a sign of weakness. He highlights that communal relationships exist because of human vulnerability. When humans recognize their interdependence and their need for each other, they cooperate and stand with solidarity among each other. Even the culture of any given community is rooted in the recognition of its members of their vulnerability and their proactive production of a unique cultural heritage which defies the mortality of its passing members. In a few words, ten Have contends that a positive understanding of human vulnerability is warranted against its weak façade and is hence able to challenge the narrow agenda of mainstream bioethics. Vulnerability for him is not only an element of the human condition but it has a normative ethical implication that fosters a global discourse in bioethics.

**II.A.6. An Ethical Principle to Challenge Ethics Inquiries**

It has been argued by several philosophers that ethical inquiries are rooted in human vulnerability. Because of the universal experience of vulnerability, humans reflect on the responsibility of the bystanders when harm is about to befall a vulnerable individual. It is in these cases that normative moral demands are discussed. In the same vein, human vulnerability challenges the mainstream bioethical inquiry in a globalized world where boundaries for responsibility and exploitation are almost effaced. While vulnerability describes the human condition (constant and evolving), it also has a normative ethical dimension that cannot be ignored. First, vulnerability is conditional in that the harm is looming, but no harm has yet been inflicted on the vulnerable person. Second, by intervening, it is possible to prevent the harm from befalling that person. In this case, it is a harm that is prevented rather than a positive outcome that is expected through intervening. It is generally arguable that intervening to prevent harm is
more morally binding than intervening to accrue a benefit. That is why vulnerability has a
normative ethical dimension which should open contemporary bioethical discourse to its global
surrounding.

II.A.7. Compatible Orthodox Christian & Secular Understandings of Vulnerability

After briefly considering human vulnerability within a secular mindset, it is clear that it
has many similarities to the Orthodox Christian perspective discussed earlier. While humans are
innately vulnerable according to the philosophical perspective, Orthodox Christian theology
concurs and attributes that vulnerability to human mortality. Similarly, the political perspective
on vulnerability emphasizes the role of social dynamics in making some people more vulnerable
than others. Orthodox theology attributes that to the fallenness of human nature and the ensuing
distorted and exploitative relationships among humans. While political systems, from a secular
perspective, are necessary to guarantee a peaceful and just social order, Papanikolaou argues
that they are necessary because of “a failure on the part of humans to relate to each other as God
relates to each one of them.” Therefore, when political and economic exchanges span local and
national boundaries and facelessly exploit vulnerable people faraway, sometimes under the
auspice of medicine, addressing these emerging vulnerabilities becomes an urgent necessity for
global bioethics.

II.B. Human Vulnerability for Secular Bioethics

II.B.1. The Use of Vulnerability in Bioethics Discourse

The use of the concept of vulnerability in bioethics discourse is relatively new. Vulnerability first appeared in the Belmont Report of 1979 in an expert report written by Dr
Robert Levine. In 1982, the guidelines promulgated by the Council for International
Organizations of Medical Sciences (CIOMS) mentions vulnerability in the context of medical
research. The World Medical Association (WMA) does not include vulnerability in the lexicon of the Declaration of Helsinki until the fifth revision of 2000. In these early uses, the notion of vulnerability was not fully explained, and respecting human vulnerability was considered under the principle of respecting human subjects in medical research. Vulnerability was then narrowly perceived as an expression of impaired autonomy.

However, the status of vulnerability in bioethics has changed in 1990s perhaps because of growing globalization and its detrimental effect on many communities. CIOMS guidelines of 1991 advocate the use of vulnerability as a fundamental ethical principle connected to the principle of respect of persons. The use of vulnerability culminated in the UNESCO *Universal Declaration on Bioethics and Human Rights* of 2005. In this document, respecting human vulnerability is adopted as an ethical principle that is broadly applicable beyond medical research. For the first time, respect of vulnerability is not only an extra consideration in the context of respecting persons and justice; respecting human vulnerability is advocated as an ethical principle with a broad scope.

Conceptually, respecting human vulnerability in its earlier use hinged on one narrow understanding of its root, namely the “limited autonomy” of the vulnerable person. However, revisions of those documents included many more vulnerable groups of people whose vulnerability derives from factors other than their limited autonomous decision-making. These factors included insufficient abilities, intelligence, or education for those vulnerable individuals to protect their own beings and interests.

By the same token, the UNESCO’s Declaration adopts vulnerability as an ethical principle that combines the previously discussed philosophical and political perspectives. To address innate human vulnerability (philosophical perspective), it is warranted to respect its
universal and unavoidable applicability on every person. However, when certain socio-political circumstances expose the vulnerability of some people more than others (political perspective), proactive and active interventions are warranted to protect those who are most vulnerable. Therefore, the scope of vulnerability in the Declaration is broad in that it does not only apply to the context of medical research, rather it is relevant to the provision of healthcare in general. Also, vulnerability in the Declaration does not only pertain to individuals who are not able to consent, but it is applicable to families, groups, communities and populations who are not able, for intertwined social and global factors, to protect their interests and prevent harm.86

II.B.2. Challenges to Vulnerability in Bioethics87

Notwithstanding its broader use over the past few decades, vulnerability as a concept still faces numerous challenges especially regarding its implementation in bioethics discourse. Yet, these challenges do not deflate the importance of vulnerability as an ethical principle and its normative implications. Challenges to the implementation of vulnerability in bioethics are classified under four categories: its status as an ethical principle, its content, its scope, and its practical implications.

STATUS: Contrary to its earlier status in official international documents as another consideration to protect human research subjects, vulnerability is advocated as an ethical principle since the promulgation of the UNESCO Declaration. However, as an ethical principle, vulnerability may still be exploited within any political system as a side effect of protecting vulnerable groups. It is arguable that the development of a politics of vulnerability, where certain people qualify as vulnerable, may itself be very harmful; those whose vulnerability is not detected are usually the most vulnerable. Further, when vulnerability ethics concentrates too
much on protection and human weaknesses, it necessarily undermines human dignity and personal abilities.  

Notwithstanding these challenges, vulnerability has a normative moral dimension that qualifies it as an ethical principle which should be balanced against the principles of respecting persons, beneficence, and justice. The rise of vulnerability as a principle has been warranted at least for two reasons. First, it is because of the narrow emphasis by mainstream bioethics on personal autonomy. Second, it is because of the growing vulnerability of several populations around the world as a result of globalization, sometimes under the auspice of medicine itself (examples were discussed above and in the previous chapter).

CONTENT: The second challenge to vulnerability in bioethics is related to its content. Earlier official use of vulnerability included labelling many individuals and groups as vulnerable; however, it is not always clear in these documents the specific criteria used to do so. In mainstream discourse, especially pertinent to medical research, vulnerability refers to the impaired ability of certain individuals to make decisions and protect their own interests. However, autonomous decision making is fundamentally influenced by surrounding social circumstances which may affect the ability to choose and the quality of the choice. Therefore, vulnerability may be related to internal and external forces which influence the ability of certain people to make choices in addition to their adaptability and resilience.  

By the same token, some ethicists challenged the philosophical perspective on vulnerability and its universal applicability to all human beings. For instance, and contrary to the above advocated positive connotation of vulnerability, Martha Tarasco Michel does not perceive in the weakness associated with vulnerability any positive side.
**SCOPE:** The third challenge to vulnerability in bioethics is its scope. In the UNESCO Declaration, vulnerability does not only apply to individuals but also to families, groups, communities and even countries. At the individual level, it is understandable that certain groups are vulnerable because of their inability to make autonomous choices. However, in certain contexts, entire groups are systematically disenfranchised because of culture or poverty, for instance, that their vulnerability cannot be narrowly attributed to their choosing abilities. In general, it may not be easy to unfold all those relevant factors and circumstances that aggravate innate vulnerability. Similarly, by expanding the scope of vulnerability, it may not be meaningful to recruit it at the practical level (see below).

Notwithstanding these challenges, the expansion of vulnerability has at least one advantage. A broader scope raises interest in a more nuanced understanding of exacerbating conditions rather than labeling entire groups as vulnerable. At least, by so doing, stigmatizing certain groups of people as vulnerable is avoided.91

**PRACTICE:** The final challenge to vulnerability in bioethics is related to its practical implications. Understandably, an ever-expanding notion of vulnerability may water down its relevance and applicability in normative contexts. However, at the level of medical research, considering the vulnerability of various persons and groups demands extra moral justification to involve them in research. Further, when enrolled in such research, extra layers of protection should be deployed to avoid exploitation and harm. More important, though, is its relevance to contemporary global dimensions of medical practice. At this level, vulnerability challenges the prevailing narrow perspectives in bioethics and encourages an authentic global outreach in medicine and health provision. Recognizing the universality of vulnerability promotes solidarity.
and cooperation among all human beings, transforms the nature and scope of medical practice, and fosters global initiatives to improve the health and wellbeing of humankind.  

II.B.3. Vulnerability Challenging Bioethics

As discussed before, mainstream bioethics frames vulnerability in terms of individual impaired autonomy. Initially, bioethics discourse evolved in the context of medical research and it was essential to guarantee the autonomy of human participants. However, framing vulnerability narrowly in terms of autonomy severs its fundamental relationship to justice. While decision-making takes place at the individual level, the social background of these decisions is equally relevant.

To illustrate, a bioethics narrowly conceived does not alleviate human vulnerability. For one thing, such bioethics would only inspire interventions to guarantee the necessary elements for autonomous decision making. Vulnerable research participants are protected as long as the process of acquiring their consent guarantees their autonomous decision without any ‘outside’ influence. For another thing, a narrow bioethical agenda has nothing to do with external factors which influence decision-making abilities outside the ‘moment’ of seeking participant’s consent. For such narrow agenda, exposure (to outside influence) is a ‘momentary’ component of vulnerability inasmuch as the outside factor affects the decision made in that moment. In a few words, a narrow bioethical agenda does not recognize the universal sensitivity to be harmed and is only interested in the momentary exposure to outside influence. Mainstream bioethics inspires interventions that will improve the individual’s capabilities to make autonomous decisions without addressing systematic injustices and crippling exploitative relations and cultures outside the moment of seeking consent.
Contrary to its limited role in mainstream bioethics, it is arguable that vulnerability may positively influence the kind and content of bioethics discourse in a globalized and pluralistic world. Vulnerability motivates more cooperation and solidarity among various members of any given community and across national boundaries and ethnic differences. It fosters a serious consideration of the needs of the most vulnerable and motivates everyone to cooperate for the wellbeing of everyone. Furthermore, recognizing the universality of vulnerability helps healthcare workers bridge the gap that separates them from their patients and to compassionately care for them.

At a general level, innate vulnerability bridges the gap between individual and social interests by re-introducing and emphasizing other ethical principles such as human dignity, justice, solidarity and social responsibility. In regard to medical enterprise specifically, recognizing their innate vulnerability, physicians would care for their patients with growing authenticity. They would recognize (as will be further discussed in the next section) that the authentic answer to vulnerability is not to do something; rather, it is to have compassion, i.e. to suffer with, and to be silently present with the suffering other. Furthermore, in his exploration of the meaning of exploitation, Henk ten Have defines exploitation as “self-interested exercise of power.” This understanding of exploitation may be relevant to medicine as an enterprise; medicine itself is exploitative inasmuch as its personnel seek to advance medical knowledge to garner more social power rather than to serve those who are most vulnerable. Establishing universal vulnerability as central to bioethics discourse is arguably the antidote of this systematic exploitation (even when no one is individually harmed or exploited).

The next section will discuss the role which vulnerability can play to foster compassion in medical practice. It is arguable that compassionate care is rooted in the vulnerability of both
physicians and patients and is therefore fundamental to change the way medicine is taught and practiced. The next chapter will build on both human dignity and vulnerability in their relationship to hospitality to advocate for solidarity in medicine and healthcare systems. Unlike the argument of other authors who hinge solidarity solely on vulnerability, vulnerability can only be felt at the particular personal level which necessitates a compassionate and personal touch. However, solidarity is not particular in that it does not relate to specific persons but to a group of them (as will be discussed in the next chapter).

**III. A Systematic Interpretation of Human Vulnerability for Global Bioethics: The Role of Compassion**

To further the discussion on human vulnerability, this section will consider the central role that compassion needs to play in contemporary mechanistic medicine to ameliorate human suffering. It may bridge the gap between two equal fellow human beings and help their medical decision making. From the discussion pursued here, next chapter will extract practical elements for medical education and training.

**III.A. Compassion & Mechanistic Medicine**

In this section, the social standing of modern medicine and its scientific foundations will be discussed. The ultimate goal of this inquiry is to find the core of medicine, which is death, and connect it to compassion as the authentic core of medical care between two equally vulnerable human beings, physician and patient.

**III.A.1. Vulnerability; The Matrix of Medical Care**

So far, vulnerability has been established as a universal human predicament that has normative ethical demands on medical practice. Since patients approach physicians because of their clearly exposed vulnerability, physicians have a duty to ameliorate their suffering. Beyond
their professional duties, physicians, as human beings, naturally approach the suffering of their patients with compassion which is the default human response to suffering. However, for many reasons, physicians are lured away from this innate compassionate response and almost mechanically (in some cases) ‘fix’ their patients. Hilfiker regrets that medicine as a humanistic enterprise has drifted away from its original goal of serving the poor and marginalized and busied its practitioners in purely scientific (and profitable) search for mechanistic fixes of illnesses and suffering.\(^{100}\)

Therefore, to establish the cardinal role of vulnerability in medical care and its moral implications, it is necessary to explore the current social standing of medicine and the philosophical foundations of its scientific practice. The social status of medicine and its underpinning theoretical premises influence the way medical practitioners are socialized into the profession and the way they care for their suffering patients.

**III.A.2. Medicalization of Society**

Over the past few decades, especially in western but also in non-western societies, many social aspects have been medicalized.\(^{101}\) Paul Conrad defines medicalization as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorder.”\(^{102}\) This definition applies to many daily aspects of life in these societies. While earlier examples of medicalization targeted women in general, most recently, medicalization dynamics target more men through commercials and advertisements. By so doing, more medical products for andropause, baldness and erectile dysfunction are sold to men.\(^{103}\) Similarly, more adults are diagnosed with attention-deficit/hyperactivity disorder (ADHD) thus uncovering deep dynamics related to medical definitions, consumer demands, and pharmaceutical production.\(^{104}\) Conrad also discusses in details similar social trends related to
using human growth hormone for idiopathic short stature, aging, and athletic performance. These examples sample the growing involvement of medicine in human enhancement enterprise. In the same vein, while homosexuality has been de-medicalized for some time, there are many evolving social and technological factors which may lead to its re-medicalization.

Although it is difficult to measure the amount of medicalization in any given society for several reasons, Conrad contends that it has been rising since 1970s. Many factors play into the medicalization of some aspects of human life at a specific time. The availability of safe technologies or interventions may catalyze the medicalization of a certain bodily event; however, the discovery of associated risks may stop the use of these interventions without necessarily demedicalizing the public perception toward that event. Conrad refers to two examples of such dynamics, hormone replacement therapy and breast augmentation surgeries. When silicone implants, for instance, were used in augmentation surgeries, many women (and their doctors) rushed to use them for reconstruction after breast surgery and for aesthetic purposes. However, when their serious side effects surfaced, many practitioners and patients retreated from their use only for a while. When safer materials became available, the number of augmentation surgeries rose again. In this example, if one were to look solely at the decline in the number of surgeries using risky implants as a sign of demedicalization, one would miss the point. Breast augmentation surgeries were temporarily at bay because of risk; breast size was practically demedicalized because of risk, but was still conceptually under the jurisdiction of medicine until safer alternatives became available.

In general, many social factors played a significant role in fueling medicalization in the United States which may have been influential worldwide. For the first three decades since 1970s, Conrad argues, the medical profession, social movements, and inter- or intra-
organizational conflicts fueled the engines of medicalization. However, most recently, biotechnology, consumer demands, and managed care play a significant role in propelling the emergence and expansion of medical markets.

III.A.3. The Power of Medicine

The example of medicalization highlights the power of medicine in shaping society and redefining social goods. On a general note, it seems that medicine aims at defeating death and obliterating its grips on human life. It has even been argued that medicine occupies a central role in controlling the dying process in society using its powers. More people are dying in hospitals and under direct medical supervision than they were a few decades ago. At this same general level, economics and politics shape the practice of medicine at different levels, from the allocation of resources to funding certain research inquiries to the shift of social understanding of death as an individual decision in the name of personal autonomy. Seemingly, medicine shapes the social understanding of the normal human body and mobilizes resources to obliterate the abnormal.  

All these aspects reinforce the biopolitics of modern societies and dictate a certain social appreciation of human life and goods. Not only medical knowledge and its practitioners have political powers in any given society, but also afflicted patients and non-human organisms have similar powers because of their influence on the political affairs of their surroundings.

To curb modern trends of increasingly medicalized society, many critics highlight numerous relevant issues. On the one hand, medicine is not the only social good to improve health. Other disciplines and social interventions may have comparable benefits on improving the quality of life and longevity, such as public health measures and enhanced access to healthy food. On the other hand, it is out of arrogance on the side of medicine to claim that medicine has the right answer to death and dying. Because humans are innately mortal, medicine has so
far failed to fend off death (if at all possible) and it cannot dictate the meaning of death and the best human response to its inevitability; simply, these dilemmas are outside the jurisdiction of scientific medicine.

By the same token, to defend against the overreach of medicine over human bodily existence, critics discuss other ways of understanding human ailment. When technological biomedicine was deepening the sense of alienation among patients, biopsychological and then biopsychosocial approaches were adopted to humanely serve patients. Ultimately, a holistic bio-psycho-socio-spiritual approach through hospice care was the answer to an ever-growing interventional medicine and to the marginalization of death. However, it has been argued that this increasingly inclusive circle of interests falling under the auspice of medicine is fueling the power of medicine even more and unveiling the totalizing (and perhaps, totalitarian) power of medicine in society.

On the contrary, religious communities and theologians may have a different approach to the growing powers of medicine. For instance, D. Gareth Jones, a scientist by training, rightly argues that Christian theology and communities should contribute to society through demythologizing science and medicine. The universal idolization of scientific medicine blurs the uncertainties of medicine and human body and attributes to medicine, in the collective mind of society, goals which medicine and its practitioners cannot meet.

In what seems contrary to D. Gareth Jones’ perspective, Engelhardt is unjustifiably demanding from the Christian physician. He contends that: “The Christian character of health care should be salient, in that health care professionals must accompany patients in facing death and therefore should also support them in preparing to stand at the dread judgment seat of Christ.” Later in the same article he states: “In the newly established laicist secular public
domain, there is no room for Christian health care professionals to appear as Christian professionals and thus challenge the secular character of the public domain. In particular, Christian health care professionals are not, like the unmercenary physicians of yore, to pray with and help dying patients to *repent and prepare for death and judgment before Christ’s dread judgment seat*” (emphasis added).\(^{118}\) Engelhardt in these examples demands from Christian physicians what should be the responsibility of the community to which the patient belongs. Physicians are not priests to take care of what the priest (and the religious community) should be doing, only because the patient happened to be dying in a hospital ward. While trying to fend off ‘secular’ medicine from intervening in every aspect of human life, Engelhardt seems to seek even more power in the hands of physicians.

Therefore, it is warranted for religious communities in general, and Orthodox Christian community specifically, to demythologize scientific medicine and emphasize the uncertainty of human knowledge and life. To do so, questioning the goals of medicine and its theoretical underpinnings is paramount; this is in concurrence with other religious and secular voices.

**III.A.4. Theoretical Underpinnings of Scientific Medicine**

There are three levels at which theory plays a great role in shaping medical practice and social perception toward sickness and dying.\(^{119}\) Although modern medicine denies having a *metaphysical dimension*, “material and efficient causation” (what Marcum calls, “mechanistic monism”) stands at its heart. Scientific medicine perceives the human body as a machine that is governed by a chain of processes.\(^{120}\) This perception reduces the human body to juxtaposed organs working within different interacting systems where function rather than purpose is the focus of medical epistemology. In this vein, *medical epistemology* depends on objective scientific knowledge that is necessarily impersonal and is dissociated from the personal
experience of the diseased body. Therefore, scientific medical knowledge had to be derived from the dead body in which the particularity of the human experience of illness is reduced to the universality of bodily functions (and their disturbances). The act of medical knowledge itself is then a violent political act which is innately connected to the social power of medicine.

These reductionistic medical metaphysics and epistemology have clear ethical and social consequences on the practice of medicine. On the one side, patients are defined through the loss of their social function rather than through a particular human-centered purpose. It is difficult to acknowledge that while diseases and death motivate medicine to care for patients, medicine is used to politically control the dying process and arrogantly dictate the meaning of death. For instance, medicine defines pain in a reductionistic way that hurts patients and is overly demanding on its practitioners. Pain in biomedicine is a series of neuronal signals which travels along certain routes and causes the associated discomfort. However, more studies show that particular human experiences and socio-cultural contexts shape the experience of pain in a way that demands “reclaiming’ pain from the exclusive jurisdiction of medicine.” This is necessary to relieve medicine from a public -but unrealistic- demand to guarantee a painless human existence.

On the other side, to stop the overuse of medical technology and face death, liberal societies took the easy route. Rather than questioning the goals of medicine and its social role, social forces -including medicine and law- shifted the responsibility near death toward the patient. Whether the patient is hooked to different machines in the ICU or under holistic care in a hospice, she is sovereign over the course of her dying process, through decision making, advanced directives or relatives with power of attorney. However, rather than empowering
patients, too much emphasis on autonomy causes the abandonment of patients by their care-givers.\textsuperscript{127}

Furthermore, in a mechanistic understanding of disease and dying, emotional detachment at the personal level prevails.\textsuperscript{128} It is thought that physicians should be emotionally detached from their patients to avoid any interference (because of emotional concern) in correct diagnosis and treatment. This approach to the ethics of clinical encounter deprives physicians of their humanness and reduces their role to that of a machinist who is well-versed in fixing the ailing organ or system. As a result, not only diseases cause alienation from one’s own body but also the emotionally-detached practitioners perpetuate this alienation.\textsuperscript{129} A detached practice of medicine does not only affect patients but perhaps also fuels physicians’ dissatisfaction and exacerbates their alienation from patients. Perhaps, this is where physicians’ burnout starts.\textsuperscript{130}

\textit{III.A.5. Death at the Core of Medicine Leading to Compassion}

The paradox of death manifests in human life every day. On the one side, death is destructive of every meaning because it puts an end to any human value and prospect. On the other side, death is the foundation and motivator of every human cultural and scientific product; culture and science aim at defeating death and its nihilistic presence in human life. More specifically, medicine is motivated by death to overcome death -the eternal human dream-inasmuch as it is propelled by social and political forces to control those who are dying.\textsuperscript{131} However, it is out of arrogance when medicine claims to know the overall good of society or attempts to dictate the meaning of aging and death.\textsuperscript{132} Clearly, within the mortal condition of humans, preventive medicine is confusing in that it exaggerates the -actual or future- abilities of medicine to defeat death. Similarly, when feeding the unrealistic public expectations of medical technology, humans are perplexed about their responsibility in causing their own disease and
death and the ways they may mourn their withering life or the life of their departed loved ones. Therefore, Callahan argues, to genuinely appreciate the role of death in human life, it is important to explore the nature and meaning of human life and health in the context of innately mortal life. Medicine alone cannot provide satisfactory answers because these inquiries fall outside the jurisdiction of medicine.

More specifically, to humanely confront suffering and dying, medicine has to unearth the original and deepest motivator of its practitioners—before they became practitioners of medicine—namely the call of the suffering other. In the clinical context, the encounter between physician and patient is transformative to both parties, although it happens between relative strangers. It is the compassionate care by the physician, rather than a cold professional encounter, that closes the gap which separates them.

For the patient, this encounter is initiated because of the symptoms which disrupted her life story; her goal is to repair the brokenness of and alienation from her ailing body. Through naming the disease, prognostics, and a treatment plan, the particular patient re-writes her own life story with evolving new meanings to her existence. The encounter itself is central to the healing process inasmuch as the physician ‘silently’ listens with compassion and addresses the existential-anxiety and fear associated with bodily and medical uncertainty.

For the physician, this encounter is originally motivated by a call of the suffering other even before this physician decided to pursue medical education. The physician, as a human being, has answered the call of a suffering other even before she became a physician. When humans encounter a suffering other they respond by first being there with the sufferer before even offering anything to relieve her suffering. Some of these people respond by deciding to go to medical school to do something to relieve suffering. The response is transformative and itself
causes suffering on the side of the aspiring physician. Encountering suffering disrupts the life story of the aspiring physician and directs her toward pursuing medical education despite all the necessary self-discipline and long-term commitment. Bishop presumes that, for most of those who aspire to become physicians, there is an encounter with a suffering other; this encounter demands their transformation and is usually described in their applications’ personal statements. In short, Bishop argues that the only answer to suffering is suffering-with, i.e. compassion, which starts long before medical practitioners encounter patients in the clinic.¹³⁸

By the same token, Bishop thoroughly analyzes the clinical encounter and criticizes the individualistic claim that physicians (and in general all humans) are unable to know the suffering of the other. According to Bishop, this claim may be related to the fear of entering into the suffering of the other and fear of the transformative power of being-with-the-suffering-other. At a deeper level, learning how to be with the suffering other is primordially communal. Those who perceived the call of the suffering other themselves have learned how to answer such call by the virtue of belonging to a community; that community answered their call of dependency while they were growing up. In other words, by growing up in a caring community, human beings are sensitized to recognize suffering and to answer the call of those who suffer; some people answer by becoming physicians. Thus, certain humans become physicians because they first embraced their own vulnerability and learned from their surrounding community how to answer the call of those who suffer. This is a reminder that vulnerable embodiment is prior to, and is at the root of, ethical inquiry and normative moral demands.¹³⁹ Psychopaths would not become successful physicians who humanely address suffering (although they may still act like ones), partly perhaps because they have not learned how to answer the call of the suffering other through genuine care.¹⁴⁰
Unfortunately, after matriculating in medical school, aspiring physicians are lured away from their original response of being-with-the-suffering-other toward a functional and machinist answer to the bodily cause of suffering. Therefore, Bishop argues that, contrary to the totalizing power of medicine (through universalizing assessment methods), the call of a particular suffering-stranger requires a practice of genuine human presence. An authentic answer to suffering is hence a suffering-with, a compassionate and transformative encounter between two vulnerable human beings.

III.B. Compassion & Human Suffering

III.B.1. Human Suffering

To understand the role of medicine in ameliorating human suffering, it is warranted to shine some light on suffering itself and what makes humans suffer in the context of ailment. Eric Cassell defines suffering broadly as “the state of severe distress associated with events that threaten the intactness of person.” Clearly, the human being as a whole is at the center of any sense of suffering which highlights its multidimensional nature.

At the bodily level, pain is not the only component of suffering. Even when patients suffer from physical pain, the legitimacy of their pain should be first accepted by others, whether physicians or family members. Further, persons may suffer because of the loss of control (e.g. incontinence), disruption of their physical abilities (e.g. losing their vision), and change in their future plans (e.g. attending a daughter’s wedding). Other factors play a role in the experience of suffering including, but not limited to, gender identity and religious experiences. At these dimensions, suffering is precipitated because of the embodied experience of life. All human projects and plans are embodied that any disruption in bodily abilities will change the relationship with the surrounding world. In other words, diseases cause suffering because they
alienate humans from the world order which they lived before falling ill. As a result, the meaning of human life itself is disrupted demanding a reconsideration of one’s priorities and future projects. This change in meaning and priorities manifests during illnesses (especially chronic and life-threatening ones) as a serious spiritual or existential crisis. In short, the experience of suffering may start at burdensome pain and then reach a sense of absurdity and disconnectedness from community. Since compassionate communities are the source of meaning for any event in human life since childhood, disconnectedness leaves the patient in a state of meaninglessness which fuels suffering.

In seeking medical care, one paradox shows up; patients suffer not only because of their disease and its prognosis but because of the medical treatment which they receive (such as chemotherapy). Their suffering starts when symptoms disrupt their life enough to seek medical attention. When a disease is diagnosed, and its prognosis is projected, the treatment they have to undergo may itself have taxing effects, such as fatigue, nausea and hair loss after chemotherapy for instance. Therefore, in the light of this paradox, further investigation of the goals of medicine is warranted to realign these goals with the human needs under the duress of ailment and its treatment.

III.B.2. Treating Diseases, Bodies, or Patients

As it was previously discussed, medicine has evolved over the past few decades using a mechanistic approach to diseases and human body. Within a narrow framework, medicine intends to prevent ailments when possible, and to heal diseases or ameliorate their symptoms and associated suffering when healing is not possible. Medicine also aspires to prevent premature death and help pursue a peaceful one. Most important when treating a patient as a whole, practitioners ought to alleviate accompanying suffering, or at least not add to it. To do so,
practitioners have to recognize the multiple dimensions involved in any disease (beyond bodily symptoms) through considering the particular narrative of the patient.\textsuperscript{154}

However, in medical school curricula, knowing patients as persons to address their suffering is not relevant to a pure scientific-mechanistic understanding of diseases. Specifically, persons are not objectively knowable through scientific methodologies of assessment and measurement; rather, it is only through experiential relationship that physicians may be able to know their patients.\textsuperscript{155} Unless doctors perceive themselves as (important) protagonists in the life narrative of their patients, they cannot fathom how the diagnosis and prognosis they utter are received as a ‘life sentence’ by their patients.\textsuperscript{156}

When a physician breaks the news of a serious disease to her patient, the latter enters into a crisis mode to reevaluate his being in the world. This being is only experienced through embodied existence whose intactness and integration is imperiled by the disease. Many dimensions and roles constitute who the human being is, and they are frequently threatened because of diseases. Any human being has a past and a life experience, has roles to play, has relationships with herself and with society, and has a transcendental dimension (whether spiritual, religious or philosophical).\textsuperscript{157} While understandably medicine has to ameliorate suffering, medicine has no authority or experience in dealing with some of the disrupted dimensions of the patient. However, to avoid deepening suffering at those levels, practitioners have a duty to know about them by entering into an experiential relationship with their patients.\textsuperscript{158} In the context of suffering, the only way to know patients more is to suffer with them, to encounter them with compassion.\textsuperscript{159} In the words of Stan Van Hooft: “perhaps all the meaning that suffering can have is that it teaches us to care for others.”\textsuperscript{160}
III.B.3. Compassion; An Answer to Suffering

In general, compassion is suffering with other fellow humans then being moved to alleviate that suffering.\textsuperscript{161} It derives from the suffix \textit{com-}: with, and \textit{passion}: suffering, \textit{pathos} (from Greek, refers to pain, and desire). Therefore, compassion may not be very popular because it is connected to suffering, a generally negative experience. Besides, many people try to avoid being objects of compassion (where they are treated with compassion), because this reminds them of their vulnerability.\textsuperscript{162}

Suffering itself has a negative connotation even if all human cultural heritage attempts to embed individual suffering in a rather hopeful bigger picture. Encountering another fellow human who suffers is a reminder of the observer’s own vulnerability and precarious existence. The observer may then choose to avoid the suffering of another out of self-preservation.\textsuperscript{163} More specifically, avoiding human suffering seems to be influential in shaping libertarian trends in bioethics as previously discussed. Mainstream bioethics frequently emphasizes the moral strangeness of human beings and the essentially procedural ways of addressing moral conflicts. Because of such emphasis, autonomous decision making is quintessential for moral medical research and practice while the intersubjective connection between physicians and patients is excluded (black-box-ness).\textsuperscript{164}

Nonetheless, compassion, as a long established human virtue, proves the opposite, namely that intersubjectivity between human beings is possible.\textsuperscript{165} Through compassionate encounter with each other, persons do not meet as relative strangers. They already know so much about each other because of the ever growing collective (and nowadays global) shared meanings among human beings. At a very basic level, when listening with a compassionate ear, many linguistic cues divulge a great deal of information about the life narrative of the speaker.
Furthermore, contrary to prevailing individualistic emphasis on privacy, personal inner life is sometimes much clearer to an outsider than it is to the pertinent person herself. In the final analysis, personal knowledge is experiential in that it cannot be completed in one encounter; humans are changing all the time and only one aspect of their life is revealed each time. In a few words, it is only through compassion that humans can connect to each other and find the host of things that are common to them all, especially their vulnerable embodied existence.

When exploring compassion *per se*, many philosophers emphasize its dual nature, as an emotion and as a virtue. On its affective nature, compassion starts as an emotion of sympathy toward another fellow human who is in distress. Yet, as a virtue, compassion answers the normative demand of the suffering other through an action to ameliorate her distress. While sympathy shares in the emotional status of its object (such as joy, sadness, hatred…etc.), compassion always shares with the sadness, fear, or distress of the suffering fellow human. In this sense, compassion is a complete virtue because it always bears with the other person her suffering. Recognizing the suffering of another is not enough to have compassion; such knowledge of human weakness and what hurts may be used to torture other people. Furthermore, compassion is universal; a compassionate perceiver does not judge the morality of the suffering other, so she is open to all those who suffer regardless of their background and values. Thus, a compassionate perceiver does not regard the suffering of another person with indifference. Compassion even sensitizes the person to every suffering creature in the world beyond the human race.

Contrary to compassion, pity negatively affects suffering. Pity is a feeling of sadness moved by the sadness of the suffering other. It does not necessarily move the perceiver to ameliorate the distress of the fellow human; it is rather self-centered and disrespectful. It hinges
on a sense of superiority on the side of the perceiver who is not necessarily moved to action. Thus, “where pity is abstract, loquacious, and generalizing, compassion is concrete, silent, and specific.” Compassion starts from a sense of love and joyous hope toward equal fellow humans. Although it is initiated because of suffering, compassion extends horizontally toward fellow humans who share in their equal vulnerability. Compassion builds on mutual respect between fellow humans and arguably propels morality in any given society. It has also been argued that compassion at the social level nourishes a sense of solidarity among strangers in any given society.

Notwithstanding the importance of compassion in nurturing social solidarity, compassion is a particular and person-oriented virtue. Hence, social compassion or solidarity needs to be built on a more universal (encompassing and socially-oriented) moral principle. This principle, I will argue in the next chapter, is hospitality. Hospitality builds on the universality of human dignity and vulnerability, and uses the sociality of gratitude and the particularity of compassion to nourish solidarity.

III.B.4. Compassion; A Duty?

Because of the affective component of compassion, Kant argues that compassion cannot be a duty; humans do not have a moral duty to encounter others with compassion. This is similar to love, for instance, where one cannot decide to love another human being. However, compassion is similar to love in that feeling compassion or love can be nourished within any given society. Compassion and love are nurtured and encouraged through various methods, especially through role modeling and mindful practice.

Nonetheless, perceiving compassion as a duty in medical practice is not unfounded. While one may not be forced to encounter every other fellow human with compassion, clinical
medicine may demand compassion. At least, this is because of the enormous difference in power between physicians and patients, and because of the enormous risk and historical antecedents of exploitation in their encounter. Moreover, medicine is practiced within a complicated web of systemic relations which could affect the physicians’ ability to show compassion toward their patients. It is from this standpoint that Dougherty and Purtilo argue that compassion is a duty. For them, medical systems (and any suggested changes to their operations) should be judged not only according to their efficiency but also according to how much they squeeze compassion out of the practice of medicine within them. In the end, physicians cannot encounter their patients with indifference because “non-compassionate competent physicians” is antithetical.

III.B.5. Compassion in Medicine

It has been discussed earlier that, generally speaking, human beings tend to avoid suffering and perceive compassion with suspicion. This is similarly noticeable, paradoxically though, among medical trainees and recent graduates whose assumed goal is to ameliorate human suffering and illness. Therefore, to re-establish the place of compassion in medical practice, one should first emphasize that the healing sought through the physician-patient encounter is holistic inasmuch as it involves both parties as human beings rather than mechanistically (and reductionistically) fixing the broken party, i.e. patients. Furthermore, notwithstanding the importance of physicians being competent in their practice of medicine (technical knowledge of medicine), medical knowledge on its own is not enough for healing. By merely reading available medical information, patients are not able to heal themselves. The personal presence of another human, a physician, who knows how to wisely use her medical knowledge and experience to treat this particular patient is quintessential. However, to use
medical knowledge ‘wisely’, it is necessary to genuinely know the patient herself.\textsuperscript{179} This has been argued so far to be possible only through compassion.\textsuperscript{180}

In general, for their encounter to bring healing, physicians should also experience, and perhaps expose, their own vulnerability and weakness. The “mysterious” relationship between physicians and patients is the foundation of any pursued healing.\textsuperscript{181} Fundamentally, healing is not only about how much doctors are able to control patients and ‘fix’ their sick bodies; it is also about the ability of physicians to confront the uncertainty of both the human body and medicine with self-mastery and humility.\textsuperscript{182} Similar to any compassionate encounter, physicians, as well as patients, change as human beings. When physicians decidedly avoid the compassionate side of their encounter with patients they put their satisfaction and the efficacy of their art in jeopardy. By so doing, physicians detach themselves from their patients and risk the loss of deeper humane meanings of their profession.\textsuperscript{183}

Here is where Bishop’s exploration of the core of medicine leads. Bishop argues that the original encounter of the physician-to-be as a human being with another suffering fellow human is transformative to the former in a lasting manner. The physician-to-be compassionately answers the call of a fellow suffering human through personal presence in the first place rather than through a (mechanical) action to cure the disease. However, because of this ‘inert’ (in that it does not do anything) personal encounter, the perceiver is inspired to transform into a physician through a long process of suffering (because the new plan disrupts the perceiver’s life plan until that moment). The aspiring physician has initially learned how to care through being a receiver of care from the surrounding community. In other words, compassionate care is interwoven into the very being of the medical practitioners because it transformed them to become who they are.\textsuperscript{184}
On the darker side, compassion in medicine may be jeopardized by two factors. First, an instrumental use of compassion in medical practice may empty it of its deeper authentic connection between two fellow human beings. Compassion can be used to measurably ‘improve’ treatment outcomes but it will thus be sapped of its transformative power. By the same token, when compassion is used instrumentally in medicine it perpetuates the power inequality in clinical practice between physicians and patients. With instrumental compassion, powerful physicians preserve their position rather than expose their vulnerability as equals with their fellow human patients. The most serious danger to compassion is in limiting its implications to the physician-patient encounter. By only thinking of compassion in terms of the encounter of two individuals, its social dimension (similar to that of health, illness, suffering, and healing) and its universal implications will wither.185

Second, medical education curricula avoid compassion talks and teaching, perhaps because of unclear (and immeasurable) definition and practical implications of compassion.186 However, by so doing, medicine lures its novices away from their original compassionate experience in exchange for ‘measurable’ and evidence-based scientific practice.187 Parallel to the formal curriculum that avoids ‘compassion’ and suffering talks,188 there exists a hidden curriculum that also shapes future physicians. At the core of this hidden curriculum is the standardization of the dead human body and the objectification of patients to pursue medical knowledge. Next chapter will discuss in more details the hidden curriculum in medical education and the possible practical interventions to nurture compassion.

IV. Conclusion

Building on the Orthodox bioethical phronema, this chapter discussed the second mid-level principle as a common ground for global bioethics. Respecting human vulnerability derives from
the prophecy of Christ which exposes the mortality of humankind if estranged from God, the only source of life. Human sickness, suffering and death are the result of human ancestors breaking their communion with God. The resulting alienation from God, others and self could only be bridged through divine compassion, suffering death with humans, to raise the humankind. This same phronema is applicable to medical care by recognizing the innate and universal vulnerability of all humans, including medical practitioners. Therefore, this chapter highlighted the centrality of universal human vulnerability, from religious and secular perspectives, in shaping the ethical discourse in a globalized world. By studying the nature of suffering and the role of compassionate personal presence as the primordial answer to suffering, it was possible to uncover the centrality of compassion in molding certain people to becoming physicians. It was also emphasized that, because vulnerability shows at the personal level, compassion is the authentic answer to suffering when two vulnerable human beings meet, especially physician and patient. It is through compassion that physicians are able to cross the artificial boundaries between objective medical science and subjective encounter with particular patients.

In the next chapter, the role of global solidarity in shaping medical systems especially near the end of life will be discussed. It will be argued that solidarity sprouts from hospitality as it relates to human dignity and vulnerability, and that it needs the universality of gratitude and the particularity of compassion to shape globally-sensitive medical systems and education.


11 Larchet, Theology of Illness, 53.


13 Larchet, Theology of Illness, 55–77.

14 Larchet, Theology of Illness, 55–77.

15 Larchet, Theology of Illness, 17–53.

16 Behr, Becoming Human, 58–71.


18 Larchet, Theology of Illness, 17–53.


20 Barilan, “From Imago Dei,” 231–59; Barilan, Human Dignity, 23–92.

21 As illustrated in Larchet, Theology of Illness, 55–77; Also, Behr, Becoming Human, 58–71.


24 Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.


29 Pentiuc, Jesus the Messiah, 139–185; Davies, Theology of Compassion, 212–224.

30 Behr, Becoming Human, 40–48.

38 Larchet, Theology of Illness, 55-77.
44 Chryssavgis, “Spiritual Way,” 150–163; Silence and stillness are important for Wirzba so that one is able to feel and listen to the presence and voices of others.
45 A similar idea is discussed in, Edmund D. Pellegrino, “The Lived Experience of Human Dignity,” In Human Dignity and Bioethics, ed. A. Schulman et al. (Washington, D.C., 2008), 513-39; Davies, Theology of Compassion, 3-23.
48 Larchet, Theology of Illness, 17-53.
53 Davies, Theology of Compassion, 231.
63 Tham, “Lessons Learned,” 223.


66 ten Have, Vulnerability, 20-36.
67 ten Have, Vulnerability, 1-19.
68 ten Have, Vulnerability, 11-19.
70 ten Have, Vulnerability, 11-19.
71 ten Have, Vulnerability, 1-19, 20-36, 149-166; Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.
72 Soelle, Suffering, 33-59, 61-86.
75 ten Have, Vulnerability, 1-19, 93-123, 124-148.
76 Barilan, Human Dignity, 93-147; Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.
78 ten Have, Vulnerability, 149-166, 207-216.
79 ten Have, Vulnerability, 93-123.
80 ten Have, Vulnerability, 207-216.
81 ten Have, Vulnerability, 1-19.
82 Similar to Judaism, for instance, Heyd, “Jewish Perspective on Vulnerable Groups,” 203–14.
83 Turner and Dumas, “Vulnerability, Diversity and Scarcity,” 663–70.
84 Papanikolau, Mystical as Political, 130.
85 ten Have, Vulnerability, 37-60.
87 ten Have, Vulnerability, 37-60.
89 In regard to women, for instance, in Macklin, “Bioethics, Vulnerability, and Protection,” 472–86.
92 ten Have, Vulnerability, 124-148, 149-166.
93 ten Have, Vulnerability, 61-92.
95 ten Have, Vulnerability, 124-148.
97 Khushf, “Illness, the Problem of Evil,” 102–20; ten Have, Vulnerability, 93-123.
98 ten Have, Vulnerability, 137.
102 Conrad, Medicalization of Society, 4.
103 Conrad, Medicalization of Society, 23-45.
104 Conrad, Medicalization of Society, 46-69.
105 Conrad, Medicalization of Society, 70-96.
106 Conrad, Medicalization of Society, 97-113.
109 Conrad, Medicalization of Society, 133-145.
117 Jones, The Peril and Promise of Medical Technology, 203-228.
122 Bishop, Anticipatory Corpse, 1-27, 28-118; Bishop’s argument is aligned with the work of Michel Foucault and Richard Zaner and is in congruence with Khushf, “Illness, the Problem of Evil,” 102–20.
126 Bishop, Anticipatory Corpse, 119-140, 197-226.
129 Hilfiker, “Unconscious on a Corner” 3155.
131 Bishop, Anticipatory Corpse, 1-27.
133 Bishop, Anticipatory Corpse, 285-313.
136 Cassell, Nature of Suffering, 94-114; Bishop, Anticipatory Corpse, 285-313.
139 Bishop, Anticipatory Corpse, 285-313.


Bishop, Anticipatory Corpse, 285-313.

Cassell, Nature of Suffering, 33.


Bendelow and Williams, “Transcending the Dualisms,” 139–65; Cassell, Nature of Suffering, 30-47.

Cassell, Nature of Suffering, 48-65.


Cassell, Nature of Suffering, 30-47.


Bishop, Anticipatory Corpse, 285-313.


Cassell, Nature of Suffering, 30-47.


Cassell, Nature of Suffering, 30-47.

van Hooft, “Meaning of Suffering,” 19.


Welie, In the Face of Suffering, 159-200, 227-272.


Cassell, Nature of Suffering, 158-175, 214-236.


ten Have, Vulnerability, 93-123.


Comte-Sponville, “Compassion,” 114.

Davies, Theology of Compassion, 212-224.


Cassell, Nature of Suffering, 66-80.
CHAPTER SIX: THE APPLICATION OF DIGNITY & VULNERABILITY TO HOSPITALITY: END OF LIFE CARE IN GLOBAL BIOETHICS

After establishing the importance of human dignity and vulnerability in bioethical discourse, this chapter elaborates on the third of the three concepts advocated for an inclusive Orthodox Christian bioethics and a substantive global bioethics. The understanding of hospitality and its relation to dignity and vulnerability will be discussed within Orthodox Christian theology and secular bioethical discourse. This relationship will have practical implications in ethical dilemmas near death.

I. Hospitality in Orthodox Bioethics: Theological and Anthropological Perspectives

This section will explore hospitality within an Orthodox Christian hermeneutics and its practical ramifications as a basis for solidarity among strangers in healthcare.

I.A. A Christocentric Hermeneutics for Hospitality

I.A.1. Christ the Priest

In the previous chapters, the kinghood and prophecy of Christ were explored in Orthodox theological *phronema* to connect them to respecting human dignity and to protecting human vulnerability, respectively. The study of Christ’s kinghood and prophecy unveiled their fundamental relationship to two concepts, gratitude and compassion, which are central to shape the practice of medicine in a globalized world. However, by introducing the third function of
Christ, his priesthood, a robust common ground is established for a substantive global bioethics, at least from an Orthodox Christian perspective.

The priesthood of Christ is epitomized in his universal mission to restore the communion between God and the entire creation. Through his incarnation, he acquires a created body uniting divinity and humanity in his person and bridging the gap between the creator and the created world. The liturgical celebration is performed on the premise of a hospitable invitation extended to the entire world to come into communion with God in the body and blood of Jesus Christ. Unambiguously, Christ is the one who offers the oblation and the one who is offered in the liturgy for the salvation of the world (The prayer of the Cherubic hymn in the Orthodox Liturgy written by St John Chrysostom). In other words, through his incarnation, Christ revives the original human mission of being the bridging microcosm between the divine and the created world (as understood in the work of St Maximus the confessor, A.D. 580-662).

I.A.2. Royal Priesthood and Hospitality

The priesthood of Christ fashions the royal priesthood (1Peter 2:9) of all those who follow him and the worldly mission of the entire Orthodox Church according to the divine hospitality as relived time and again in the liturgy. Hospitality in its Greek origin, philoxenia: the love of the stranger, is central to this worldly mission since it aspires the bringing back of estranged humanity through Christ’s incarnation. Christ loved the alienated human race (alienated because of their fallenness) and welcomed them back to his kingdom through his providential work. Thus, St Paul exhorts the early Christian community in Rome saying: “welcome one another... as Christ has welcomed you” (Romans 15:7).

In terms of the Christian mission to the world, divine hospitality substantiates two important aspects. First, God is still working in the created world outside the boundaries of the
church through his own mystical methods. The Holy Spirit who abides in the world leads this mission (John 14:26). Second, in the Church, God has fully revealed the divine economy, in words and in deeds, which puts more responsibility on the shoulders of the faithful (than the outsiders) when engaging the world outside the church. Therefore, in the Eucharist, the church recognizes her own identity and mission toward the world, not as an entity in opposition to an - allegedly - inimical world, but as a hospitable and priestly missionary led by the Holy Spirit to bring the entire creation back to God.

In a world full of different religious and philosophical identities, Orthodox Christians live among strangers who, Christians believe, are equally dignified but vulnerable neighbors; they all are dignified, because God has also created them in the divine image, and they all are vulnerable because they also descend from the same fallen humanity. It has been previously argued, that Orthodox Christian bioethics should be perceived within this inclusive hospitable phronema which aspires the place of icons in the Orthodox theology.

**I.A.3. The Hospitable Dimension of Icons**

It was previously argued that an iconic phronema for a globally-sensitive Orthodox Christian bioethics is warranted. In the previous two chapters, the other two dimensions of this iconic phronema were discussed, the eschatological and realist. However, a third dimension is necessary to have a complete picture of that phronema, the hospitable dimension. While the eschatological dimension of icons offers a bright destination for humans, the realist dimension recognizes the fallen condition of humanity. To cross from one dimension to the other, a hospitable - and hopeful - leap is necessary to bridge the ontological gap that separates them. Icons stand as windows open toward, and constantly inviting, the world; a converted and
microcosmic beholder, embedded in a hospitable community, then extends the invitation to the entire world, in bioethics and in all other dimensions of life.  

I.A.4. Hospitality Shaping the Christian Ethos

As referred above, the Greek origin of hospitality, *philoxenia*: the love of stranger, is the term that shapes the argument of this dissertation. However, a working definition is necessary to explore the practical ramification of loving a stranger. Parker Palmer offers the following definition of hospitality: it means “inviting the stranger into our private space, whether that be the space of our own home or the space of our personal awareness and concern”. Hospitality is the “bond between utter strangers” that leaves a friendly space for the stranger to discover herself without the fear of being judged according to preset expectations. A hospitable host expresses in her welcoming to a stranger their common humanity and recognizes the worth of the stranger solely for being a human. Hospitality between strangers does not require growing an intimate friendship between the two (although this may happen) because hospitality is fundamentally built on common humanity. On the contrary, inhospitable host renders the stranger invisible, or visible but on harsh trial for who she is. Further, in English, *hospes* (the origin of hospice and hospital) semantically refers to the unity between host and guest recognizing their unity despite their apparent otherness. Although strangers meet in a public space, the resources available to hospitable encounter are available in a private space, whether physical or emotional. As a result, a hospitable encounter does not only benefit the stranger who receives a physical or emotional shelter (hospitable space) but even the host accrues significant benefit from welcoming others. A host is propelled to perceive his space in new eyes; even his relationship with God and the world is deepened and expanded.
More specifically, hospitality has been shaping the Christian ethos and mission in the world for many centuries. Initially, Christians aspired the divine hospitality which welcomed the chosen people and they extend it, according to the divine command, toward the marginalized and voiceless including the orphans, widows and passersby. When exploring Christian hospitality, Christian authors frequently refer to the advice offered by the author of the letter to the Hebrews (13:2): “Do not forget to entertain strangers, for by so doing some have unwittingly entertained angels”.

Therefore, it is arguable that a hospitable ethos is integral to an authentic Christian mission at any given time, and has been inspired by the various books included in the New Testament although it is not literally mentioned in any of them. Through the mission of Jesus Christ, the feast of the heavenly kingdom was opened to the entire world obliterating all the traditional boundaries that previously separated different races and ethnicities. In his letters, the apostle Paul encourages Christians to welcome to their own the strangers whom they encounter. By so doing, the new humanity, recreated in the incarnate Christ, can experience the divine grace in abundance. Similarly, in his two-volume work, Luke emphasizes the hospitable host-guest relationship as central to the universal mission of Christ through his providential incarnation. For Luke, gathering around a table for meals is the leitmotif around which God’s hospitality is extended toward the entire world.

Within an ethos rooted in hospitality, Christians continued to welcome strangers and care for them along many centuries taking various shapes. In the fourth century, Christians established hospitals (xenodocheion, house of strangers) which became precursors for modern-day hospitals. St Benedict’s monastic communities cared for the strangers and passersby as an essential duty of their order. Most recently, many Christians unwaveringly endangered their lives
to protect some Jews from being executed during the Holocaust and vehemently advocated for a better treatment of the refugees.\textsuperscript{15}

By the same token, it has been argued that hospitality is necessary to mitigate the environmental crisis that is detrimental to all humans. Hospitality demands an ascetic approach to the world by consuming less resources in order to leave enough space for the voiceless and distant stranger for her to flourish.\textsuperscript{16} Similarly, several Christian voices defend in theological terms the unavoidable global dimension of bioethics, especially to care for the most vulnerable whose well-being is dependent on others.

Hospitality is also strongly present in other religious and cultural practices which gives it a universal normative implication in every society.\textsuperscript{17} In Judaism, for instance, hospitality hinges on a respect of the embodied experience of humans and its underpinning religious taboo against violating the stranger’s body. In Jewish ethos, communal hospitality is paramount to preserve bodily integrity of its members and of every stranger as created in the image of God.\textsuperscript{18}

\textit{I.A.5. Hospitality and Ethics}

Beyond its particular importance to a Christian ethos, hospitality has a profound presence in secular ethical discourse. Derrida argues that ethics is itself hospitality. Without a hospitable perspective toward the stranger, i.e. a recognition of her presence and dignity, there will be no need for ethical discourse; if a stranger does not exist (or is not recognized), no moral responsibility toward her is established. More specifically, morality hinges on that two strangers (or groups of them) recognize both the presence of a dignified other and an embedded moral obligation toward the most vulnerable of the two, especially when one of them can help. Therefore, a hospitable recognition of the dignity and vulnerability of a stranger other is the
foundation of any moral discourse among strangers. Without hospitality, strangers do not have moral demands on each other; And, to be moral, one has to be hospitable toward strangers.¹⁹

To adopt hospitality in a pluralistic society, one has to grapple its broad moral demand and possible risky implications. On the one hand, Levinas’ radical hospitality is demanding in that it gives the guest an authority over the physical and emotional space of the host, thus switching their roles. Hospitality is also demanding in its scope. Adopting a radical hospitality prevents the use of reasonable criteria to limit its beneficiaries which may risk emptying it of any meaningful moral implications. Further, when a host obliterates her boundaries (physical and emotional), she risks her well-being by welcoming malevolent intruders. Therefore, however important hospitality is to morality, it cannot offer unnegotiable directions for all moral inquiries. Hospitality is rather important to question different perspectives and to raise ethical dilemmas in any social discourse among strangers, without advising final policies.²⁰

I.A.6. Tolerance, Hospitality and the Public Space

To overcome the demands of hospitality in pluralistic societies, tolerance is advanced to achieve peaceful social order. By tolerating the differences with strangers, one does not have any moral imperative to engage in dialogue, to care for their duress, or to actively protect their interests when they are vulnerable. Thus, while tolerance may guarantee a minimal state of social peace among strangers, it hinders the possibility of nurturing a coherent and caring community of strangers. In facing the vulnerability of dignified humans, tolerance is morally inert while hospitality is engaging and caring.²¹

Building on a deeply rooted heritage of hospitality, Christians are exhorted to go beyond tolerance and to engage with others in a hospitable public space. Similar to God welcoming fallen humans through the priestly mission of Christ, Christians have a moral obligation toward
the most vulnerable and marginalized. By their pursuit of an eschatological unity with all humans, Christians have to foster a genuinely hospitable dialogue with others wherever they are to improve the lives of the vulnerable. Through hospitality, Christians and all others have the opportunity to genuinely stand within their particular traditions, and at the same time, respect the otherness of the stranger. By so doing, the anthropological similarities among strangers, especially their dignity and vulnerability, prove to be overwhelming compared to their differences. Furthermore, benefit accrues to both parties; the stranger is cared for in the midst of her vulnerability, and the hospitable care-giver recognizes his own vulnerability and his need for others.

At the political level, Christians have a responsibility to establish a hospitable public space that is welcoming and caring to strangers. Parker Palmer argues that such hospitable environment is “pre-political” in that its pre-existence is fundamental for a flourishing political life. Christian churches have a vested interest in supporting such political environment since both Christianity and politics pursue a unity among humans. Although both Christianity and any secular political system pursue different understandings of unity, they both attempt to overcome human alienation by emphasizing their connectedness and interdependence. Palmer likewise contends that a Christian -private- identity and spiritual life is not separable from the way Christians live and interact with strangers in the public space. Christianity is epitomized, rightly contends Palmer, in a sincere search for human commonalities rather than in a narcissistic fixation on differences.

Therefore, it is incumbent on the church to create an internal safe environment where people can learn how to hospitably meet strangers and how to engage in a meaningful and flourishing public life with other strangers. Through their hospitable involvement in public life,
Christians may bring hope to their community, by emphasizing the goodness embedded in a
caring social milieu.\textsuperscript{26} In the same vein, by taking hospitality seriously, Christians have to bring
to heart their responsibility toward the voiceless and marginalized in a globalized world where
exploitation and injustices prevail.

\textit{I.A.7. Hospitality in Healthcare}\textsuperscript{27}

In a more particular context, hospitality is fundamental for an ethical practice in
healthcare where vulnerable strangers constantly seek help. As it has been previously discussed,
physicians and patients do not only meet as moral strangers; rather, they meet as utter strangers
since medicine is currently practiced within faceless institutions using powerful technologies that
almost control life and death.

When physician and patient meet, they both willingly enter the space of each other as
strangers. However, without hospitality, care cannot evolve. Medical care is embedded within a
hospitable encounter within which the physician recognizes the dignity of her patient and his
vulnerability exposed due to illness. Furthermore, hospitality in physician-patient relationship
helps them balance against the uncertainty of human body and medical knowledge. When cure is
not certainly attainable because of bodily and medical precariousness, hospitable care frames the
encounter to bring healing in an unfamiliar environment. More specifically, hospitality in the
clinical encounter is asymmetrically reciprocal. When the patient enters the unfamiliar territory
of illness and healthcare institution, her physician becomes her host because of his knowledge
and familiarity with them. In contrast, the patient invites her physician into the private space of
her body, thus playing a host to a novice physician: physician is novice in terms of the patient’s
embodied experience of illness. In other words, while the patient needs her hospitable physician
to seek health, the physician needs his patient’s hospitality to understand and heal her affliction.
In short, when physicians and patients encounter each other with hospitality, they both recognize their common vulnerability and henceforth genuinely care for each other, though in asymmetrical ways. Therefore, hospitality plays a cardinal role both in shaping a moral encounter between physicians and patients and in fashioning medical systems that are hospitable to the most vulnerable and marginalized, locally and globally.

I.B. Hospitality as an Inclusive Basis for Solidarity among Strangers

I.B.1. Hospitality as a Basis for Solidarity

Christian ethos of hospitality aspires the primordial hospitality of God. Not only divine love was the *raison d'être* of the entire created world out of nothingness, but also divine hospitality toward fallen humanity brought the entire world back to its creator. The divine hospitality was embodied in the person of Jesus Christ who incarnated (taking a human body) and stood in solidarity with all humans bearing the anguish of death on the cross. His divine love brings humanity, and the entire creation, back to life and reconciliation with the creator through his resurrection.

Despite the alienation of human beings from their creator, Jesus Christ took on a human body and suffered as an expression of solidarity with humans. He willingly entered the created realm as a “guest” to bring his alienated human “hosts” back to where they originally belong: his divine kingdom, where Christ is the host (Ephesians 1:9-10; Colossians 1:17-22). In a few words, despite the ostensible façade of alienation among humans, a genuine Christian hospitality demands an active solidarity with strangers. Because they experience the solidaristic hospitality of Christ, Christians bear a grave responsibility to highlight the commonalities among humans rather than differences.
Other authors have argued that compassion toward the vulnerable is the basis for solidarity in any given society. However intuitive this may sound, it serves the argument of this dissertation to root solidarity in hospitality rather than in compassion for several reasons. On the one hand, it was argued that hospitality is the basis for empathy and compassion. Without a hospitable attitude toward a distressed stranger, the beholder is not able to establish an intersubjective rapport to empathically recognize her suffering and to then be moved by compassion (suffering with) to relieve her distress. Thus, empathy and compassion are primordially rooted in hospitality toward a particular other.

Furthermore, solidarity is relatively more universal than compassion. Solidarity does not need a specific and concrete other to move the person into action. In medical care, it was previously argued (chapter 5) that compassion may be faultily used to distract the ethical discourse away from the systemic problems afflicting health systems. However, by adopting solidarity, policy changes to mend systemic injustices in healthcare planning and delivery are possible without sacrificing the healing personal compassion in the clinical setting. A solidarity that is rooted in hospitality helps shape a universal approach to bioethical dilemmas that takes both the personal and the global dimensions of healthcare seriously.

I.B.2. Solidarity for Ethics and Public Life

To shape public policy, it is important to understand the role of solidarity in ethics and public life, locally and globally. Similar to many other intuitive concepts, solidarity may prove to be difficult to define. Like love and friendship, solidarity is broad enough a concept to bear a broad spectrum of meanings. Unlike love and friendship which are personal and private in their perception, solidarity has a more public applicability. Most people recognize their need for solidarity in times of crises when their vulnerability is most exposed; however, it would be
challenging to pinpoint its nature. It may be perceived as an emotion, an ethical or political ideal, or a personal virtue. Some critics even deem solidarity to be an empty concept especially in regard to public policy or social ideals.30

Prainsack and Buyx define solidarity as “enacted commitments to accept costs (financial, social, emotional, or otherwise) to assist others with whom a person or persons recognize similarity in a relevant respect.” They explain that solidarity has three tiers: interpersonal solidarity (individuals recognizing their commitment toward other individuals); group solidarity (collective commitment to the well-being of others); and solidarity as contractual, legal, or administrative norms (societal and governmental commitment to the welfare of every citizen).31

Although solidarity has only recently emerged in bioethical discourse, Prainsack and Buyx trace its ancient history back the Roman Law. In modern history, solidarity is associated with the French revolution under the disguise of fraternité (fraternity-brotherhood) although it did not literally appear in formal documents until 1848. Henceforth, solidarity was used among the members of trade unions and Marxist-socialist groups as a unifying force against evolving powerful capitalist and individualistic ideals. Because of the industrialization in the west, drastic social changes gave rise to an organic solidarity in society because of growing specialization in production processes and unfolding interdependence among various groups. Organic solidarity stands in contrast with a mechanistic solidarity which prevailed in the preceding era whereby close-knit and like-minded members of a community ‘mechanically’ supported each other in an agricultural society. Unlike communitarianism which may emphasize the collective well-being of a community at the expense of individual interests, solidarity respects individual rights as central to collective prosperity,32 where everyone submits her unique talents for the service of others.33
The influential presence of solidarity in western societies (especially Europe) did not only hinge on growing secular mentality after the French revolution. Rather, a deeply rooted religious solidarity continued to be dominant despite the rift between Roman Catholic and Protestant churches. For Christians in the west, solidarity among strangers was rooted in their similarities as fellow humans created according to the divine image, despite their disputes.³⁴

Unlike the virtue of charity which embeds asymmetry between the involved parties, solidarity is built on symmetric relationship among individuals for the sake of their collective well-being. Thus, solidarity is necessarily connected to social justice and the common good without sacrificing the individual well-being. In general, a Christian concept of solidarity in the west has emerged as reminiscent of Christian love (agape) in an increasingly secular society without necessarily sacrificing the core meaning and motive of that love.³⁵

Moreover, in a globalized world full of disparities, it is argued, Christians of western countries should adopt solidarity as a way of living.³⁶ Similar to Christian thinkers who embraced liberation theological premises as a way to advocate for the poor and marginalized in developing countries, western Christians are invited to repent (experience metanoia as a change of mind) in order to be loyal to an authentic Christian ethos. In this vein, Rebecca Peters encourages privileged western Christians to espouse a “gospel of solidarity” instead of the “gospel of prosperity” which they have adopted for a long time. While a gospel of prosperity perceives western privileges as a divine blessing, a gospel of solidarity questions the systematic, political and historical reasons behind the inequities prevailing in other countries.

As a result of this metanoic change in mentality, western Christians would assimilate an ethics of accountability that moves them away from charity toward a more concrete, and global, sense of social justice. Peters describes her solidarity ethics as a “liberation theology for the
privileged”. In order to motivate Christians to adopt her theological agenda, Peters recognizes the challenges associated with this profound change: first, the challenges of examining one’s own personal and collective privileges, and second, the challenges of establishing relationships across traditional dividing lines. Nonetheless, Peters entreats privileged Christians to assume solidarity ethics through a sincere commitment to building -perhaps risky- relationships, whereby trust and care may grow out of mutual vulnerabilities. Consequently, solidarity will move the privileged to engage in structural changes to ameliorate global inequalities.37

In the bigger scheme of public life, Peters contends that an ethics of solidarity, though rooted in the Christian ethos, is open to dialogue with other value systems, religious or non-religious. Even if rooted in religious ethos, solidarity defies any threat of theocratic or exclusivist trends; it rather expands the public space to become ultimately global in scope. Such countercultural ethics is preeminent to confront unjust neo-liberal understanding of globalization which is precipitating economic disparities and environmental crises.38

By the same token, other authors cultivate solidarity as a corrective measure to public and global policies that are solely built on distributive justice, especially those related to healthcare resources. Although Ruud ter Meulen does not deprecate the role of right-based concept of justice, he believes that solidarity complements the shortcomings of justice by emphasizing the relational dimension of social goods such as healthcare. Therefore, in healthcare at least, solidarity is quintessential, not merely because of mutual interest in the well-being of others, rather out of a humanitarian association built on respect and solidaristic responsibility.39

**I.B.3. Solidarity in Health Care**

For many decades in Europe, solidarity has been at play in the provision of healthcare. However, it has been recently used in several contexts related to health including public health
policies, justice in healthcare systems, and humanitarian aid during international crises. Contrary to the American ideal of solitude,\textsuperscript{40} solidarity highlights the divergence between the health systems in the US and other European countries. Although the development of healthcare systems in Europe took different routes depending on the unique political, economic, social, and historical circumstances of each country, the underpinning motif of all these systems remains a collective responsibility to care for everyone.\textsuperscript{41} However, due to recent medical advancement and their increasing cost, the sustainability of these systems and their underpinning solidarity were brought to the surface.

However, the surfacing debate over solidaristic healthcare systems, Prainsack and Buyx contend, helps reshape scholarly and public discourses. Such debate unveils the importance of inter-individual and communal relationships for social prosperity and for overcoming traditional impasses in bioethical debates. For example, Prainsack and Buyx explore the practical implications for solidarity in health databases,\textsuperscript{42} precision and individualized medicine,\textsuperscript{43} and transplantation and organ donation.\textsuperscript{44}

At a global level, solidarity has more implications because of the prevailing disparities, in healthcare and in other health-related resources.\textsuperscript{45} Solidarity at the global level extends the circle of moral responsibility beyond national boundaries and highlights the anthropological similarities despite the prevailing cultural plurality. For instance, in a multi-layered ethical dilemma similar to the migration of healthcare workers from low-income countries to more developed ones, using solidarity to lead the debate is informative. When personal and transnational interdependence is highlighted, global solidarity can motivate different national governments to cooperate in overcoming health inequalities and diseases that afflict the most vulnerable around the world.\textsuperscript{46} Over the past two decades, global solidarity was influential in
shaping the global bioethical discourse especially in adopting the UNESCO *Universal Declaration on Bioethics and Human Rights* in 2005. Although solidarity is not directly mentioned in this document, it is arguable that this document amounts to a solidaristic covenant between various nations.\(^{47}\)

**I.B.4. Challenges to Solidarity**

Although solidarity is gaining grounds in bioethical debates, locally and globally, one should not ignore the challenges to the concept and the limitations of its applicability. Conceptually, solidarity may be a vague concept that means different things to different people. Solidarity may not always refer to a positive thing; criminals may show solidarity to each other but not for the well-being of their community. Similarly, a subtle sense of exclusion may lurk behind solidarity; by showing solidarity toward a certain group of people, one may, intentionally or unintentionally, exclude other groups of people. Nonetheless, a decidedly exclusive perception toward others cannot be considered solidaristic, no matter how helpful it is to its beneficiaries. Therefore, solidarity cannot be considered a normative concept per se because of all the subtleties which may disguise under its mantra. A serious consideration of the historical and social context of solidaristic policies and their frequent re-evaluation are warranted to guarantee their intended solidaristic aspirations.\(^{48}\)

Practically, solidarity is costly and risky. Thus, its applicability is contingent upon factors other than the good intentions of its advocates. For instance, perceiving similarity with a vulnerable group depends on how costly it is to offer them help, in terms of financial, emotional, political and national resources. Solidarity, similar to its foundational hospitality, is risky since building trust among strangers takes a great deal of time and effort.\(^{49}\) These issues have recently surfaced because of the refugee crisis spreading through Europe. Recognizing similarities with
the refugees proved to be very costly in some of the hosting countries, not only financially but also in terms of national and cultural identities.\textsuperscript{50}

In the same vein, several examples of exploitation under the disguise of solidarity are detrimental to their victims. Advocates for offshore commercial gestational surrogacy in the US frame this practice as a solidaristic sisterhood across national boundaries. They contend that, through this practice, adoptive mothers help gestational mothers in developing countries escape their exploitative conditions. However, such rhetoric glosses over pervasive transnational injustices and disguises an exploitative relationship behind a solidaristic façade.\textsuperscript{51}

In general, although people cannot be obliged to show solidarity toward others, it is warranted to nurture a hospitable environment which unveils similarities rather than accentuate differences. Therefore, here comes the role of the anthropological similarities advocated in this dissertation. By emphasizing the universality of human dignity and vulnerability, it becomes possible to advocate for an inclusive solidarity in global bioethics. Such solidaristic framework will have local, national, and international implications regarding the provision of medical and health-related resources. More specifically, to foster solidarity among healthcare professionals, Prainsack and Buyx argue, it is necessary to nurture an educational environment that emphasizes similarities among various stakeholders.\textsuperscript{52}

This is the goal of the following two sections, namely to explore how to establish a hospitable environment, in academic medicine and in clinical practice, that can nourish solidarity in healthcare, locally and globally. Regardless of the possible challenges facing a global solidaristic approach to healthcare, solidarity is pregnant with hope in the goodness of the human society. Whereas human fallenness brings alienation and enmity, solidarity brings hope in a better human condition.
II. Hospitality & Dignity: The Role of Gratitude in Global Bioethics

To stand in solidarity with patients across the globe, gratitude was previously argued to be an important value in shaping medicine. In chapter four, gratitude was advanced as a fundamental value in shaping the personal relationship between physicians and patients. In this section, gratitude will be extended beyond that particular clinical encounter to address the environment of medical practice within its broader social context. Since gratitude was derived from a socially-constructed understanding of human dignity, its hospitable application in medical care should transfigure both involved parties, physicians and patients. The leitmotif of the solicited change is hospitable openness toward each other.

II.A. Physicians and healthcare workers

Out of gratitude toward their current and previous patients, physicians, healthcare workers and systems should be humbly open to patients especially regarding the following themes. Such openness aims at fostering reasonable expectations of medicine among patients along with public appreciation of the limitations of medicine and human life.

II.A.1. Social Dimensions of Medicine and Health

Physicians and healthcare systems should be humbly open about the broad spectrum of factors affecting health beyond access to medical services. They should be at the forefront of social movements to advocate for mending any public misconceptions and national and international injustices affecting health.

Over the past few decades in the US, physicians have evolved as strangers to their patients for many social changes. Because of ingrained social injustices, physicians pursue medical training in a social context that is drastically different from their own. While they mostly come from a privileged background, their initial exposure to patients takes place in inner-city
hospitals with underserved populations. Many of these physicians grow numb to the social injustices that are detrimental to these patients including homelessness, along with many other racially and culturally rooted injustices. Consequently, when physicians unconsciously classify their patients according to their social worth, patients’ health may unnecessarily be jeopardized. Unveiling those biases is warranted for a more solidaristic health care system.

Further, recent studies in the humanities unequivocally unveils the social and cultural construction of individual’s experience of pain and suffering. Hence, physicians have a vested interest in explaining these socially and culturally constructed experience of suffering. When relieved from a powerful public demand for a painless human existence, pain control would have a broader set of tools to address. Similarly, when patients seek a treatment of their affliction in a sophisticated and bureaucratic medical system, it is important for providers to recognize the epistemic injustice that befalls them. Patients are the weakest party within the medical system, partly because they are forced into it (since no one would ever like to be sick), and, because of its science-centered mentality, medicine is more interested in what is objectively verifiable than in the patient’s experience of her ailment.

At a more general level, the social hype related to recent medical advancement has fueled an expensive “research imperative” which has a dire local and global social cost. In the same vein, the influence of money and outside forces on medical agenda is rarely integrated into medical practice and training, although it may negatively affect the health of patients. Along with the rising cost of medical care, especially in western countries, healthcare disparities are yawning and increasingly disadvantaging the most vulnerable communities. At a global level, the burden of diseases unduly disadvantages poor nations and is exacerbated by off-shore and laxly
regulated pharmaceutical research (among other injustices) that narrowly benefit the already privileged citizens of the world.\textsuperscript{60}

\textbf{II.A.2. Hidden Curriculum in Medical Training and Practice}

The hidden curriculum of medical training and practice is another aspect that needs to be unearthed for an authentically solidaristic practice of medicine. Rather than being mere educational institutes with a clearly defined teachable curriculum, medical schools are arguably moral communities and “learning environments” for adult learners. In such environment, not only what students are taught is important, but also what they learn while immersed in the demanding context of medical education. Therefore, Frederic Hafferty explains that a medical curriculum constitutes of formal, informal, and hidden components that influence the professional development of future physicians. The \textit{formal} component of the curriculum stands for the directly taught concepts, behaviors, and skills to the students in the classroom. The \textit{informal} component includes all the educational opportunities that help mold future physicians through their interaction with other colleagues and faculty members. However, the \textit{hidden} component of the curriculum includes those systemic and social elements embedded in medical care which insidiously influence the development of students’ professional identity. Those elements include institutional policies, evaluation activities of students and faculty, resource allocation decisions, and institutional slang.\textsuperscript{61} Unsurprisingly, the hidden curriculum of an institution does not only shape students, but a similar hidden curriculum is embedded in faculty development activities. Both curricula equally influence each other.\textsuperscript{62}

In an educational milieu that is partly shaped by a hidden curriculum, medical atrocities cannot be prevented solely through comprehensive ethical training. While formal ethical training hones the morality of already-moral adult learners, its presence as part of the formal curriculum
does not guarantee its efficacy. Thus, a narrow perception of medical ethics as a set of teachable skills does not suffice to nurture a moral professional identity in physicians. Rather, a broad perspective that address the school’s cultural milieu is paramount. Therefore, to build a solidaristic health system that delivers to vulnerable patients, medical schools should not narrowly underscore formal instruction in cultural competence for instance; rather they ought to sensitize their students to the broader social context at the root of health disparities through formal, informal and hidden aspects of their curricula.

Furthermore, out of gratitude toward, and transparency with, future generations of physicians, medical schools and systems have to empower incoming students to be agents of change and to resist the negative aspects of the hidden curricula. A medical school, it is argued, unveils its hidden curriculum and helps students resist it through a longitudinal program that starts in the pre-clinical years and continues throughout their training. It is necessary to (1) prime students on what they will perhaps encounter on the rounds and among colleagues, and (2) sensitize them to identify their own motivations and actions within a powerful environment that demands tame conformation. (3) Students should be then encouraged to analyze their experiences along with other students in a safe environment. (4) They should finally be supported to choose their behaviors and attitudes in a way that cultivates their best possible professional identity.

While these aspects of the hidden curriculum have been extensively studied in medical schools in the US, similar aspects are surely at play in schools around the world. Hence, a serious global effort to unearth their unique implications on future physicians’ professional identity is warranted.
II.A.3. Medicine is Not a Science

The relationship between medicine and science is very important for a satisfactory practice of medicine for both patients and physicians. However, because of the lure of modern science, it is necessary to openly and publicly discuss this relationship to correct any public misconceptions and unrealistic expectations of medicine.

In the face of human fragility, scientific medicine may soothe any sense of uncertainty that accompanies serious illness. However, the clinical practice of medicine does not narrowly follow a simplistic understanding of science; practitioners have to use the general scientific medical knowledge of pathology and apply it to the particular patient’s case. Hence, practical reasoning, or phronesis in Aristotelian terms, is preeminent for the practice of medicine which is not a pure science nor a technical art (skill-centered). The importance of practical reasoning substantiates during the apprenticeship of medical novices where clinical judgement is honed through narrative case studies using various approaches including, thorough exploration of medical history and skeptical dissection of clinical and laboratory findings. This pedagogical model highlights the unviability of standardized or computerized medical algorithms because of the uniqueness of every case, even when patients are afflicted with the same disease. Several pedagogical tools depart from scientific standards, such as (1) using informal and contradictory rules, (2) emphasizing complexity and flexibility through challenging maxims, and (3) ingraining ritualized hierarchies according to clinical experience rather than exam achievements.

Because of the uniqueness of each patient, medical practice dissociates from a simplistic understanding of scientific causality. While it is possible to explain the pathology and symptoms of a certain disease after it happens using linear causality, more difficult questions remain unanswered regarding the specific reasons behind the particular patient’s affliction at the time it
happened. At a deeper level, and what matters for most patients, arises the question of “why me?” which opens up to anthropological dimensions that defy any possible scientific answer.70

Furthermore, while adopting a scientific façade may assuage human fear of uncertainty through “quantified uncertainty”, pure scientific inquiry into diseases equally harms patients and physicians by overlooking their deeper yearning to human rapport. By shaping their profession on scientific objectivity, physicians pronounce death as their insidious, but inevitable, enemy, and easily hide behind a procedurally ethical, but anthropologically indifferent, professional practice. In the same vein, by hiding behind science, physicians avoid questioning the certainty of medical science, especially when biomedical advancements overshadow lurking uncertainties. Hence, a detached practice of medicine arguably impairs the ability of some physicians to make sound medical judgements.71 Emotional detachment from their patients has serious ramification on physicians’ professional and personal lives, such as dissatisfaction with their practice, emotional detachment from family and friends, and exaggerated sense of invulnerability that is detrimental when they fall ill.

By the same token, patients are possibly harmed because of over-occupation with scientific facts. While some patients may choose not to be fully informed about the scientific details of their illness, all patients deeply yearn to assuage their fear of an uncertain future. Along with their fear of losing control, patients seek the assurance of their physicians, friends, and family members of non-abandonment. Hence, even when physicians are not qualified to answer the teleological questions rising near death, they have a moral obligation to acknowledge the anguish of their patients when facing a serious illness.

From the side of physicians, when they are overly occupied with medical science, they may neglect the relational dimension of their profession. Their deeper yearning to a friendlier
relationship with their patients is rarely acknowledged in the prevailing “medicine of strangers”. However, a “medicine of neighbors” does not demand building friendships with patients (though not totally excluded); rather, it recognizes, through its embedded hospitality, the humanity of both strangers: physician and patient. At a global level, a “medicine of neighbors” recognizes the neighborliness of all patients, regardless of how far, physically or culturally, they seem in a globalized world.\(^72\)

**II.A.4. Narrative Medicine**

To build a neighborly and hospitable medicine, it is necessary to understand the important role that narration play in shaping the clinical encounter. Works of literature, it is arguable, are indispensable resources for physicians to imagine the inner lives of their patients. Because of their brief encounter, physicians are not able to unveil all the personal, emotional, and historical particularities of their patients. Therefore, it takes a leap of imagination for physicians, with the help of fictional literature, to address the unique experience of particular patients in cases of devastating disease or looming death.\(^73\)

Furthermore, in medical education, narrative medicine has been introduced to emphasize the relational dimension that shapes the story of both physicians and patients. By developing their narrative competencies as neophytes, it is contended, future physicians can recognize, absorb, and interpret their patients’ verbal and nonverbal communication bits. At a deeper level, physicians and patients evolve to humbly recognize their shared humanity and more openly share their personal struggles.\(^74\) As a result of hospitable openness toward each other, physicians change inasmuch as their patients heal. Physicians assuage the fears of their patients through naming their disease, proposing a prognosis, and promising to not abandon the patient during her
ordeal. In certain cases, only attentive and compassionate listening to the patient’s story can unveil the meaning of her ordeal and bring about healing to her entire person.\textsuperscript{75}

In general, the positive role of the humanities in medical education, Jeffery Bishop argues, should not be measured using narrow scientific standards. The use of the humanities in medicine, including narrative medicine, reminds physicians of their original call into medicine: a call of a suffering other which initially exhorted them to pursue medical education.\textsuperscript{76} Contrary to a simplistic preoccupation in measurable efficacy, healing accrued in hospitable encounters may not meet the rigorous standards of evidence-based medicine. The most that a humanistic encounter may prove is that both physicians and patients are vulnerable humans awaiting the consolation of each other.

\textbf{II.B. Patients}

Out of gratitude to the services that physicians and medical systems offer to them, patients are expected to play a hospitable role toward their providers at various levels. On the personal level, patients need to recognize the dignity and vulnerability of their physicians. The ordeal of becoming a physician is not easy to comprehend by outsiders. Despite the public fascination in medical technology in the US for instance, very little is said about what doctors actually go through before they acquire their prestigious social status. Along with the many years of training, self-disciplining and delayed gratification, physicians are trained in less-than-perfect environments where their embodied humanity is constantly harassed (more details in the next section). Physicians are always short on time, sleep, and family activities, and they are expected by their patients to not have emotions in the face of suffering and death.

However, articles in popular newspapers and magazines can tone down medical jargon and explain to the public the inner works of medicine. By so doing, these articles expose public
misconceptions about physicians and re-establish their human side in the public eye. In an article in *The Atlantic*, for instance, Meghan O’Rourke reviews a wide array of books that narrate the human side of physicians, in the making and in practice. She unpacks the practice of medicine in the US to the general public and highlights some of the reasons behind the difficulties of communication between physicians and patients. She explains the duress which physicians must endure when their time is constantly running short, when a faceless insurance representative or hospital bureaucrats have to validate their professional decisions, and when their practice is constantly under the microscope for possible legal prosecution. O’Rourke ultimately argues that it is necessary to reform the medical system in the US not only for the sake of better healing services to patients, but equally for the sake of physicians. Therefore, an important public discourse should evolve to highlight the challenges of becoming a physician and practicing medicine. This is to counter the public perception of physicians which feeds on commercials-saturated celebrity-physician-led talk shows or an increasingly negative portrayal of physicians in movies.

To counterbalance the unrealistic public demand on physicians and medical systems, it has been recently argued, even by physicians, that patients have to be actively involved in their own care. Proponents do not advocate this involvement from the individualistic and autonomous perspective; rather they recognize the vulnerability of physicians as human beings and encourage patients to be partners in their care because they have equal epistemological authority compared to their physicians. As a physician himself, Jerome Groopman initiates his lay readers into the world of physicians, how they think and how they make medical decisions. He argues that many of the errors that doctors fall prey to are not because of ignorance of clinical facts. Rather, physicians are sometimes misguided by their emotions and temperaments, by their ingrained
prejudices toward certain patients, by their falling into cognitive traps, or because of outside financial interests in their medical decisions.

Hence, it is important for physicians to honestly acknowledge the uncertainty of their medical knowledge and the fallibility of their human skills. Similarly, it is important for patients to recognize those limitations, to not demand of medicine what it cannot deliver, and to gracefully ask for a second opinion whenever necessary. Groopman envisions an open (hospitable) relationship between physicians and patients-families, whereby patients help their physicians hone their expertise through honest feedback and increasing self-awareness.

Fundamentally, patients play a crucial role to guard the well-being of their physicians, in two examples at least. First, when physicians commit medical errors for any reason, patients-families can prevent them from becoming second victims; they can facilitate the healing of physicians through reconciliation, especially that the culture of peer-reviewed medicine does not have a place for absolution. By being open to human vulnerability and lurking mistakes, patients-families understand the possibility of error and harm, without downplaying the need for systemic interventions to prevent future errors. Furthermore, physicians experience an abundance of guilt and shame throughout their training and practice so an act of kindness on the side of patients-families brings a great relief. Second, and equally important, patients are not defined by their illness. They are rather active members of society who can shape the politics of medical care delivery through democratic and civil-society initiatives. Patients and their families can stand in solidarity with their physicians and other marginalized patients through demanding systemic and educational changes that take the well-being of both patients and physicians seriously.
III. Hospitality & Vulnerability: The Role of Compassion in Global Bioethics

To stand in solidarity with strangers across the globe, compassion was previously advocated as central to the practice of clinical medicine. In chapter five, compassion was discussed as the proper answer to the suffering other and defended as a basis to profound changes in medical education and physicians’ self-awareness. In this section, two important themes are discussed, namely the vulnerability of physicians and the role of compassion in medical education. This is the final step before bringing the different threads of this dissertation together to discuss end of life care in the final section.

III.A. The Humanness and Vulnerability of Physicians

When hospitality shapes the encounter between strangers, the vulnerability of both parties surfaces. A hospitable host recognizes her anthropological similarities with her guest, specifically their common dignity as humans and their shared and inevitable vulnerability. Although her vulnerability may not be readily clear at that encounter, a self-conscious host is aware of her ingrained vulnerability which would show up sooner or later. Hospitality is the basis of compassion toward the vulnerable other.84

In the medical encounter, physician’s vulnerability is not always clear both to the physician herself nor to her patients. Ironically, being a medical professional does not give practitioners any immunity against diseases and suffering.85 However, the vulnerability of physicians, though unjustifiably ignored, manifests in many ways, during medical training and practice, through their unconscious avoidance of human suffering, and through their high rate of burnout and suicide. It is therefore arguable that by consciously accepting to suffer-with, have compassion toward, their patients that their practice of medicine is built on a robust and fulfilling basis.
III.A.1. Vulnerability of Physicians

As embodied experiences, medical training and practice expose the vulnerability of physicians at different levels. Medical training and practice are embodied in that a great deal of violence afflict both the bodies of physicians and patients. Through their constant interaction with patients, physicians may acquire or spread infections which might harm them, their families, and many other patients. Within healthcare institutions, strict ‘embodied’ procedures are put in place to prevent the spread of those infections, the simplest of which are hand sanitization and mandatory yearly vaccination against influenza. Similarly, resuscitating a patient epitomizes the violence done to her body by the physician’s body.

Furthermore, the demands of medical practice are taxing on the bodies of physicians starting in medical school. Students and residents in training complain of sleep deprivation, unhealthy eating habits, and a sense of uncleanliness after many hours of work. They are inundated with a torrent of scientific medical information that needs to be absorbed through one’s own skin. In the same vein, several trainees highlight the insidious role of discrimination in shaping the culture of medicine during training and practice. Racial and gender discrimination afflicts the educational environment (hidden curriculum) for many physicians in training and influence their own perceptions toward patients.

Moreover, physicians struggle with power dynamics and personal relationships during their training and beyond. Very early in their training, medical students start feeling their separation from the world of lay people, including family and friends, because of the demands and nature of their studies. Yet, the culture of medicine is built on extreme competitiveness that precipitate their anxiety and sense of isolation from peers and teachers. Not only medical students and residents are at the bottom of medical hierarchy, but they also find themselves at the
mercy of (sometimes) abusive teachers and patients. While it is illogical to consider a vulnerable and sick patient a threat to medical trainees, the complexity of power relationships in medicine may justify to some trainees several distorted perceptions and behaviors.\textsuperscript{90}

For instance, Terry Mizrahi argues that internal medicine residents develop an attitude of getting rid of patients that seems to them as necessary to survive their training with the least possible damage. This attitude, she contends, results from a socialization process in which both other colleagues and patients play a central role rather than ‘exemplary’ faculty members. It is a ‘hidden’ subculture among trainees that motivates them to classify patients according to their social and medical worth within the unique and underprivileged social context of urban academic medical centers (unlike the trainees’ mostly privileged backgrounds). Because of this socialization experience, physicians will experience lasting effects on their relationship with patients and on their career choices.\textsuperscript{91}

The most hidden side of physicians’ vulnerability is that related to their emotions and how they affect their practice.\textsuperscript{92} Because of the exhausting demands of their training, physicians start to lose their empathy toward patients when they first encounter them in third year medical school. This is partly attributed to their fatigue and sense of disorientation in the hospital’s strange and disorganized land. Compared to the organized environment of the classroom, patients in real life never follow textbook rules or shift schedules. During this chaos, trainees become focused on survival while unconsciously integrating many negative emotions. Fear of harming patients,\textsuperscript{93} shame of previous mistakes or near-misses,\textsuperscript{94} and sadness and grief for losing a patient,\textsuperscript{95} are among the most influential emotions acquired in training. While a bit of concern to not make mistakes is essential for the safety of patients, too much fear may be paralyzing. Similarly, while grieving a patient is a normal human reaction, ignoring the grief by colleagues
and faculty members is detrimental to the practice of medicine. Both extremes, numbness to human suffering and debilitating sorrow, may lead to physician burnout.⁹⁶

These negative emotions grow their roots in an environment that seems hostile to its dwellers. As mentioned above, because of the complex power dynamics within this environment, powerless trainees victimize their patients and classify them according to their social and medical worth. Because trainees in urban medical centers come from a different cultural, ethnic and educational background compared to their patients, it is very difficult for them to empathize in the hostile and demanding environment of the hospital. After years of self-disciplining and delayed gratification, physicians encounter patients who are perceived to be manipulative of the system or self-destructive through over-eating, alcoholism or drug addiction. Thus, when the suffering of those patients does not make sense from the perspective of privileged and disciplined physicians, empathy and compassion are rarefied and the ability to heal is shattered.⁹⁷

III.A.2. Avoidance of Suffering

One of the detrimental results of a demanding training experience is a tendency among physicians to avoid suffering. Although humans generally tend to avoid suffering when possible, the detrimental effect of such avoidance in the context of medical care cannot be ignored. When physicians avoid their patients because of how much they are suffering, patients feel abandoned by their physicians, and the quality of care they receive is notably compromised. Ultimately, when medical cure is not available, healing through powerful personal presence is not achievable.

However contrary to their professional ideal, physicians tend to avoid suffering because of their unacknowledged vulnerability. Physicians may identify with patients, may feel inadequate in facing complicated diseases, or may have unresolved emotional issues stirred by
certain patients. At a deeper level, physicians may struggle with their own fear of dependence, suffering and death, which is fueled by unrealistic appreciation of medical advancements and an ingrained image of “a lone and heroic physician.” Therefore, when physicians avoid their suffering patients and abandon the opportunity of healing through personal rapport, they fail to connect with their inner vulnerable self; that is what makes it even more difficult for them when they inevitably fall ill.

**III.A.3. Burnout and Compassion Fatigue among Physicians**

As vulnerable humans, physicians are prone to burnout because of the demands of their jobs and their mitigated ability to cope with them. Burnout afflicts normal people on their demanding jobs perhaps because of prevailing negative attitudes, ineffective communications with colleagues, and inadequate self-awareness. Burnout is detrimental to both physicians and patients because it compromises the well-being of physicians and their ability to care for themselves and others. Burned out physicians tend to perform less on the job because of emotional exhaustion, cynicism and a sense of detachment (depersonalization), along with a sense of ineffectiveness and lack of personal achievement (negative self-evaluation). Some specialties have a higher risk of burnout compared to others, such as orthopedic surgery. During their training and beyond, orthopedists and other specialists are more prone to burn out, depression, errors and unprofessional behaviors because of their sense of loneliness and the absence of an effective support system.

Furthermore, as they are constantly exposed to suffering and dying patients, physicians may be prone to compassion fatigue because of compromised boundaries. It might be difficult to strike a healthy balance between compassion and self-care in a time-restrained work environment. Because of burnout and compassion fatigue, physicians are more susceptible to
higher substance abuse behaviors and higher suicidal risk compared to the general population. Therefore, to preserve the well-being of physicians, it is the responsibility of their departments and institutions, and even more broadly of the entire health system, to address their challenges. Although individual well-being programs are useful in some cases, a social and cultural discourse is crucial to publicly discuss the premises of medicine and its goals and limitations.

In short, the well-being of physicians and patients may be severely compromised when medicine is solely perceived as a scientific venture rather than a call to compassionately care for suffering patients using scientific knowledge.

**III.B. The Role of Compassion in Medical Education**

**III.B.1. Compassion as a Basis for Satisfying Physicianship**

It has been previously argued that compassion is the initial motivation of those who pursue medical education. It is because of the call of a suffering other that some people decide to become physicians and extend their compassionate service toward other suffering strangers. Thus, compassion, it is argued, is the basis of the medical enterprise and its primordial moral motive rather than any outside source of morality, whether religious, secular, or market-driven.

Despite the recent advancements of medicine, its practice continues to hinge on phronesis (practical wisdom) which balances the general scientific rule with the particular condition of patients. Phronesis then demands a personal transformation of the practitioners as she initially answers, affectively more than cognitively, the call of a suffering and vulnerable other. Therefore, it has been argued that the presence of a suffering stranger is the first normative demand asking for the sympathy of the practitioner. Sympathy in this case is a precondition of morality. However, hospitality is endorsed in this dissertation as the precondition for
sympathy; to sympathize with a stranger, one should be open to the other. Through hospitality, the physician recognizes the dignity and vulnerability of her patient and is then moved in sympathy to have compassion (suffer with) and offer help. On the contrary, when physicians meet their patients as objects, they objectify themselves and hinder the healing process even when a cure is available. Hence, a compassionate relationship between physicians and patients brings healing to physicians inasmuch as it brings it to patients. The satisfaction of both physicians and patients depends on their hospitable and compassionate interaction.\textsuperscript{111}

For a long time, concerned detachment was the ideal of medical practice. Sir William Osler argued in 1889 to be the ideal of medical practice to prevent physician’s burnout and clinical errors, and to provide scientifically sound clinical judgement.\textsuperscript{112} A professional ideal of emotional detachment with patients grew out of exaggerated emphasis on the scientific and objective side of medicine;\textsuperscript{113} such detachment has tangible negative consequences on the well-being of patients.\textsuperscript{114} Although their unchecked emotional involvement with their patients may influence their reasoning processes, physicians need their empathic abilities to better understand their patients. Initially, physicians need to humbly validate the patient’s story and believe her symptoms,\textsuperscript{115} contrary to the unavoidable epistemic injustice that frequently befall vulnerable patients in a complicated medical system.\textsuperscript{116} Through empathy, physicians use their imagination to better comprehend their patient’s experience and to offer accurate diagnosis and suitable treatment options to fit the patient’s needs.

In medicine, empathy is a kind of “emotion-guided activity of imagination” or “emotional reasoning” that uses emotional connections with other human being to better understand her experience. Although emotions in clinical practice may be risky, physicians need to be self-aware to avoid projecting their own emotions and to fine-tune their imagination. By so
doing, physicians serve their patients through better diagnosis, more accurate understanding of patient’s autonomous decisions, and ultimately a satisfactory healing experience to both patients and physicians. Even empirical studies have shown better clinical results when physicians treat their patients with compassion.

At a deeper level, patients do not heal solely because they autonomously make their own medical decisions. Patients make decisions that are partly shaped by the ways physicians frame their diagnoses and by how much their physicians are emotionally involved in their care. While understandably protecting patient’s autonomy is quintessential for their well-being, non-interference and leaving them alone to sort through their options amount to abandonment and hinder their healing. In other words, empathic rapport with patients preserves their autonomy, however counterintuitive this may sound from an objective scientific perspective. As Jodi Halpern puts it: “empathy can help patients recover the ability to imagine a livable future.” Ultimately, a hope of healing grows out of the presence of a hospitable and compassionate other.

To bring a hope of healing to the patient, a compassionate care giver (a physician, a family member, or a friend) needs to appropriately address suffering as it unfolds. Suffering after a dire diagnosis passes through three phases: a mute phase, an expressive phase, then the evolvement of a new identity (a healed self). Comparatively, to show compassion to the suffering person, compassion should pass through similar phases: (1) a silent empathy; (2) an expressive empathy that helps find a voice to the voiceless (giving a diagnosis helps the patient and her support system to transform her life story using new words and reimagined meaning); and (3) a new identity (a healed self that has its own renewed and hopeful voice). Along with the transformative healing that the patient experience, the compassionate person who cares for her also experiences similar transformation by identifying with his compassionate self. The problem
in medical education and practice resides here: the physician is rarely given the opportunity to be in touch with her compassionate self. Many reasons are to blame including overly emphasized scientific and objective medicine and paternalistic benevolence rather than a sense of common vulnerability between physicians and patients.

Furthermore, to empathize with her patient, a physician needs the patient to empathize with her as well since she also experiences distress when she constantly has to deliver bad news or has to be in the presence of dying patients. Patients have to acknowledge the vulnerability of their physicians for the latter to be compassionate with them in return; an entitled patient repels her doctor who would, when forced, only offer a lip service to compassion. When Ivan Ilyich recognized the distress of his servant Gerasim, he re-evaluated his life anew and accepted death as natural contrary to the cultural ideal he thus far lived. Ivan started to heal when he found himself in the presence of a caregiver who recognized the universal human reality, death, without being apologetic about bringing it up.

In summary, although healing may be narrowly thought of as a physician’s responsibility, it is clear that healing is achieved within a social context where physicians, along with other friends and family members, bring hope and meaning to the suffering patient. Consequently, medical education should center on training physicians in a healing-centered environment. Such environment does not only emphasize the vulnerability of patients but also recognizes and cultivates a sense of vulnerability among physicians for a truly transformative and healing clinical relationship.
III.B.2. Compassion in Medical Education

After establishing compassion as crucial to a satisfying practice of medicine for both physicians and patients, it is warranted to explore the ways to ‘teach’ or cultivate compassion in medical education.

One important starting point for this quest is the bravery to question what has been taken for granted in medical education and to make necessary changes even if they break with long standing practices. Several philosophical and historical inquiries were explored so far in this dissertation so far; however, many inspiring scholars have already used philosophical methods to rethink the efficacy of academic practices and their influence on medical trainees. Similar scholarship should be continued within medicine to equip future generations of practitioners with necessary tools for a healing practice of medicine. While science has overtaken the public and professional perception of medicine, compassionate care of vulnerable patients remains the core of healing. Physicians should recognize their professional identity as scientific healers rather than medical scientists. However effective empathy and compassion are, there remains a danger of using them as another tool to perpetuate physicians’ power, thus emptying them of their personal and human dimension.

Thus far, several factors that interfere with compassionate care has been discussed. Some factors are related to the simplistic understanding of medicine as science rather than a scientifically-inspired healing venture. In identifying medicine with science, suffering is avoided, in training and practice, because it is not measurable nor objectively verifiable. Similarly, the hidden curriculum in medical institutions may shape trainees, practitioners, and faculty members in a way that is indifferent to vulnerable patients. Extreme competitiveness, exhausting workload, and overlooked embodied and emotional experiences of trainees dries up their
reservoir of compassion and fosters a sense of individualistic heroism as central to their professional identity. Further, social and cultural disparities between trainees in urban medical centers and their patients may impeded any sense of similarity, thus shattering the very basis of compassion.

Other factors related to medical education further phase out compassion as irrelevant to the practice of medicine. The environment in pre-medical education initiates aspiring physicians into the competitive environment of medicine through competitive organic chemistry courses, MCAT preparatory courses and exam, and illusionary compassionate volunteering (though mandatory) activities. Even admission officers in medical schools appreciate more robust scientific achievements than compassionate personal attributes. In the same vein, after admission to medical school, students are quickly initiated to medicine’s mode of thinking. Through anatomy lab experience, for instance, students integrate the importance of their eyes/vision in verifying normalcy and ailment more than their listening ears to patient’s experience. Cadavers and their anatomy, unconsciously, become more real for medical decision-making than a personal encounter with a suffering patient. Objective and depersonalized scientific knowledge is enshrined, early in medical training, as the epitome of medical care.

Furthermore, the emotions of medical students are lastingly shaped during their anatomy lab experience. There, students are socialized into medicine through integrating a basic emotional rule, namely detachment. Through humor, an emotional distance is established between students and cadavers; a distance that is replicated with every future encounter with patients. Similar to the instrumental use of human cadavers to gain medical knowledge, students
instrumentally treat patients to advance their career,\textsuperscript{129} while feeding the prevailing denial of death in medicine.\textsuperscript{130}

By the same token, medical knowledge is transferred between teachers and students by the way of classifying patients according to their diseases, rather than as a humane healing encounter.\textsuperscript{131} Such pedagogy, saps the student’s reservoir of compassion because it pushes them to classify patients some as deserving sympathy (because their diseases are scientifically intriguing), while others are blamed for their afflictions (such as an alcoholic diagnosed with liver cancer).\textsuperscript{132}

In general, many educators have ventured into the territory of teaching compassion in medical school and have highlighted relevant points regarding the efficacy of their interventions. It is broadly admitted that teaching empathy and compassion starts early on in life within a compassionate family and a caring community.\textsuperscript{133} It has been also explained that applicants to medical schools have usually been moved by a suffering other to become physicians.\textsuperscript{134} Therefore, the role of medical education is arguably to nourish existing compassion rather than ingrain it in a previously fallow land.\textsuperscript{135} However, Henk ten Have and Bert Gordijn warn of a broader challenge to teaching empathy. They contend that in a globalized world, it is not the sole responsibility of academic medical centers and bioethics to nourish compassion in future generations of healthcare workers. Because of growing inequality, political manipulation and growing nationalistic interests, fostering compassion becomes a collective social-global responsibility.\textsuperscript{136}

It is suggested that admitting students who show more compassion, through their pre-admission activities and/or in a personal interview, is warranted.\textsuperscript{137} However, because of the environment of medical training and practice, students’ compassion may be sapped if no
effective interventions were implemented to prevent that.\textsuperscript{138} Similarly, other educators emphasize the positive influence of good and compassionate role models on shaping compassionate students.\textsuperscript{139} However, such approach presumes a homogeneously compassionate faculty and expects students to acquire compassionate attitude through “osmosis”. Hence, it is argued that an engaging discussion between faculty and students, in a leisure-like and safe context, about their distressing experiences with patients and other colleagues, is necessary.\textsuperscript{140}

One of the most implemented educational interventions among students are those that foster a healthy personal curiosity in patient’s experience and suffering. Unfortunately, many physicians do not recognize the dearth of compassion in medical practice until they themselves fall ill and are treated as patients. When they experience, first-hand, what their patients endure, physicians recognize the harm caused by the ideal of equanimity.\textsuperscript{141} Therefore, to correct their detachment from patients, physicians have to cultivate a hospitable openness and personal (rather than pure scientific) curiosity toward their patients to better understand their ordeal.\textsuperscript{142} Rita Charon and many other educators suggested that nourishing narrative abilities among students has a positive effect on the latter’s compassionate rapport with patients. Through a curious approach to patients, physicians read the verbal and nonverbal communication bits and use them to mitigate the uncertainty of human body and medical knowledge. Encouraging students to write medical histories from the perspective of their patients helps them imagine and participate in their ordeal. In addition, educators have used stories to foster a meaningful discussion about patient suffering and physician experience.\textsuperscript{143} Some even suggest using stories written by faculty members to teach self-reflection and explore unconscious prejudices toward patients.\textsuperscript{144}

Moreover, through openness to patients, physicians embrace their own compassionate selves and inner emotional lives. Activities that foster reflection and self-awareness, whether as
part of medical curriculum or within their religious or broader community, help students unveil their inner selves and suppressed emotions. Self-awareness shields students within the demanding practice of medicine against burnout and compassion fatigue. Similarly, by teaching students to accept their own vulnerability as integral to their embodied professional experience, they are better equipped to encounter patients with emotional honesty and healing personal presence. Flexible clinical demands on students provide enough time for reflection and personal engagement with patients. Also, developing interview skills to be patient-centered rather than symptoms-centered nourishes the students’ compassionate rapport with their patients.

**IV. Hospitality and End of Life Care in Global Bioethics**

This final section will discuss the moral issues related to end of life care and its two options, euthanasia and physician-assisted suicide (PAS) on the one hand, and palliative and hospice care on the other. The brief discussion will use the moral mindset developed in this dissertation to argue against euthanasia and PAS and to advocate an earlier and broader use of palliative and hospice care to attend to those close to their death. The discussion is not meant to be exhaustive of all the arguments relevant to those practices; however, it highlights that end of life care, along with other pressing global ethical issues, should be seen through a broader, more inclusive perspective to overcome impasses in ethical discourse.

**IV.A. The Hospitality Case against Euthanasia and Physician-Assisted Suicide**

Over the past few decades, euthanasia and PAS have gained ground in liberal societies and were legalized (or introduced for voting) in some countries and states. Regardless of their technical differences, euthanasia/PAS are introduced as a legal option under the banner of “death with dignity” or “a right to die”. Yet, it has been previously discussed that the peculiar
understanding of human dignity and rights in this context is controversial. Both opponents and proponents of euthanasia/PAS use human dignity to advance their arguments, though each on different understanding of the concept.\textsuperscript{149}

Proponents of euthanasia/PAS use dignity in its ‘attributed’ sense to justify an -almost absolute- freedom to patients to end her life. This sense hinges on the respect one can garner within her community. However, because of illness and invasive medical interventions, a person may feel that her life is so deformed and is not worth living anymore. She hence has the right to end her life while still having her dignity and ability to decide. To protect her vulnerability against the encroachments of medical technology, the argument goes, autonomous decision-making is her shield. In short, proponents of euthanasia/PAS use a narrow sense of human dignity and vulnerability to justify an overly individualistic autonomous decision making.

However, their argument does not square with a deeper questioning of their premises within the hospitable framework advanced in this dissertation. Other relevant senses of dignity were discussed previously. Along with the ‘attributed’ sense, dignity refers to the ‘innate’ and inalienable worth of humans for merely being humans. Also, ‘inflorescent’ dignity manifests in achieving human excellence through going above and beyond what every person is expected to do.\textsuperscript{150} Further, ‘residual’ dignity is the value communities bestow on individuals even when the latter have not acquired (or are not able to acquire) any human excellence. It is a universally recognized sense of dignity that is recognizable in respecting dead people and ritually burying them.\textsuperscript{151}

Ultimately, any understanding of human dignity presupposes a human community that equally dignifies each member (regardless of their achievements). A community ingrains in its members a communal identity through embracing every member with dignity; a community
extracts its sense of dignity from the dignity with which it embraces every member. In medical care, patients do not have consensus on the meaning of dignity close to their death. Dignity has a subjective and dynamic meaning that evolves over time. While some patients value independence near death, others perceive dignity in preserving meaningful relationships, in relative freedom from distress and pain, and in being surrounded with respectful, calm and safe environment.

Furthermore, proponents of euthanasia/PAS contend that human vulnerability in front of death is mendable through autonomy. However deeply connected are vulnerability and autonomy, autonomy cannot stand on its own without recognizing the importance of human vulnerability for a healthy development of autonomy. Fundamentally, humans strive to be autonomous, but they will always be dependent on others as members of a human community. As previously argued, vulnerability is deeply rooted in the mortal human condition in a way that only compassionate neighbors can mend. In contrast to one’s own autonomy -and responsibility-stands the vulnerability of the other. Therefore, the moral question should be “HOW to act as a compassionate neighbor toward the vulnerable other” rather than “WHO is vulnerable around me,” because ultimately everyone is vulnerable. Consequently, a relational turn in bioethics has recently materialized to correct the over-individualistic discourse in bioethics. More voices express the importance of relations in shaping a meaningful and substantial discourse in bioethics within a changing world, locally and globally. Yet, such emphasis on relationships does not have to come at the expense of individuality and autonomous decision-making.

At a general level, it is important to understand the context within which arguments for euthanasia/PAS have evolved. Because of recent medical advancement and multiplication of -sometimes- effective technological interventions, euthanasia/PAS grew as a protest against the
encroachments of a powerful medicine on the dying process and its unnecessary prolongation.\textsuperscript{157} Many authors have detailed the changes brought by medicine to the dying process in the US from the side of medical practitioners, such as Haider Warraich’s \textit{Modern Death: How Medicine Changed the End of Life}.\textsuperscript{158} Other studies have shown the role of medical advancements in aggravating a public denial of death,\textsuperscript{159} even among physicians who constantly encounter death. Without acknowledging death as integral to the human condition, doctors may be easily tempted to extend life as long as medical technology permits,\textsuperscript{160} especially when they forget that they also are vulnerable and inevitably mortal.\textsuperscript{161} Acknowledging death is not only crucial for medical care, but is similarly vital for a meaningful living.\textsuperscript{162} By the same token, not only death shapes how humans live, but also how humans live and perceive life (at its different stages) also shapes how they die.\textsuperscript{163}

Therefore, it is warranted to invoke a substantial social discourse to articulate a contemporary \textit{Ars Moriendi}. The goal should be to establish a communal, non-relative,\textsuperscript{164} understanding of the good death, not as an individualistic confrontation with death, but as a communal embracing of human mortality.\textsuperscript{165} Along with elaborating on an \textit{Ars Moriendi} for modern times, a robust discourse should also explore the meaning of old age, especially when medicine and public health interventions have extended longevity alongside chronic illnesses and long-term disabilities. Hence, a dialectic balance between frailty and strength is inevitably at play with advanced age.\textsuperscript{166} However, one of the hurdles for a sensitive discussion of aging in modern society is the prevailing bourgeois morality, specifically in western countries, which values the accumulation of wealth and health and perceives bodily decline as a failure.\textsuperscript{167} Such distorted morality is still at play even when it is used to oppose age discrimination in the workforce. When proposing an equal footing for all workers regardless of their age, devaluation
of physical decline lurks within the discussion. Similarly, by defending euthanasia/PAS in the name of dignity, a morality that negatively perceives aging underpins the discussion and may insidiously foster an obligation to end one’s own life before it lapses from its dignified status to a senile embarrassment.  

Ultimately, a great deal of communal imagination and hospitality is necessary to reach a meaningful Ars Moriendi to confront a globalized and aggressive practice of medicine. Most importantly, a social adoption of hospitality toward aging patients should open the bioethical discourse to those aspects of suffering and dying that are usually overlooked because of advanced interventions. A hospitable healthcare embraces palliative and hospice care for every mortal human being, even those who are not yet on their deathbed.  

IV.B. The Hospitality Case for Hospice Care  

Historically and linguistically, hospitality to strangers was at the roots of the first hospital and contemporary hospice movement. Although in both cases Christian ethos inspired welcoming those who suffer and caring for their needs, hospitality toward strangers is valued among various religious and value systems for the same reasons. Because she recognizes her own innate dignity and vulnerability, a hospitable host acknowledges her moral responsibility toward a valuable but stranded stranger and is moved to stand in solidarity with him.  

The hospice movement has evolved in the late 1960s because of the efforts of Cicely Saunders who established the first hospice of St Christopher in London in 1967. Her work to address the human suffering in a time of increasingly aggressive medicine was to counter-balance the rising voices to legalize euthanasia/PAS in Europe. While palliative medicine refers to the medical interventions to ameliorate physical suffering, hospice care addresses all physical, psychological, social, emotional and spiritual aspects to facilitate a peaceful death to the patient
and a healing mourning environment to her family. This multi-dimensional approach to suffering gave rise to the concept of “total pain” advocated by Saunders; many scholars since then have emphasized a holistic approach to suffering and chronic illness.171

At the end of life, human vulnerability is most exposed because of its rootedness in innate mortality. Although physical pain, especially persistent pain, feeds one’s sense of vulnerability, other elements of suffering are crucial near death, such as the burden of self-care, the disruption of daily activities, and the fear of death, loneliness and uncertainty. It is therefore very important for hospitable physicians to recognize the human anguish near death and its many intricacies to facilitate the healing of the whole person.172 Furthermore, health systems and medical schools should be hospitable to the premises and practice of palliative and hospice care to ingrain them in the new generations of practitioners. Palliative and hospice care has gained grounds in medical education over the past few decades, but its integration has not changed the way medicine perceives its goals. As with other useful tools, palliation is used as a tool to improve patients’ satisfaction within an ever-powerful medicine, rather than as a way to nourish physician-patient human rapport. Unfortunately, using palliative medicine instrumentally deprives physicians of the opportunity to perceive accompanying patients near death as a privilege: a privilege that has a healing effect on them and on how they perceive their own lives.173

Furthermore, education in palliative medicine and its use is still limited and far from occupying a central role in future practice of medicine regardless of the specialty. Physicians tend to perceive death as their enemy and use every available tool to fend it off. Further, in the US, Medicare and other insurance companies reward aggressive interventions with higher reimbursement than more peaceful (palliating) care. In medical schools, palliative medicine is not integrated into the curriculum in a way that advances healing rather than intervention regardless
of specialty. Rather, palliative and hospice care are usually introduced in pre-clinical lectures when students are not in direct contact with suffering patients.\textsuperscript{174}

Nonetheless, several attempts to expose new practitioners to aging and death were successful. Even a theoretical seminar in old age had a positive, long-term effect on the attitude of medical students toward the elderly and their health needs.\textsuperscript{175} Yet, a more sophisticated pedagogical intervention in pre-clinical years may have a profound influence. It has been suggested that broadening the perspectives of medical students to include psychological, social, cultural, and spiritual determinants of health may counterbalance a narrow-minded interventionist understanding of medical care. Further, it is necessary to unveil the hidden curriculum in medical institutions that disproportionately rewards physicians for more interventions and to immune students against such mentality through constant reflection and self-awareness.\textsuperscript{176}

Moreover, while it is necessary to train more practitioners in palliative medicine to meet the growing need,\textsuperscript{177} it is equally important to encourage all specialties to introduce palliative medicine early. In a chronic illness, for instance, consulting with palliative care team to establish the goals of care is warranted rather than waiting until all effective medical interventions are exhausted.\textsuperscript{178} To avoid unnecessary and debilitating interventions, physicians ought to visit the goals of care, early and frequently, to adjust them as the disease progresses.

Since suffering and death do not only afflict those who are sick but may also compromise the well-being of their family members and friends, a public health approach to dying and bereavement is warranted. It is argued that a public health approach to bereavement increases the availability of community services outside the umbrella of sophisticated medical institutions.\textsuperscript{179} By moving bereavement from the private space to the public, human mortality becomes more
salient in society offering a better opportunity to address suffering at various levels. Further, by moving bereavement to the public space of strangers, a public discussion would challenge the community to find a common ground on which to build its own palliative care. The province of Kerala, in India, for instance, proves that developing a hospitable and healing palliative care system does not require lavish resources. Rather, a social acknowledgement of universal vulnerability close to death nurtures a sense of communal solidarity to shape palliative and hospice care within its available resources to reach everyone who is in need. Extensive work has been done to advocate approaching palliative and hospice care from a public health perspective; however, the detailed arguments in favor and the projected advantages of such approach are beyond the scope of this dissertation.

Unfortunately, the presence of palliative and hospice care in schools of public health in the US is meager. Very few schools of public health expose the new generation of practitioners and policy makers to the details and intricacies imbedded in palliative care. This will make it even more difficult to the growing number of patients and their family members to heal in a system that ignores death and its scathing presence. Moreover, policies that demand evidence of the effectiveness of palliative care, similar to other medical interventions, does not recognize the difficulties associated with research in patient- and family-centered care near death. When healing is subjectively constructed to serve the specific needs of a patient in her social context, it is very difficult to measure the healing effect of the personal presence of a hospitable and compassionate healthcare worker. Notwithstanding the importance of rigorous research in palliative medicine, by unnecessarily emphasizing an evidence-based practice, palliative care lapses into the status of another tool in the hands of medicine, again, ignoring the importance of personal presence in healing a wounded humanity.
Obviously, close to death, religious communities play a significant role. Because of their long-standing reconciliation with death, regardless of their specific metaphysics, religions provide their believers with tools to heal. Despite their vulnerabilities, believers are healed, not because of a dogmatic-theoretical explanation of diseases and death, but because of a ritualized presence of other believers with the dying person and her family. By the same token, it is warranted that religious leaders and theologians engage in substantive discussion with physicians and healthcare workers who belong to their communities. Such discussion should help tailor the healing approach of both the community and the providers toward dying people and their families. Ultimately, preparation for death should not be left till the very end of life when death is imminent. Rather, confronting death takes unceasing living toward dying within a caring community.

V. Conclusion

Building on the Orthodox bioethical *phronema*, this chapter discussed the third anthropological concept as a common ground for global bioethics. Hospitality is fundamentally related to both human dignity and vulnerability discussed in the previous two chapters. The divine reconciliation between the creator and the creation materialized through the incarnation of Jesus Christ. By becoming human, the Second person of the Trinity performed the mission which humans failed to pursue, i.e. bridging the existential gap between the divine and created realms. His priesthood shapes the royal priesthood of every believer and underlines the responsibility of the Church to find a common ground in a social-global order of strangers, especially in medical practice and ethics. It was therefore argued that hospitality toward the strange other is ingrained in the Christian ethos and demands standing in solidarity, especially in dire times of illness. Building a solidaristic healthcare system does not only provide care for everyone who is in need,
but also shapes the entire enterprise of medicine through sincere openness toward new practitioners and the public. Through a hospitable openness in medicine, a more satisfactory and humane care would evolve. These ideas were briefly used to discuss ethical dilemmas at the end of life. Approaching dying patients and their families with hospitality, preserves their dignity and tends to their vulnerability. Not only patients receive care that is centered on their needs, but also physicians practice a personally-fulfilling and ultimately healing medicine.

19 Owens, Hospitality to Strangers, 7-31.
21 Bretherton, “Tolerance, Education and Hospitality,” 80–103; Also, Bretherton, Hospitality as Holiness, 121-159.
22 Bretherton, “Tolerance, Education and Hospitality,” 80–103; Bretherton, Hospitality as Holiness, 121-159.
27 Owens, Hospitality to Strangers, 7-31.
30 Barbara Prainsack and Alena Buyx, Solidarity in Biomedicine and Beyond (Cambridge: Cambridge University Press, 2017), 1-42.
31 Prainsack et al., Solidarity in Biomedicine, 52-57.
34 Prainsack et al., Solidarity in Biomedicine, 1-18; Peters, Solidarity Ethics, 17-32.
35 Peters, Solidarity Ethics, 17-32.
37 Peters, Solidarity Ethics, 69-91, 111-120.
38 Peters, Solidarity Ethics, 111-120.
41 A detailed exploration of solidarity in the healthcare systems of various European countries is discussed in Ruud ter Meulen, Wil Arts, and Ruud Muffels, eds. Solidarity in Health and Social Care in Europe (Philosophy and Medicine, Dordrecht: Kluwer Academic Publishers, 2011).
42 Prainsack et al., Solidarity in Biomedicine, 97-122.
43 Prainsack et al., Solidarity in Biomedicine, 123-144.
48 Prainsack et al., Solidarity in Biomedicine, 43-96.
49 Prainsack et al., Solidarity in Biomedicine, 169-186.
50 Noble et al., “Hospitality as a Key to the Relationship,” 47–65.
52 Prainsack et al., Solidarity in Biomedicine, 169-186.
60 Ruth Macklin, *Double Standards in Medical Research in Developing Countries* (Cambridge: Cambridge University Press, 2004).
77 Meghan O’Rourke, “Doctors Tell All and It’s Far Worse Than You Think,” *The Atlantic*, 2014.

Poirier, Doctors in the Making, 45-71.


Poirier, Doctors in the Making, 95-153.


Ofri, What Doctors Feel, 64-94.

Ofri, What Doctors Feel, 124-139.

Ofri, What Doctors Feel, 98-121.


Ofri, What Doctors Feel, 6-22.


Poirier, Doctors in the Making, 125-153.

Montgomery, How Doctors Think, 157-175.


Owens, Hospitality to Strangers.

Halpern, From Detached Concern to Empathy, xi-xvi.


Halpern, From Detached Concern to Empathy, 1-13.

119 Halpern, From Detached Concern to Empathy, 11, 101-127.
135 Charlton et al., “Caring for Ivan Ilyich,” 93–95.
139 Ekstrom, “Liars, Medicine, and Compassion,” 159–80.


CHAPTER SEVEN: CONCLUSION

In this dissertation, anthropology has been argued to be a possible ground for consensus in a global and pluralistic bioethical discourse. From an Orthodox Christian perspective, anthropology derives from Christology to understand the genuine human condition and its eschatological potential. Thus, an Orthodox Christian hermeneutics was explored to highlight a social construction of universal human dignity and innate vulnerability. When both dignity and vulnerability were explored, it was clear that they are embedded in a human community that is able to protect dignity against the circumstances that expose vulnerability. In the medical encounter, it was also emphasized that the dignity and vulnerability of physicians should be recruited as central to a healing relationship.

Therefore, human dignity and vulnerability were connected to what was argued as the basis of ethics among strangers, namely, hospitality (philoxenia): the love of the stranger. The core relationship between hospitality, dignity and vulnerability in Orthodox hermeneutics, it was suggested, derives from the triadic Christological mission of priesthood, kinghood, and prophecy, respectively. When a physician encounters her patient with hospitality, not only the physician but also the entire medical enterprise is challenged to stand in solidarity with vulnerable patients regardless of how different or far they may seem. A hospitable physician recognizes the dignity and vulnerability both in herself and in her patient, challenging her to a healing rapport using gratitude and compassion. Both gratitude and compassion shall change, it was argued, the way medicine is taught to new students and the way it is practiced, locally and
globally. The example of end of life care is used to illustrate how such a phronema may change the way a society cares for dying patients and their families.

In the introductory chapter, the layout of this dissertation and its ultimate goals were discussed within a universal mission of the Orthodox Church in a pluralistic and globalized world. The cultural and scientific context where medicine developed in Western countries is relatively foreign to Orthodox Christianity; however, Orthodox Christians today, those who live in the East or the West, have to deal with the consequences of recent medical advancements and related ethical dilemmas. Furthermore, since some of these moral issues afflict vulnerable humans across the world, the Orthodox Church should engage in a vehement advocacy to protect them, building on her claimed catholic (universal) mission.

Nonetheless, Orthodox Christian bioethicists have yet to engage in this global dimension of bioethics: not only Orthodox bioethicists have avoided engaging the international dimension of medical practice, but they also avoided, in the most part, discussing the social determinants of health beyond the access to medical care.

In line with the majority of Orthodox bioethicists, this dissertation explored the Orthodox Christian heritage to unveil a unique phronema for an Orthodox bioethics. However, this dissertation goes a step further in this regard in that it seeks an inclusive and dialogical bioethics which highlights the responsibility of Orthodox Christianity in a pluralistic world. While those bioethicists established what is unique about Orthodox bioethics, this dissertation pursued the commonalities with other religious and secular value systems. Therefore, in absolute contrast with Tristram Engelhardt who, philosophically-but-in-theological-garments, rejects the possibility of ethical common ground, the argument advanced here established this common ground using an authentic Orthodox theological anthropology. The advocated common ground
derives from a common anthropological experience of life, suffering and death, rather than from a rational consensus on ethical principles. To address evolving global bioethical issues, this dissertation challenged the universal mission of the Orthodox Church that is rooted in the personal truth of Jesus Christ as the only savior of humanity from death.

Chapter two discussed the hermeneutics on which Orthodox theology can actively engage in bioethical issues at the global level. This hermeneutics aimed at developing a patristic phronema that is relevant to the mission of the Orthodox Church in global bioethics. Building on an inclusive anthropology, the Orthodox Church should bear the responsibility to find a common ground with other groups (regardless of how different they may seem in their ethos) so that the church may be consistent with her universal eschatological-eucharistic identity and mission.

Discussing the hermeneutics of Orthodox theology involved an exploration of its theological premises for an Orthodox Christian bioethics. The first premise was related to the historical encounters between Orthodox Christianity, on the one side, and Western Christianity and post-modern ideas where contemporary medicine has developed, on the other. This brief historical background was essential to understand the internal dynamics of theological and hermeneutical evolvement of Orthodoxy regarding modernity and post-modernity.

The second premise of this hermeneutics explored the theological tenets which support an active and inclusive involvement of Orthodox Christians in global bioethical discourse. Building on the triadic mission of Christ, Orthodox Christianity should establish an inclusive global bioethics and a common ground with other value-systems. As God and man, Jesus Christ was the king, the prophet and the priest; these three callings fashion an authentic mission of the Orthodox Church in a globalized world. The core relationship between hospitality, dignity and
vulnerability is established in their respective derivation from Christ’s priesthood, kinghood, and prophecy.

In order to bring practical insights to the study of global bioethics, the previous hermeneutical premises were used to unfold the anthropological tenets shaping humanity’s mission in the world. The first tenet was related to the Orthodox Christian understanding of the Imago Dei which contradicts the modernist and post-modernist narrow understanding of humans as rational beings. Because of the ancestral sin, the divine-human relationship was shattered, and consequently sin fostered alienation, corruption and death in the world.

The second tenet of this anthropology explored the role of Orthodox Christian embodied spirituality and asceticism in fashioning the lives of the believers and their mission in the world. It was argued that embracing one’s own vulnerability is the first step to stand in solidarity with other vulnerable humans and to recognize that the human experience of vulnerability and death unites them more than their rational agreement.

Starting from a missionary anthropology, eschatology serves as the interpretive lens for a phronema that shapes the Orthodox Church’s responsibility in today’s world. Aspired by the economy of the Holy Spirit, Orthodox Christians may hospitably extend their liturgical experience of the eschata (the last things) and engage in a transfiguring mission in the world. Because of what happened in the Pentecost, this mission puts the onus of finding a common ground, in bioethics at least, on the shoulders of Christians. When extending the liturgy beyond the liturgy, and by taking the “sacrament of the brother [and sister]” seriously, Christians recognize the unity of the entire universe in its createdness and in its longing toward God. Adopting this inclusive phronema challenges Christians to transfigure the world through a pastoral, missionary and prophetic way of living.
Chapter three discussed the current status of bioethical discourse within the pluralistic and complex global context. It highlighted the prevailing trends in secular and religious bioethics over the past few decades. Ultimately, this chapter advocated an inclusive iconic *phronema* for Orthodox bioethics which helped find a common ground for global bioethics.

To situate the advocated inclusive *phronema* and substantive discourse within the contemporary global scene, an exploration of the pluralistic context of contemporary bioethics was initiated. Several factors shape the contemporary global context for medical practice including, communication and movement, consumerism and ecological crises, and the effacement of national boundaries and power. These changes highlight the universal responsibility toward those who are most disadvantaged especially in regard to health and bioethical dilemmas. Arguing against a “culture war” and a “clash of civilizations” perspectives toward the current world order, this chapter adopted a dynamic understanding of human culture and identity. The discussion highlighted the responsibility of Christians to be neighbors of everyone else, near and far.

Through a brief historical analysis, this chapter also demonstrated how mainstream bioethics developed over the past few decades. While its first pioneers perceived a global (comprehensive and international) version of ethical inquiry into life sciences, bioethics in the US evolved as an individualistic and procedural enterprise. However, because of recent global developments, a deeper scrutiny into medical practices, and a broader approach to health and illnesses, a global and multi-disciplinary bioethics evolved in academia and at the international governmental level. However, a broader adoption of global bioethics ethos is warranted; this dissertation advocated a deeper involvement by Orthodox Christians in this global ethos. This
dissertation challenged Orthodox Christians to actively stand in universal solidarity with the vulnerable and marginalized, at least pertinent to health disparities.

Secular bioethical discourse was not the only salient discourse over the past few decades. Some religious voices in bioethics were influential in shaping the public discourse. However, religious bioethicists approached the prevalent secular discourse in two different ways. On the one hand, some religious bioethicists are entrenched in the prevailing individualistic and procedural bioethical discourse although they offer a different -religious- ideology. On the other hand, other bioethicists venture within an original religious mindset into a broader territory in bioethics. Furthermore, while the former group advocates a bioethics in religious garment, the latter group perceives bioethical dilemmas through different lenses. The latter group is usually open to substantive dialogue with other value systems because of its acknowledgement of a unifying human experience of illness, suffering and death.

Two examples were discussed under the first approach in religious bioethics: Robin Gill’ Health Care and Christian Ethics and Dennis Macaleer’s The New Testament and Bioethics: Theology and Basic Bioethics Principles. Comparatively, two other authors are discussed as representative of the other approach in religious bioethics: Allen Verhey’s Reading the Bible in the Strange World of Medicine and Lisa Sowle Cahill’s Theological Bioethics: Participation, Justice, and Change. Despite their different religious traditions, Verhey and Cahill are both critical of the prevailing individualistic mindset and both advocate an activist involvement in public life. To protect the health and well-being of the vulnerable, Verhey argues for compassion and Cahill aspires a social ethics to eliminate health disparities.

Aspired by the examples of Verhey and Cahill, the argument of this dissertation proceeds in favor of an inclusive and globally-oriented Orthodox Christian phronema in bioethics. The
discussion briefly explored the work of a few notable Orthodox theologians and bioethicists to situate the dissertation’s argument within the broader Orthodox theological scene. Ultimately, the goal was to extend a liturgical Orthodox identity beyond the traditional boundaries of the church and to challenge believers to address contemporary ethical challenges. A detailed critique of Engelhardt’s version of Orthodox Christian bioethics is offered to demonstrate how he departs from the inclusive theological bioethics advocated in this dissertation.

Consequently, an iconic Orthodox Christian phronema for bioethics was advanced to engage in global bioethics. In Orthodox theology, icons stand as windows that bridge the existential gap between the created and divine realms. Icons extend a hospitable and constant invitation to the created world in the person of a faithful beholder who belongs to the community. It was argued that the eschatological, realist and hospitable dimensions of the icon are important in shaping an inclusive bioethics. While the eschatological dimension brings hope in a glorified eschatological reality, the realist dimension is cognizant of the fallen, mortal and vulnerable reality of this world. In its hospitable dimension, an icon gives hope to the world through those who in faith take its universal mission seriously. This phronema emphasizes the serious responsibility that the Orthodox Church should bear to find a common ground for substantive dialogue in global bioethics.

In chapter four, the discussion concentrated on the first concept advocated for an Orthodox Christian bioethics and as a basis for a common ground in global bioethics, namely human dignity. The foundations of human dignity were discussed in Orthodox theology and in secular bioethical discourse. Through this discussion, gratitude was promoted in healthcare as the first concept in a content-full and globally-sensitive bioethics. Ultimately, gratitude should play a major role in shaping medicine in its clinical and systemic enterprises.
This chapter started by reiterating the theological principles discussed in the second chapter to defend an Orthodox Christian understanding of human dignity as cardinal to a constructive engagement in a global bioethical discourse. Within a Christocentric hermeneutics, human dignity was initially argued to derive from the creation of humans in the image and according to the likeness of God. Hence, respecting human dignity was advocated by emphasizing the dignity’s embodied and communal experience in times of sickness and suffering; that is in contrast with a misplaced emphasis on respecting autonomy as equal to respecting dignity.

To build a common ground, human dignity was then explored within the prevalent philosophical framework of contemporary secular bioethics. This discussion established a non-religious support for the use of human dignity in bioethical discourse. The narrow understanding of human dignity as solely related to autonomy was deemed insufficient for a substantive global discourse.

A detailed historical development of the concept of human dignity and some of its philosophical and practical difficulties were explored. Dignity has several meanings and its innate and inalienable sense was emphasized as central to an ethos that is respectful to all humans. Furthermore, the relationship between human dignity and human rights emphasized the importance of respecting human dignity as a social ethos whereby human rights are used as a tool (rather than as an ideology) to guarantee a decent life for everyone. Dignity was consequently discussed from the vantage point of health and illness especially because of its special presence within an aggressive practice of medicine. Dignity and vulnerability were shown to be organically connected in confronting human fragility in front of illness and death.
To further the discussion of dignity in global bioethics, the practical dimensions of respecting human dignity were considered. Gratitude was argued to be the proper virtue for a dignified humanity. In return for a socially constructed and bestowed dignity (a social gift), gratitude fashions any given community, and should therefore fashion medicine as an enterprise and as a clinical encounter. Because of globalization, human lives are more entangled than ever before. Further, medical practice and research today overlooks traditional boundaries and has, in several cases, harmed the dignity of many people around the world. Over its recent history, medicine has benefited from the sacrifice of many practitioners and patients, so it has to show gratitude not only toward those who passed but also toward current contributors to its knowledge and development. Physicians have to even be grateful to their own patients whom they serve. Hence, a brief discussion of gratitude and its moral repercussions is pursued in religious, philosophical and psychological perspectives.

Chapter five elaborated on the second of the three concepts central to the advocated Orthodox Christian bioethics and the common ground for global bioethics. The understanding of human vulnerability was discussed within the Orthodox Christian theology and secular bioethical discourse as it derives from the universal embodied experience of all human beings. The goal of discussing vulnerability was to promote compassion as central to the practice of medicine. In combination with gratitude, compassion shall fashion a solidaristic medicine through medical education and systemic changes to care provision for the suffering and dying.

This chapter starts by briefly exploring a theological understanding of human vulnerability within Orthodox Christian hermeneutics and its practical ramifications to ameliorate human suffering. In Christological terms, human vulnerability is related to Christ’s prophetic mission which announces that God is the only source of life. Humans are vulnerable
because of their mortality which was the result of their alienation from God since Adam and Eve’s sin. Illness, suffering and death result from the state of estrangement, away from God, others and self. Therefore, the role of Christ’s incarnation in mending the state of alienation and its consequent vulnerability and mortality was discussed. To re-establish the broken relationship between God and the universe, Christ took a human body and compassionately suffered with humans through the anguish of death on the cross; it was his compassionate providence that redeemed humans from their mortality.

While Orthodox Christianity positively perceives medicine and its practitioners, theologians warn against enshrining medicine as a savior of humanity. Rather than vehemently fighting death, embracing one’s own vulnerability, in an ascetic and spiritual life, is the way to bear the vulnerability of others and then redeem the entire creation.

To advance a common ground, the concept of human vulnerability was then discussed as it relates to the prevalent secular bioethical discourse. Because of its growing presence in secular discourse, vulnerability can play a central role in shaping a common ground in global bioethics. The premise of a secular adoption of vulnerability is its fundamental relation to human dignity as if vulnerability and dignity were the two sides of the same coin; if humans were not invaluable, one should not be concerned when they become/show as vulnerable.

Therefore, a central presence of vulnerability challenges the narrow agenda of mainstream bioethics, especially in regard to its intertwined philosophical and political perspectives. Its recent adoption in the UNESCO *Universal Declaration on Bioethics and Human Rights* opens the door for more international cooperation among nation-states to improve universal human health.
In general, vulnerability has a normative ethical dimension that challenges everyone to care for those who are vulnerable wherever they are. By embracing universal vulnerability, contemporary bioethical discourse would espouse a broad and solidaristic agenda among various communities, nations, and racial groups. Furthermore, recognizing the universality of vulnerability helps healthcare workers to bridge the gap that separates them from their patients and to compassionately care for them.

Therefore, to further the discussion on human vulnerability, this chapter considered the central role that compassion, i.e. suffering with, needs to play in medicine. In the face of a mechanistic medicine, compassion helps bridge the gap between two equal fellow humans and helps them make relevant and personally fulfilling decisions. The ultimate goal of this inquiry was to find the deepest motivator for medicine and its practitioners. Death proved to be at the core of medicine, not as a foe to be defeated but as the universal experience that motivates some equally vulnerable but compassionate people to become physicians.

To achieve this goal several themes had to be explored. The first theme dealt with the presence of vulnerability in the matrix of medical care. Although all humans are vulnerable because of their mortality, patients are especially vulnerable because they are forced to seek healing in the strange land of medicine. The land of medicine was then explored at various levels: its social standing and its underpinning theoretical premises, which both influence how physicians are socialized into the practice of medicine and how they care for their suffering patients. The second theme was related to the motivation behind becoming a physician. Through a deeper questioning of medical care, it was revealed that compassion toward the suffering and dying is what motivates some people to pursue medical training and become physicians. It is
only through suffering with others, i.e. compassion, that an encounter between two vulnerable strangers can be transformed into a healing relationship.

Furthermore, to fully understand the role of compassion in healing, a third theme was discussed, namely, the meaning of human suffering. Suffering was shown to be more than physical pain. In case of suffering, it was argued, the goal of medicine is not only treating the underlying disease or fixing the ailing organ; rather it is healing the whole person whose relation to the world and self is disrupted. However, in medical schools, this holistic approach to healing is thwarted for future practitioners and it should be re-established as paramount to the entire enterprise of medicine. Even if some aspects of suffering fall outside the jurisdiction of medicine, practitioners should acknowledge them to prevent further suffering.

In chapter six, the role of global solidarity in shaping medical systems especially near the end of life was discussed. After establishing the importance of human dignity and vulnerability in bioethical discourse, this chapter elaborated on the third of the three concepts advocated for an inclusive Orthodox Christian bioethics and a common ground for global bioethics. The core relationship of hospitality with dignity and vulnerability was discussed within Orthodox Christian theology and secular bioethical discourse. Ultimately, solidarity sprouts from hospitality as it relates to dignity and vulnerability. Solidarity needs the universality of gratitude and the particularity of compassion to shape globally-sensitive medical education and systems. All the threads of this dissertation were used to discuss end-of-life care within the advocated inclusive phronema and substantive bioethics.

This chapter starts with exploring hospitality within an Orthodox Christian hermeneutics and its practical ramifications as a basis for solidarity among strangers in healthcare. In Christological terms, hospitality (philoxenia, the love of the stranger) derives from Christ’s
priesthood through which Christ bridged the existential alienation between the divine and created worlds. In the Eucharist, the church extends the priesthood of Christ and recognizes her own identity and mission toward the world as a hospitable and priestly missionary to bring it back to God. Therefore, hospitality was found to be integral to the Christian ethos and even to non-religious ethical discourse. Without hospitality, a moral agent is not able to recognize the presence of a stranger other and cannot bear any moral responsibility toward her. However, with hospitality, the stranger is recognizable and thus has a moral demand upon the beholder.

Consequently, hospitality, it was argued, is cardinal to foster a healthy public space where strangers meet and thrive. Similarly, hospitality is important to the physician-patient relationship since they meet as strangers and each one of them has to enter to the personal space of the other to heal and be healed.

At a broader level, hospitality is the basis of solidarity among strangers when utter strangers are willing to accept a cost for assisting others who are similar to them. Solidarity was shown to be deeply rooted in human history and Christian ethos. Most recently, solidarity shaped the provision of health care in European countries and has also inspired the UNESCO *Universal Declaration* to address rising global bioethical issues. Notwithstanding possible challenges to its relevance at the global level, solidarity is pregnant with hope in the goodness of human society. Whereas human fallenness breeds alienation and enmity, solidarity brings hope in a better human condition.

To establish the practical ramifications of the core relationship between hospitality, dignity and vulnerability, the discussion addresses first the role of gratitude then that of compassion in global bioethics.
First, to stand in solidarity with patients across the globe, gratitude was previously argued to be an important value in shaping medicine. In chapter four, gratitude was advanced as a fundamental value in framing the personal relationship between physicians and patients. Here, gratitude was extended beyond that particular clinical encounter to address the environment of medical practice within its broader social context. Since gratitude was derived from a socially-constructed understanding of human dignity, its hospitable application in medical care should transfigure both involved parties, physicians and patients. The leitmotif of the solicited change is hospitable openness toward each other.

On the one side, out of gratitude toward their current and previous patients, medical practitioners and systems must be humbly open regarding several important elements of the practice of medicine. This openness helps foster reasonable expectations from medicine among patients along with a public appreciation of the limitations of medicine and human life. These elements include, it was argued, the social dimension of medicine and health; the hidden curriculum in medical training and practice; the un-scientific nature of medical practice; and the role of narration in fostering a satisfactory and healing medical practice.

On the other side, patients can arguably play an active role in their health and in molding a healing practice of medicine. By standing in solidarity with their physicians, patients recognize the vulnerability and dignity of physicians and appreciate the ordeal they had to live to become physicians. Patients are therefore able to heal their physicians when reconciliation is necessary. They are also able, as active citizens, to shape the medical system so that it serves the well-being of patients and physicians at the same time.

Second, to stand in solidarity with strangers across the globe, compassion was previously advocated as central to the practice of clinical medicine. In chapter five, compassion was
discussed as the proper answer to the suffering other and was defended as a basis to profound changes in medical education and physicians’ self-awareness. However, to model a global bioethical discourse, two important themes were discussed here, namely the vulnerability of physicians and the role of compassion in medical education.

On the one hand, the vulnerability of physicians is not always clear in a science-oriented and technology-dependent medical practice. However, when hospitality aspires the encounter of physicians and patients, physicians become deeply aware of their own vulnerability and are therefore able to practice a fulfilling and healing medicine with authenticity. The vulnerability of physicians was demonstrated through the discussion of several themes including, their embodied experience of training and practice, their struggle with power and negative emotions, their avoidance of suffering patients, and their risk of burnout and compassion fatigue.

On the other hand, compassion has an important role in shaping a healing practice of medicine. It was argued that compassion is the basis for a satisfactory physicianship contrary to the prevailing concerned detachment ideal. Thus, by cultivating a sense of vulnerability among aspiring physicians and nourishing their compassion toward suffering patients, medicine is transformed into a truly healing encounter. Unfortunately, medical students are socialized into the medical profession in an environment that harasses their innate and motivating compassion. Nonetheless, many pedagogical interventions, it was discussed, have proved to foster hospitality toward patients and openness toward one’s own inner compassionate self.

Finally, this chapter brought the different threads of this dissertation together to briefly discuss the moral issues pertinent to end-of-life care. Against arguments in favor of euthanasia and physician-assisted suicide, a broader adoption of palliative and hospice care in medical practice, especially for patients close to their death, was promoted.
While many liberal individualistic arguments are recruited to defend euthanasia and physician-assisted suicide, the *phronema* developed in this dissertation questioned many of the premises of these arguments such as the meaning of autonomy and dignity. Eventually, it is argued, a social discourse to establish an *Ars Moriendi* that is pertinent to contemporary global reality is warranted. Therefore, a broad presence of palliative and hospice care in medical practice is necessary to achieve healing even when death is imminent. Through palliative and hospice care, the suffering and anguish near death are addressed within a holistic mindset by mutually-hospitable physicians and patients. Further, through a hospitable health system, solidarity becomes the motivator of every effort to ameliorate human suffering, whether through public health interventions or broad medical training in suffering and dying. Ultimately, because of their long-standing experience with death, religious communities can play a central role in nourishing a humanistic practice of medicine at a global level.

In the final analysis, although the developed *phronema* may not offer final answers to all pressing global bioethical issues, it is able to raise new questions especially those related to moral responsibility. This hospitable *phronema* shifts the global ethical discourse toward a new territory where all value systems can meet to initiate a meaningful and substantive ethical discourse.


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