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Editor’s Note: This two-page section has been prepared for you to tear out and keep as an easy reference and contact list for CMDA’s resources, services, and ministry opportunities. Use it to show your colleagues what CMDA is doing and also as a guide for your prayers for our ministries and those who lead each effort. Go to www.cmda.org/ministroyoverview for the latest revisions.

Transformation

1. **Campus Ministries** [Al Weir, MD - al.weir@cmda.org] A team of over 50 staff who have organized campus Bible Studies, mission teams, leadership training, and outreach functions on over 235 medical and dental campuses in the U.S.

2. **Christian Dental Association** [Will Gunnels - wdgunnels@charter.net] Encouraging and supporting dentists in living out their Christian faith in their professional and personal lives.

3. **Chapel and Prayer Ministries** [Debra Deyton - debra.deyton@cmda.org] Mobilization of staff and members to pray on a daily basis. Chapel services held in Bristol with recording available at www.cmda.org/chapel.

4. **Local Ministry Groups** [Al Weir, MD - al.weir@cmda.org] An opportunity for members to connect with fellow members to provide mentoring and ministry resources to assist them in their educational and professional careers.

5. **Saline Solution** [Melinda Mitchell - melinda.mitchell@cmda.org] A team of staff and members who provide training for healthcare providers via conferences or a small-group video series on how to appropriately and effectively help their patients with spiritual issues.

6. **Side By Side** [Robin Morgenthaler - sidebyside@cmda.org] A Bible study based outreach ministry to female medical/dental spouses.

Services

7. **Christian Doctor’s Digest** [Rusty Sluder - digitalmedia@cmda.org & Margie Shealy - communications@cmda.org] Bimonthly audio magazine resource containing interviews on timely topics of interest to doctors and their families.

8. **Center for Medical Missions** [Susan Carter, BSN, MPH - susan.carter@cmda.org] A CMDA department aiding in the recruitment, training, and retention of career medical missionaries, including pre-field orientation training for new medical missionaries.

9. **CMDA Leadership - Board of Trustees** [President of CMDA, Bruce MacFadyen, MD - board@cmda.org] The Board of Trustees, which meets three times a year, is the governing body of CMDA. It makes policy, strategically sets the goals for the organization, and provides financial oversight. The CMDA House of Representatives (HOR) represents local councils, states, students, residents, missionaries, Commissions, and Specialty Sections. They meet annually to promote the mission, vision, and needs of CMDA. The HOR exists to provide a voice for all CMDA members.

10. **Commissions** [Debra Deyton - executive@cmda.org] Continuing Medical & Dental Education (annual two-week continuing medical and dental education conference in Kenya or Thailand), Marriage Enrichment (provides weekend retreats each year to help doctors strengthen their marriages), Medical Malpractice Ministry (prayer, resources, and encouragement to doctors experiencing malpractice suits), Pan-African Academy of Christian Surgeons (surgical residencies in African mission hospitals), Singles (networking, conferences, mission trips, and resources to meet the unique needs of single members), and Women in Medicine and Dentistry (conferences, resources, and networking to meet the distinctive needs of women in healthcare).

11. **Global Health Outreach (GHO)** [Sam Molind, DMD - sam.molind@cmda.org] One of CMDA’s short-term mission programs, sending forty to fifty medical/dental mission outreach teams annually; designed to disciple participants, grow national churches, share the Gospel, and provide care.

12. **GAP Program** [Sam Molind, DMD - sam.molind@cmda.org] A partnership with Prison Fellowship International to bring health and Christ to prisoners in foreign countries via GHO teams.

13. **Global Missions Health Conference** [www.medicalmissions.com] A medical/dental mission conference, co-sponsored by CMDA, and held the 2nd weekend in November at Southeastern Christian Church in Louisville, KY. The mission is to inform, train, and equip healthcare professionals and students to use their medical skills to further God’s kingdom.

14. **Healthcare for the Poor** [Al Weir, MD - al.weir@cmda.org] Innkeepers (applying policies and providing care in a way that reflects God’s heart for the poor), Domestic Missions Outreach (partnership with Christian Community Health Fellowship to maximize efforts toward healthcare for the poor), 4 Percent Solution (a commitment of 4% of your time, talent, or treasure to the care of the underserved).

15. **Medical Educational International (MEI)** [mei.director@cmda.org] Sends short-term teams of doctors to provide education to colleagues overseas and to build relationships with them.

16. **Placement Service** [Allen Vicars - allen.vicars@cmda.org] Recruiting service that brings together Christian physicians and practices throughout the U.S. to enhance their ministry and advance the kingdom of God.
17. Scholarships [www.cmda.org/scholarships] Johnson Mission (provides $500 to $1,000 scholarships to residents doing rotations in mission hospitals), Owen Grants (for short-term missions), Risser Fund (training and ministry to Third World orthopaedic doctors), Steury ($100,000 awarded annually to a medical student going into career missions), Tami Fisk Mission (for medical personnel desiring mission service in East Asia), and Westra Mission ($200-500 to medical students doing short-term mission trips or rotations overseas).

18. Specialty Sections [Al Weir, MD - al.weir@cmda.org] Academic, Dentistry, Dermatology, Emergency Medicine, Encore – a ministry to and through retired doctors [George Mikhail@cox.net], Family Medicine, OB/Gyn, Christian Pediatric Society, Psychiatry, and Uniformed Services. These sections equip, network, and provide a voice for CMDA members to their areas of specialty or service.

19. Today’s Christian Doctor [David Biebel, DMin - dbbyv1@aol.com] A quarterly magazine with the goal of helping doctors become all that God has designed them to be.

Equipping

20. Affinity Programs [www.cmda.org] CMDA Credit Card, a rewards program that supports the ministries of CMDA.

21. Audio/Video/Print Resources [www.cmda.org] Just Add Water (DVD resources that provides an “instant” meeting), Life & Health Resources (a distribution service for CMDA-produced and recommended resources), and Life Support (Podcast audio magazine covering topics of interest for students and residents).

22. Completing Your Call [Al Weir, MD - al.weir@cmda.org] A twelve-month course (mostly distance learning) to motivate, train, and equip doctors for ministry.


24. Continuing Medical/Dental Education [Barbara Snapp - barbara.snapp@cmda.org] AMA/ACME and PACE accreditation for medical and dental education.

25. Ethics Committee [423-844-1000] Member volunteers that formulate CMDA’s ethical position statements for Board and House of Representative approval and also provides a bioethicist on-call program to assist members who face difficult patient care decisions.

26. Membership Services [Lynnia Graybeal or Raquel McLamb - memberservices@cmda.org] Assists members with information regarding the services and resources available through CMDA, membership renewals, as well as membership recruitment.

27. Mission Management Consultation [Susan Carter, BSN, MPH - susan.carter@cmda.org] Consultation service offered to international medical mission ministries.

28. Newsletters [www.cmda.org] CMDA Weekly Devotions, e-Pistle (monthly training/news for career missionaries), GiftLegacy (monthly stewardship information), Heartchanger Updates (monthly update for regular financial sponsors), Infusion (quarterly orientation for new members), News & Views (bimonthly public policy education on bioethical issues), On the Side (monthly newsletter for medical wives ministry), Progress Notes (bimonthly regional news and developments at CMDA), The SCAN (a summary of major medical journals for medical missionaries), Your Call (produced bimonthly to encourage and equip those called to career missions).

29. Speaker Referral Bureau [Margie Shealy - communications@cmda.org] An on-line speaker’s bureau of CMDA members.

30. Development/Stewardship Ministries [Jamey Campbell - jamey.campbell@cmda.org] An educational service, teaching members to be good stewards of the resources God has given them.

31. CMDA Website www.cmda.org [Margie Shealy - communications@cmda.org] The organization’s website with over 2,000 pages of resources – position papers, magazine articles, meeting calendars, audio and video files, and other information.

Voice

32. Amicus Curiae Briefs [Jonathan Imbody - washington@cmda.org] A cooperative endeavor with Christian lawyers to develop legal briefs advocating for life and human dignity in important court cases.

33. American Academy of Medical Ethics® [www.ethicalhealthcare.org] A forum to help train and equip healthcare professionals to adopt the ethical tenets defined by the Hippocratic tradition.

34. Media Training [Margie Shealy - communications@cmda.org] Hands-on training to members so they can effectively communicate to the media.

35. News Releases [Margie Shealy - communications@cmda.org] CMDA’s response to breaking news on vital healthcare issues resulting in hundreds of media interviews each year.

36. Professional Testimony [Jonathan Imbody - washington@cmda.org] Opportunities for CMDA experts to testify before the US Congress and state legislatures.

37. Public Service Announcements (PSAs) [Margie Shealy - communications@cmda.org] Library of PSAs on ethical and healthcare topics available to radio stations each year.

38. Standards 4 Life [Margie Shealy - communications@cmda.org] Free web-based resource for the church or personal education that deals with the scientific and biblical issues surrounding tough bioethical issues in simple, easy-to-understand language.

39. State Public Policy Campaigns [Margie Shealy - communications@cmda.org] Grassroots campaigns to promote life-honoring legislation/referendums at the state level on physician-assisted suicide, embryonic stem cell research, and other issues.

40. Washington Office [Jonathan Imbody - washington@cmda.org] A liaison with Congress, the administration, and policy organizations, presenting life-honoring perspectives through the national media, and publishing resources on vital issues.
Tossed About?

I’ve never experienced a tsunami, but I have been tossed about by huge waves. We arrived later than planned at Kisite Marine Park on the edge of the Indian Ocean just above the Kenyan-Tanzania border. After a difficult trip by road, I was determined to snorkel despite the rising tide and increasing waves. The small and decrepit boat we hired, with an even smaller motor, had to go full throttle to fight through the waves to get over the famous coral reefs. By then it was so rough that the poorest swimmer decided not to get in. Jody and I eased over the side. Where we stopped, the waves, funneled by the unseen reefs, were coming from two directions and we were bobbing like corks. With maximum effort, we could barely keep from being swept away. Within a few minutes, we returned to the safety of the boat. Our local skipper was happy to turn the stern to the maelstrom. He was sure his boat was about to broach.

That description is not far from what doctors are experiencing in the medical morality maelstrom today. You turn to face one ethical breaker and another one hits you from your blind side. Since I came on as CMDA’s CEO in 1994, we have battled partial-birth abortion, the legalization of physician-assisted suicide, embryonic stem cell research, human cloning, genetic determinism, sex selection, embryo selection, mandated abortion training, and we’ve had to defend our most basic right - conscience. Last fall we were fighting a three-front war: a physician-assisted suicide referendum in Washington; a constitutional amendment in Michigan that prohibited any regulation of embryonic stem cell therapy; and, for right of conscience protection at the federal level. At the same time there were skirmishes on many other issues.

CMDA, by God’s grace, has won many more battles than we have lost, but looking at the horizon, I see bigger waves coming. For example, where do you draw the line between treatment and medical enhancement in genetic repairs and cyborg technologies? It would be wonderful to give a double amputee brain-controlled artificial limbs, but what about making them stronger and faster than normal human beings? Is it okay to take a drug to increase your concentration before an important exam?

My cell phone contains a computer much faster and more complex than the one that took a spacecraft to the moon. What if I could hook it directly to my brain? Forget text messaging. Hello wireless thought projection.

Better yet, shrink the computer through nanotechnology. An implantable computer the size of a sugar cube will contain all the information in all the medical libraries that exist. Tempting isn’t it? No more medical school or continuing education. Just get a download.

Want to be five times stronger? Get the Schwarzenegger gene inserted into your genome. You could be in the Olympics and bench press 2,000 pounds!

Of course, with genetic and computer augmentation, we would have two classes of human beings – the enhanced and the unenhanced. We will have gene doping instead of drug doping and it will be almost impossible to detect.

These technologies are not science fiction. Reputable scientists are working on them every day. Put them together and you create the burgeoning field of “transhumanism.” Proponents claim, “Why be stuck in your aging body? With nanotechnology, genetic enhancement, and cyborg technology, you could live forever.”

So how do we deal with the many challenges we face now and in the coming ethical tsunami?

• We must dare not to despair: Remember that God is still in control and we stand on higher ground.
• We must seek the best and flee the rest: We should heal, but not augment. Our personal goal should be to enhance the fruit of the Spirit in our life, not the worldly idols of intellectual or physical power and prestige.
• We must show up, but not give up: It’s not up to us to win these battles, but to be a faithful voice for righteousness in them. Ultimately, God is going to win the war.
• We must not misapprehend the misguided: They need our understanding. They see science as their savior. With our love, we can introduce them to the only One who can save their souls and give them eternal life.

There has never been a better time for Christians in science and healthcare. As the tidal wave approaches, dig your roots deeper in the Rock. Be a lighthouse in the storm. †
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Members Testify on Conscience Rights at President’s Council on Bioethics

Four members of the Christian Medical Association testified on September 12 before the President’s Council on Bioethics, on the critical issue of conscience rights in healthcare.

- **Jonathan Imbody, MA**, CMA Vice President for Government Relations, testified, “As life-honoring medical students, residents, physicians, and other healthcare professionals are systematically forced out of the field of obstetrics and gynecology, their loss ultimately impacts patients. Their loss will impact life-affirming pregnant women who specifically seek physicians, as my wife did, who share their views and do not participate in abortions. Their loss will impact healthcare professionals are systematically forced out of the field of obstetrics and gynecology, their loss ultimately impacts patients. Their loss will impact the medical community, which is enriched by the reminder that time-tested objective standards of medical ethics protect patients and constrain the physician to ‘first, do no harm.’”

- **Sandy Christiansen, MD**, representing CareNet, related, “As an obstetrician/gynecologist who has chosen not to perform elective terminations of pregnancy, I can attest to the difficulties and pressures that physicians face when attempting to practice according to their conscience. When I began my residency in 1986, I fully expected it to be physically and emotionally draining, but I wasn’t prepared for the intolerance and hostility that I would face because of my faith. I was the only intern who elected to not perform abortions, and it was understood that it was because of my Christian convictions. One of my fellow interns was frequently given the opportunity to scrub in on gynecologic cases, and I approached my chief resident and inquired, ‘I would like the same opportunity.’ And she said, ‘Well, this person was working hard at doing the abortions, and so she gained this privilege, which you refused to do, so you do not get the perk.’”

- **Karl Benzio, MD**, representing the Lighthouse Network, recalled, “As a teenager in Northern Jersey as an Italian with friends involved in organized crime,
I was approached to go to medical school for free, residency for free, undergrad for free, and have a very nice practice. In response, I would be able to give certain care to their constituency as well as cover up mistakes. Interestingly, they approached me because of my trustability, then asked me to practice unconscionably as a result. When physicians do unethical things, it erodes the trust that doctors and patients have in each other. It interferes with the open exchange of information that patients can have. It also opens the door wide open of the slippery slope that leads to other, more egregious behaviors in that … the bubble of intractable cases grows and grows and grows larger.”

- Donna Harrison, MD, representing the American Association of Pro Life Obstetricians and Gynecologists, noted, “All of these current issues arise from the continuous professional harassment, which pro-life physicians experience from the American College of Obstetrics and Gynecology. ACOG’s effort to eliminate pro-life obstetricians and gynecologists from practicing is longstanding. We have been battling the right of conscientious refusal for the last twenty years, as illustrated by the past and current continuous effort to make participation in abortions mandatory for OB/Gyn residents in training programs. I also experienced very similar harassment as Dr. Christiansen during my residency program.”

President Bush announced the formation of the Council in September 2001 during his speech to the nation concerning stem cell research. The Council provides the President and the nation with robust debate and analysis of cutting-edge ethical issues. Edmund Pellegrino, MD, long familiar to CMDA members through his contributions to Today’s Christian Doctor and Christian Doctor’s Digest, chairs the Council.

CMDA’s Office Hours Have Changed: CMDA has gone to a 10 hour-a-day, four day work week to provide better service to our members who are often busy during normal office hours and to be more accessible to members in different time zones. The national office is now open from 7:30 am ET to 6:00 pm ET, Monday through Thursday.

With increased fuel costs, this also provides a savings for staff, some of whom drive long distances. As an additional benefit, CMDA will save on utility bills. Our electricity rates are scheduled to go up 40 percent in January, 2009.

You may leave a message at any time.

Federal Employees: If you are a federal employee and wish to contribute through the Combined Federal Campaign, CMDA’s CFC# is 11866. We appreciate your donations, which support the many ministries of CMDA.

Attention Dentists: If you would like to be involved in moving our dental initiative forward and staying informed about upcoming conferences, dinner meetings, prayer breakfast meetings, and new resources, please make sure we have your e-mail address on file.
E-mail: dental@cmda.org with your preferred contact information.

ICMDA Conference 2010 – Advance Notice: The 14th ICMDA World Congress will be held July 4-11 (Student Junior Graduates Conference July 4-7; Main Congress July 7-11) in Punta del Este, Uruguay, South America. To download the Preliminary brochure and expression of interest go to: www.icmda2010.org.

Some of humankind’s greatest tools have been forged in the research laboratory. Who could argue that medical advances like antibiotics, blood transfusions, and pacemakers have not improved the quality of people’s lives? But with each new technological breakthrough comes an array of consequences, at once predicted and unpredictable, beneficial and hazardous. Outcry over recent developments in the reproductive and genetic sciences has revealed deep fissures in society’s perception of biotechnical progress. Many are concerned that reckless technological development, driven by consumerist impulses and greedy entrepreneurialism, has the potential to radically shift the human condition – and not for the greater good.

Biotechnology and the Human Good builds a case for a stewardship deeply rooted in Judeo-Christian theism to responsibly interpret and assess new technologies in a way that answers this concern. You can explore worldviews and delve into the complex issues of biotechnology with a who’s who of Christian ethicists. This thought provoking book will take you deep into the analysis and implications of cybernetics, nanotechnology, and genetics and their consequences.

Paperback. 192 pages. Available from Life & Health Resources for $24.95. Call 888-231-2637 or visit our website at: www.shopcmda.org to order.

If your tastes run to something lighter, we have the following novels in stock—each with a bioethical theme: Fated Genes; Healing Noelle; and, Deadly Cure, each $12.99 or less!
Many of us have been practicing for many years and have experienced the challenges of medical practice. At times we can be overwhelmed with the rapidity of the changes in medicine: new therapeutic options, radically new surgical procedures, changes in healthcare delivery, decreased reimbursement, increased paperwork, and a decrease in time to provide the type of patient-centered care that originally had challenged us to go into medicine.

In addition, other issues are coming to the forefront that challenge us to take a stand: end-of-life issues, euthanasia, right-of-conscience, new technologies, changes in societal thinking, and political agendas. These issues affect our thinking, and our decisions affect our patients.

Other doctors and our own patients may hold very different positions from ours. Our position on issues may impact our practice, our interaction with our colleagues who may hold very different positions from our own, and our position may also affect our career.

Yet as Christians, we must be prepared to express our viewpoints clearly, and it is imperative that what we say be based on Scripture. Our medical training to deal with problems has been to define the issue, collect the data, interpret the data, solve the problem, and apply the solution to the management of the patient. We must be constantly evaluating new journal information and incorporating it into best practices. In this way, we become competent physicians and credible with our patients and peers.

Similarly, we must be studying God’s Word on a daily basis and asking God to show us through His Word how we are to address medicine’s ethical issues with accuracy, conviction, and authority. 2 Timothy 2:15 says: “Study to shew thyself approved unto God, a workman that needeth not to be ashamed, rightly dividing the word of truth” (KJV).

We must face these ethical challenges with our patients and co-workers with the strength and power of the Holy Spirit. Colossians 4:1-6 tells us how to prepare for these types of situations. We should devote ourselves to prayer and be wise in the way we act toward outsiders, make the most of every opportunity. “Let your conversation be always full of grace, seasoned with salt, so that you may know how to answer everyone.”

James 1:2-8 says we must not be “double-minded” in dealing with others with an opposite point of view, because “a double-minded man [is] unstable in all his ways” (NSAB). We must be firm and consistent as we give answers that are biblical in a way that is both convincing and authoritative.

Bruce V. MacFadyen

Be Prepared
If you’re like me, you like to (or must) plan ahead for overseas trips, but that’s not always God’s way! Have you ever marveled by what God can do in a short time when He wants you somewhere? This summer I learned that the first nationwide conference for Christian medical students and young doctors was planned in the Ukraine in August and that they would like one or more American physicians to participate. I replied that I was open to trying to find someone to go, but doubted it would be possible on such short notice. Within twenty-four hours, a missionary in Ukraine had offered free housing and an MEI team leader had offered to give me expiring frequent flyer miles if I could use them! Clearly, God wanted me to go!

About twenty-five medical students and young doctors came from all over the country, plus two other physician speakers from Lithuania. Topics included being a Christian doctor, overcoming fear, Jesus as the Great Physician, seeing medicine as a calling from God, and team building. Many were blessed and we could tell we were supported in prayer. Comments included:

• “I have so many new ideas to think about.”
• “A doctor is a servant of God and should serve with joy.”
• “I learned the proper attitude between a doctor and their patients.”
• “I want to start a small group very badly in my school.”
• “This has been a blessing for me and as I have talked with others...they agree.”
• “I would like even more depth.”

• “Could we add one more day next time?”

If God makes this type of opportunity available to you, are you ready to answer His call? The members of another short-notice, summer MEI team did! We had the opportunity to deliver three donated electroconvulsive shock (ECT) machines to treat severe depression to a war torn area badly in need of them, and to train medical personnel how to use them. We had only about a month to prepare. God called a psychiatrist and an anesthesiologist to go. They went, despite the security risks and the high cost of travel to that country. As a result, strong and high level relationships were established and MEI has an open invitation to return.

Our God is the God of the unexpected. Seeing God’s work made me exclaim, “O, me of little faith!”

FOR INFORMATION ABOUT MEI OPPORTUNITIES, VISIT: WWW.CMDA.ORG/MEI

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Internet Website: www.cmda.org • Winter 2008 11
Reflections on a Recent Mission Trip To Africa

The sick from the slums of Kibera gathered outside our makeshift clinic on a rainy and cool day in July. Hard to imagine, but on a warm, sunny day in Wilmore, Kentucky, it is actually winter in Kenya, Africa. As patients pushed their way into the clinic, we preached the gospel while they waited to visit the doctor to receive medical or dental attention. I had just stepped into the pharmacy to warm up and dry off after making another salvation presentation. I had not even had a chance to sit down when one of the workers came to the door and said, “Pastor Bert, one of the patients wants to meet with you.”

As I walked to the door, I immediately recognized the young man who stood waiting to talk with me. He stood out among the crowd that morning when I asked those who wanted to receive Christ to raise their hand if they wanted to invite Jesus Christ into their heart. His hand quickly went into the air and after we called those interested to come forward to pray the sinner’s prayer, I will never forget the smile that sprang to his face, reflecting the joy of the Lord. You could tell that his conversion was not conjured up.

Before he left the clinic, he had two requests. Through his broken English and with the help of the translator, he asked if I could give him a Bible to read. God had provided some Bibles for our team, so I handed the man a copy that he immediately clutched to his heart as one of the most precious gifts ever given. “One more request,” he said. As the pastor translated, I thought: He probably wants money. We were, after all, ministering among some of the poorest people I had ever seen in my life. Who could criticize him for asking?

Yet when the second request was made, it was not for money, but for my time. He told me that when he prayed that morning he felt something very real take place in his heart. “If I walk home and get my wife and bring her back, would you share with her this same story?” he asked.

In just a few hours I was summoned again, “Pastor Bert, Joel is here with his wife and their son.” I reached for my evangel cube and sat down to share the story one more time. I never get tired of telling the story to people who are hearing it for the first time. As Joel’s wife prayed that day to become a follower of Christ, I couldn’t help but think of Acts 1:45, “Philip found Nathanael and said to him, ‘We have found Him of whom Moses in the Law and also the Prophets wrote–Jesus of Nazareth, the son of Joseph.’”

You will discover at the heart of a missionary a life that has been changed and just has to go tell someone the good news.
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*Note: The first phase of this gift-giving outreach is
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*“It has been such a restorative and
rejuvenating experience working
with CMDA where loving and
passionate people are beautifully
demonstrating Christ’s love through
their profession.”*

- Ali Ka, MD

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Changing Hearts In Healthcare
I will never forget those haunting television images of December 26, 2004 as vacationers and villagers played innocently and carefree on the beaches along the Indian Ocean. Curious and transfixed, they watched as the sea mysteriously withdrew, unaware and unprepared for the massive 100 foot wall of water that was racing toward them, triggered by an undersea earthquake hundreds of miles away off the coast of Sumatra, Indonesia, and destined to sweep them and whole villages, towns, and cities away in a matter of minutes. The massive scale of the tragedy—over 250,000 lives lost in over eleven countries—shocked the world and reminded us of how unprepared and unaware we can all be of the awesome power nature can have over us.

Unprepared and unaware, unfortunately, may describe the situation of many Christians, and the church in general, for the oncoming tsunami of biotechnology that is rapidly descending upon us. The ethical and theological issues inherent in these new technologies will challenge the Christian believer in ways unprecedented in history and will surely threaten to engulf a church unprepared to offer an informed and biblical response. Christian physicians and healthcare workers, who will be most affected by these developments, need to understand the fundamental issues driving this new science and be on the forefront of representing a Christian perspective within the public arena.

In this issue of Today’s Christian Doctor, noted Christian thinkers will be exploring areas that may seem like science-fiction, but are only a newspaper’s headlines away from impacting our daily lives. Imagine being able to see and understand the very thoughts of a person in real time. Or imagine being injected with tiny micro-robots (nanobots) the size of molecules that seek out cancer cells and destroy them, or monitor your every physical function and...
movement. What about the possibility of computer implants that will be able to extend our memories or upload our consciousnesses into a smarter-than-human artificial intelligence? As we grapple with the ethics of human-animal chimeras, how about a full-blown merger of humans and computers, replacing the body's often imperfect molecular blueprint, DNA, with software, which, unlike DNA, wouldn't suffer mutations? How would you feel about the real prospect of living decades, or even centuries longer, disease-free and healthier than the most accomplished Olympic athletes?

All these real and imminent scenarios will change forever the nature of bioethics. The “old” bioethics (or “bioethics one,” a term coined by Christian bioethicist Dr. Nigel Cameron) dealt with issues that have and continue to polarize our cultural landscape and politics for the last several decades. These issues pertained primarily to the beginning and end of human life, e.g., abortion and euthanasia. But the “new” bioethics (or “bioethics two” according to Dr. Cameron) moves beyond the questions of when human life begins and ends and asks a more fundamental question altogether, “What does it mean to be human?”

The gurus of these new technologies, the self-proclaimed “transhumanists,” promote moving beyond our current definition of “human” and “humanity” to re-create and re-define what it means to be human, to move beyond Homo sapiens on the evolutionary scale, and even break down the separation between the biologic and the material. The goal is to move beyond the limitations and imperfections of our bodily existence by integrating it with computerized technology. According to these transhumanists, our current accepted medical technologies, such as cochlear implants, artificial joints, genetic engineering, mood-altering and memory-enhancing drugs, are all mere preludes to an era when people will routinely enhance their brains, improve their bodies, and perhaps live forever.

Christians have never been called to be anti-science or anti-technology. In fact, Christian scientists and physicians should embrace all that God has given us in nature and in our capacity as thinking, reasoning beings to reflect His love and mercy by caring for our neighbors and being good stewards of His creation. But it is also a fact that science and technology are not unmitigated blessings, because our use of science and technology is always overshadowed by the impact of the fall and, like all of life, is in need of redemption. Understanding our current technological culture from a biblical perspective determines how Christians should react to these developments.

The current technological search for human fulfillment and a form of everlasting life apart from God is deeply rooted in the Genesis account of the origin of sin. God had given to Adam and Eve all the goodness of His creation to be at their disposal and use with one exception: the couple was not to eat of the Tree of the Knowledge of Good and Evil. Adam’s temptation by Satan, and eventual fall, was to trust not in God’s word and promise, but in the Devil’s lie. That lie was essentially that wisdom and insight into human fulfillment and life eternal could be found apart from God and His word. Whatever else the Tree of the Knowledge of Good and Evil represented, it meant that there exists a wisdom that is God’s alone: a wisdom that lies behind our particular humanness, a wisdom to the entry of evil and sin into God’s “good” creation, and a wisdom related to suffering and death.

Foundational to the goals of these new technologies is a so-called wisdom that relies on human autonomy in morality and rationality, coupled with a faith in evolving technologies that promises to make good on these goals. It is all part of the “lie” of Satan, and our feeble human attempt to make ourselves in our own image.

Man was created in the image of God, the imago Dei. To be created as image bearers of our creator God means to reflect His character, do His will, and rule on earth on His behalf as stewards and vice-regents. Our fulfillment as human beings is to be found nowhere else, but in that relationship and in that role that we, according to God’s wisdom, are uniquely suited for as rational, willing, embodied, soul-bearing beings. Adam and Eve were placed in the Garden to serve and to keep it. The Hebrew words translated “to serve” and “to keep,” which can apply to simply cultivating and protecting their
Garden home, are filled with theological overtones in the rest of the Old Testament Scriptures. These words are used throughout the Pentateuch to refer to the functions of “serving” God in the Temple and “keeping” the commandments in service to Yahweh. To “serve” and to “keep” refer to man’s original purpose to worship and honor God in reflecting His will and holiness and “keeping” the Garden from all uncleanliness and unholiness. It is possible that the first opening to sin was Adam’s unfaithfulness to his calling in not keeping the Serpent out of the Garden in the first place.

To be “as God” is to embrace the Serpent’s lie that something else is required other than God’s image for human fulfillment. For many in our culture, modern biotechnology has become a false messianic hope that will hopefully lead them to that fulfillment. The hubris and pride of being our own savior is the essence of our sin and the basis of God’s judgment. In characteristic fashion, God judges us by letting us have it our way and “gives us over” to our own pride, to our own autonomy, and to our own technology to create ourselves in our own fallen image and in the image of those things we create. How backward can that be? As God’s covenant curse is enforced, creation is now something that must be overcome, controlled, and re-imagined.

But isn’t part of the image of God the concept of man as “co-creator” with God? And haven’t we been given such scientific and technological gifts from God to do our part in reversing the effects of the curse? How can we look the other way and condemn such technologies that may preserve life and promote the end of suffering and disease? Is not this part of the so-called “creation mandate” of Genesis 1:28? A great deal of this sentiment, however much it seems to borrow from the biblical narrative, owes more to the modern scientific vision of creating our own future. It also owes much to such non-biblical beliefs as process theology (that both man and God are open to the future and are free to co-create that future) rather than to true biblical revelation. One cannot interpret the *imago Dei* in terms of a creativity that is always referred to and reserved by God alone – a creativity that man does not share in, but is to faithfully preserve and cultivate. Furthermore, such views suggest that we have insight into the purposes of God in the natural order; that there is, in some sense, equality between God and man. Neither human persons nor collective humanity with its technological creations are or can be equal with God.

Human rule over God’s creation is never absolute, but moderated by service, always subsumed under the higher rule of God and for His glory alone. Man’s relationship to creation is one of covenant-stewardship, not “co-creator.” It is a stewardship that we must use for the Master’s purpose, not ours, and one that we will give an account of when the Master returns.

All this is to say that the fundamental issues driving these new technologies are, at their core, theological. They offer the adherents the hope of an everlasting, perfect existence that brings “solace to those struggling with the injustices of daily life,” according to Anne Foerst, a professor at St. Bonaventure University who studies these new technologies from a theological perspective. “There is the thinking that we will get the ‘real us,’ the better, higher us, from technology,” says William B. Hurlbut, MD, a Christian and Stanford biologist who serves on the President’s Council on Bioethics. But Hurlbut argues that what makes us human depends on being in bodies that
aren’t always perfect and that can fail. “Our bodies are not just pieces of biochemical equipment,” he says, “our bodies are ourselves.”

There is also the promise that the “last enemy,” death, will be overcome with just enough computer power and nanotechnology to overcome the evolutionary-inherited defects of our biological containers. For the believing Christian, we understand that it is only through Christ’s death that our own death is now a source of blessing, no longer the enemy to be avoided, and a way to a new life truly incorruptible and imperishable. Our fulfillment as humans and our true image of what it means to be human can only be found in the perfect *imago Dei*, our Savior Jesus Christ, and in our union with Him through faith in His death and resurrection.

It is worrisome that many Christians are asking what resources we have as believers to confront the coming tidal wave of biotechnology. Because these issues are about fundamental questions at the root of man’s sinful predicament, they are questions that God’s revelation of the gospel of Jesus Christ is uniquely and purposively given to answer. The coming bioethics tsunami can be a blessing as well as a judgment as it presents a unique Gospel opportunity. The extent to which the Christian church feels ill equipped to address these issues of our age may be the extent to which the church has strayed from its theological, confessional, and biblical roots and embraced a religion of emotion, pop-psychology, and cultural-compromising self-fulfillment.

The coming bioethics tsunami will present a host of challenges for the Christian. While we must be active, especially as Christian physicians, in educating the public, becoming proactive politically, speaking out in our educational institutions, and engaging with the culture around us, we must also remember that our real power resides in the gospel message itself. Weak and foolish in the world’s eyes compared to the egotistical sense of power that lobbying, politics, news interviews, and congressional hearings brings (as necessary and good as these things are for the Christian to be actively involved in), the gospel message is our true power and holds the only answer for that which all men are truly seeking - a full, satisfying, and meaningful life that extends even beyond the boundaries of what we call mortality. ✝

*The Coming Bioethics Tsunami*

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It was noon grand rounds at a hospital just outside of San Francisco and I was the bioethicist they were having for lunch. The hot issue was the legislature’s consideration of a “Right to Die” law, so I spoke on physician-assisted suicide. Starting with Hippocrates and patient trust, I moved on to what major medical organizations had concluded. I then covered the risks to patients, physicians, and society, supporting each point with data as well as anecdotes. I then opened it up for questions.

An anesthesiologist across the table didn’t waste any time, “That was the most biased and unscientific presentation I have ever heard,” he asserted. I asked him which of the study data I presented he was challenging. Instead of answering, he spent long minutes pillorying me in particular and Christians in general. I later found out he was a member of the Hemlock Society.

National Public Radio called a few months ago and asked me to phone in as a guest for an hour-long debate about the right of conscience on a national show. They were “fair” - all the guests got equal time. The only problem was there were four against it, including the host, and then me. One of the guests, a lawyer from Planned Parenthood, went for the jugular: “You shouldn’t have ever become a doctor if you aren’t willing to perform a legal procedure. You are denying women their basic healthcare rights.”

It didn’t take me long after coming to CMDA to learn that if you speak for righteousness in the public square, some will be more than happy to throw you to the lions. I guess we shouldn’t be surprised. Just look at how the New Testament characters Paul and Stephen, and in more recent times, Wilberforce and Lincoln were treated.

I never planned to be a “preacher of righteousness,” as Peter described Noah in 2 Peter 2:5. It all started a few weeks after I became the CEO of CMDA in 1994. The most common comment from graduate members in those days was, “CMDA was great when I was in training, but what does it do for me now?” As I was pondering that question one day, I pulled down from the shelf CMDA’s superbly written ethics statements. Each was concise, scientific, biblical, and the official position of our organization on a wide range of impor-
tant issues, yet the church and the public didn’t even know they existed.

I can’t remember what the issue was in the news a few days later, but we had a statement on it. We took the plunge, crafted our first news release and sent it to news outlets with no real idea of what their response would be. The next day the Associated Press called, a reporter and photographer came to the office, and that evening CMDA’s position was quoted in the Washington Post and the Los Angeles Times.

In those days, I had no ethics or media training, and only bare bones experience in dealing with the press, but the wisdom of our members and God’s Word was being read in newspapers by hundreds of thousands of people at almost no cost to the organization. Our collective voice was being heard and influencing the public and decision makers. The board was enthused and many members were excited that we were speaking for them.

One of the primary reasons that physician-assisted suicide (PAS) was legalized in Oregon in 1997 was that the Oregon Medical Association took a “neutral” position. Though we spoke out, after that battle was lost I realized that CMDA needed to do more than just communicate our views. When the Hemlock Society tried to legalize PAS in Michigan, CMDA led a grassroots campaign to defeat the referendum. We worked hard to motivate, train, and equip healthcare personnel to influence church members, professional groups, and the public. We created a video of interviews with doctors and patients that we distributed to thousands of churches. We trained and equipped doctors to speak in churches and to community groups. Doctors learned how to write letters to the editor or op-ed pieces for their local newspapers. Many physicians sent a letter we created to their private practice patients telling them why PAS was dangerous to their doctor-patient relationship. I did a highly visible tour across the state, speaking on medical school campuses, doing media interviews, and mobilizing members.

When we initiated this grassroots campaign, polls showed that 70 percent of the voters favored the referendum. On Election Day, 70 percent voted against it. There is no doubt that our most secret weapon made the greatest difference. Members and churches across Michigan, not only did what they needed to do, but they also prayed. As He had done with Elijah in the Old Testament, God intervened in a miraculous way.

Michigan was the training ground for our efforts in Maine where PAS was defeated 51 to 50 percent. I have no doubt that CMDA’s efforts moved more than 1 percent of the vote. Battles in California, Vermont, and other states followed.

Hawaii was unique. We faced overwhelming odds. A former governor led the charge, the legislature was overwhelmingly for it and this time a bill was being considered. It seemed that nothing could stop the juggernaut in this David and Goliath battle. We only had around fifty members in the entire state.

But God had prepared some stones for His sling. CMDA had created the American Academy of Medical Ethics to increase our access into battlegrounds where the term Christian was not accepted. After I met with the Hawaiian Medical Association, they asked the AAME to work with them on a weeklong campaign to educate legislators at breakfasts and lunches held in the capital building. Dr. Ruth Matsuura, a CMDA member, was a political matriarch in the state. Her husband and son had both served in the legislature with distinction and were highly respected.

Here is what God did.

I did a concise twenty-five-minute presentation on PAS at each function. We then had members who specialized in pain treatment or geriatrics share their concerns before we opened the session for discussion. Some of the main proponents and backers of PAS didn’t attend, so between times Ruth and I would go office to office to meet them.

It was like having Queen Esther at my side. The front desk assistant at the Speaker of the House’s office told us we might get a meeting in two months. When she asked for our names and Ruth gave hers, she excused herself, went into the Speaker’s chambers and two minutes later we were sitting down with one of the most powerful men in the state. After all the niceties, Ruth looked at the Speaker, called him by his first name and stated, “I’ve brought an ethics expert with me and I want you to listen to what he has to say. This legislation to legalize PAS is a bad idea.”
It was my first introduction to direct lobbying, something we don’t normally do, but I figured if the Old Testament Esther, after prayer, could go to the power broker, so could we!

The stone that finally felled the giant came from an unexpected source. The third morning, as I welcomed legislators that were coming in, I met one who introduced himself as a “doctor.” I quickly found out that he was an ER doc, starting his first term and the only physician in the legislature. When I asked him his views on PAS, he related he was for it, but assured me he was going to listen with an open mind.

At the end of the session when we gave an opportunity for attendees to comment, he stood up and said, “I came in here supporting PAS, but I’m walking out opposed to it. What each of you has shared makes sense. It would be a disaster to legalize PAS in Hawaii.”

After the session he invited me back to his office and we talked. I gave him some resources to read and equip him. Later that month, he was appointed co-chair of the committee that was scheduled to consider the bill. He made sure the voices of those opposed to PAS were heard; the bill never got out of the committee.

That is just a few snapshots of how your membership in CMDA has made a difference in the cultural wars that are raging in medicine.

Today, our influence as an organization has never been greater. We have over a hundred CMDA members who we have trained to be media spokespersons. We provide expert testimony before Congress and have hundreds of contacts with Congressional and Administration officials each year to provide them with the medical, scientific, and ethical information they need. We work with many like-minded organizations to give them access to our expertise. For example, we work with the Christian Legal Society to file _amicus curiae_ briefs on important cases before federal and state courts. The Weldon Amendment, which protects your right of conscience, has been constitutionally challenged three times. In each instance, CMDA made powerful arguments to defend your right to practice according to your deeply held religious beliefs.

Each year CMDA does hundreds of media interviews. In the last two weeks prior to my writing this article, those interviews have included the _Washington Post_, _Associated Press Radio_, _Family News in Focus_, the _San Francisco Chronicle_, the _Moody Network_, _Bloomberg Radio_, and many other Christian and secular news outlets that blanket the country.

One of our greatest assets is Jonathan Imbody, our Vice President of Government Relations, who lives in the Washington, D.C., area. He is our only full-time person focused on public policy, but he has a huge effect. For example, next month there will be a national conference sponsored by Health and Human Services to educate healthcare professionals on recognizing and treating the health consequences of human trafficking. That is an idea that originated with CMDA, that we have been promoting tirelessly for the past two years, as a way to rescue victims.

CMDA is now seen as the main champion of right of conscience and has brought it to the forefront with other organizations and the U.S. government.

Jonathan is a superb writer and has had letters to the editor and op-ed pieces accepted regularly for publication across the country from _USA Today_ to the _New York Times_. During the height of the right of conscience battle a few months ago, he wrote as many as five or six pieces a day responding to false assertions in papers from coast to coast.

The question I’m sometimes asked is whether CMDA has become just another public policy organization, since members hear about it a lot through _News & Views_ and our public policy alerts. You may be surprised to learn that we spend less that 5 percent of our budget in this arena compared to over half of our budget being spent in campus and community ministries. Besides Jonathan, only a handful of staff work in this area part-time. Yet, our efforts have become very visible and a high-impact part of our ministry that only
requires a modest investment of our time and resources. God is still looking for men and women who will speak the truth in love. “The Lord loves righteousness and justice,” Psalm 33:5 states, and He has uniquely equipped us as Christian healthcare professionals with the knowledge and experiences to be preachers and prophets to our culture. It is not our job to win the battle, but it is our job to be faithful voices. Anything less and we are fiddling while Rome burns. ✝

David Stevens, MD, MA (Ethics), is the CEO of CMDA. From 1981 to 1991, Dr. Stevens served as a missionary doctor in Kenya, helping to transform Tenwek Hospital into one of the premier mission healthcare facilities in that country. As a leading spokesman for Christian doctors in America, Dr. Stevens has conducted hundreds of television, radio, and print media interviews. Dr. Stevens holds degrees from Asbury College and the University of Louisville School of Medicine. He is board certified in family practice. He earned a master’s degree in bioethics from Trinity International University in 2002.

How Does CMDA Establish Its Official Positions?

The Ethics Committee, made up of member volunteers, spends a year or longer crafting each draft statement, which is then forwarded to the Board for feedback, editing, and approval. The result is taken to the House of Representatives for further editing, referral back to the Ethics Committee, or approval. The votes for and against the final approved statement are recorded and attached to the statement.

Once approved, each concise statement becomes the official position of CMDA, though it is not binding on members. In other words, you don’t have to agree with every statement to be a member.

But our statements do give the administration permission and guidance to speak for the organization, and they are helpful to members and the public as they think through each complex issue.

CMDA Offers Media Training Workshops

It is imperative that we have well-trained Christian doctors and leaders ready to speak out on issues that are affecting our culture. That is why one of the many ministries of CMDA is to provide training to our members. The next “Voice of Christian Doctors” Media Training will be held at the National Headquarters in Bristol, TN, May 14-15, 2009.

The two-day workshop teaches attendees how to:

* Prepare for a media interview.
* Control the “agenda” during a media interview.
* Turn every media encounter into an opportunity to educate.
* Avoid being misquoted.
* Turn sound-bytes into headlines.
* Become a repeat guest source.
* Make news, not noise.

Since this program’s inception, CMDA has trained more than a hundred members and other Christian leaders in how to speak to the media effectively. We know without a doubt that the training is indispensable when we receive comments like these from member Dr. Eugene Smith: “Two weeks ago I was asked to comment on our senator’s position on stem cells. A local TV station wanted a physician to offer a contrasting view. Because I had attended this recent course, I understood the need to respond to this request. At the time of the request, the only unscheduled hour of my day was the next sixty minutes. I accepted an interview time thirty minutes from the time I hung up the phone. I called my wife to ask her to pray for me, spent thirty minutes in preparation, and went to the interview. The newsperson complimented my efforts. I drew heavily on principles I learned in the course. I thank God for how He used this course to help me in that moment. I wanted you to know how much I appreciate your work.”

Similar training costs between $2,000 and $3,000, yet we only charge $100.00 to help cover miscellaneous expenses for each participant. Participation is limited to sixteen in order to provide one-on-one training. If you are interested in participating, contact Margie Shealy at: margie.shealy@cmda.org to receive an application and registration information.
A panel of Princeton University scientists recently gathered together to deliberate “whether strong religious belief can coexist with reliance on science.” Constraining their definition of truth to “factual human knowledge,” the panel, led by professor of molecular biology Lee Silver, posed the provocative question, whether “science has effectively demonstrated that religious beliefs have no place in the rational mind.” How one decides that question guides the answer to a related question essential for the Christian physician. How can faith in Jesus Christ coexist with medical science?

Central to newfound confidence in the claim that science has superseded faith is the expanding scientific account not only of nature, but also of human nature. At the leading edge of this research, neuroscience is unveiling spectacular discoveries about the brain. Neuron by neuron, the brain is yielding its intimate details to sophisticated neurochemical, neurogenetic, and neuroimaging methodologies. The molecular basis of perception, reasoning, decision, faith, and belief – every category of thought – has become accessible to the scrutiny of neuroscience. Neuroscience thus offers an increasingly detailed account – in purely physical terms – of mental processes that previously were understood to be within the purview of philosophy, religion, and the arts.

Functional magnetic resonance imaging (fMRI), which detects regional increases in blood flow that accompany neural activity, has become a powerful tool to investigate the neuronal architecture of the brain systems underlying specific cognitive functions. Whereas in the past, localizing brain functions relied on the study of patients with brain lesions that happened to destroy those functions, fMRI permits precise, noninvasive, spatial, and temporal resolution of psychological processes in the intact, living brain. Brain regions showing increased metabolic activity over baseline will “light up” on fMRI scans. Language, for example, has been mapped in this way, as fMRI studies have shown involvement of the occipital cortex in reading text, the left posterior temporal lobe (Wernicke’s area) in comprehending language, the right temporal lobe in assessing context, and the left inferior frontal lobe (Broca’s area) in producing speech.

In recent years fMRI has turned to investigating the moral domain. Studies of subjects presented with moral dilemmas have shown that there is no one moral center in the brain. Rather, moral thought corresponds to a complex network of complementary cognitive processes traceable to a variety of discrete brain regions. Moral discernment engages systems of sensory decoding and abstract reasoning. Intuitive judgments heed long-term memories’ emotional tags. Conscious decision integrates the sometimes competing neural streams of reasoning and intuition in the dorsolateral prefrontal and anterior cingulate cortices, where there exists what C.S. Lewis recognized metaphorically as a liaison between “cerebral man and visceral man.” Finally, implementation, planning, and self-control of moral action require healthy frontal lobes.

Religious thought, too, has reclined under the scanner for analysis. Some of the brain correlates of belief
and disbelief have recently been identified. Just as for language and moral judgment, investigations have not found any one “God spot” in the brain, as if religious ideas were compartmentalized and detached from other thoughts and concerns.

In an experiment that produced a brain phenomenon apparently indistinguishable from spiritual experience, neuroscientist Michael Persinger applied transcranial magnetic stimulation to the cerebral cortex of healthy volunteers. Even when the subjects were not told that the device was turned on, they reported a mystical sense of another’s presence. Philosopher Patricia Churchland cites that study as evidence that all religious experiences are ultimately neurobiological in cause. However, one synthetic experience in the laboratory does not invalidate the spiritual awareness that many Christians testify has provided them comfort or insight during life’s trials. Artificially inducing what Lewis called a numinous sensation by stimulating the parietal cortex no more disproves the existence of the transcendent than would stimulating the occipital cortex and causing the illusion of light disprove the existence of the sun and stars. The intensity of subjective experience in isolation from reason is not necessarily a reliable guide to truth.

If future technologies were to penetrate the brain with even higher resolution and, applying every conceivable biophysical stimulus, still fail to extract an objective sign of mental transcendence, the case for Christianity would not be weakened. Scientific facts, while valid and useful, are not the only ways of knowing about the world. The competence of science is limited to the measurement of phenomena that are quantifiable and consistently reproducible. These include the structure of inanimate matter and predictable patterns of fields of energy. Even here nature conceals subtle details that are permanently incalculable and forever untraceable. Most importantly, the universally human questions of origin, purpose, and ultimate meaning surpass what can be fully answered at the material level. Such questions engage the mind and its capacities for abstract thought, conscience, and personal agency, all of which resist a complete explanation in scientific terms. At the patient’s bedside, physicians understand that beyond scientific diagrams, gene maps, and charts, there is a further aspect to human nature. The truly spiritual aspect of the human mind may be a gentle whisper, which science, despite its remarkable proficiency, overlooks (1 Kings 19:12; John 3:8; Heb. 11:3).

Prevailing interpretations of neuroscience research presuppose that all brain phenomena are causally determined chains of biophysical events. If truth be established by the volume of data, then a naturalistic appraisal of the human mind would seem to be gaining in acceptance. Frequent comparisons of the brain to the computer reinforce the broader cultural plausibility of a materialistic understanding of human nature. Within that framework, there can be no assurance that the concept of free will, with its weighty implications for personal moral responsibility and autonomy in medical decision-making, has any meaning. Neuropsychologists now debate whether free will might be nothing more than an illusion, since the outcome of a decision can be predicted by changes detectable in the prefrontal and parietal cortices seconds before entering conscious awareness. Alongside increasing optimism in science is a growing skepticism among many contemporary philosophers who ask whether all of consciousness ultimately reduces to an accidental matrix of synaptic impulses. According to that view, one’s decision to choose the good over selfish interests would be automatically determined solely by antecedent physical forces. Whatever one’s reply to Jesus’ question, “Who do you say I am?” (Matt. 16:15), the materialist recognizes only a reflex, as if belief were equivalent to a yawn.

So impressive is the expanding horizon of neuroscience that Francis Crick, co-discoverer of DNA’s
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double helix, has posited what he called his “astonishing hypothesis,” which is, “... that ‘You,’ your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behaviour of a vast assembly of nerve cells and their associated molecules.”

Despite the rhetorical certainty that the words, “in fact” seem to imply, Crick’s claim is no more than a hypothesis. It is not, of course, a scientific hypothesis, but rather a metaphysical one, which exceeds what science can legitimately claim. Crick’s sweeping negative assertion that we are no more than cells and molecules defies verification, since the scientific method is qualified to describe only what can be empirically observed and quantified. By defining human consciousness exclusively in terms of matter in motion, Crick assumes as a premise the very conclusion that he wishes to reach.

The contributions of neuroscience are necessary, but not sufficient, to explain human thought. A functional neuroanatomical account of moral reasoning broadens the explanation of how one reasons, but it cannot show how one ought to reason. Nor can a scientific description limited to factual knowledge about the brain inspire the care of the sick or resolve difficult dilemmas in medical ethics. Less astonishingly, acceptance of Crick’s hypothesis would reduce the value one accords to others. A materialistic appraisal of human nature would thus impoverish medicine. The obligations to love one’s neighbor (Lev. 19:18; Mark 12:31) and serve one another (Gal. 5:13) would make little sense if the ethos of healthcare were based on the lonely view that patients are essentially churning aggregations of molecules.

Nor does the naturalistic methodology of neuroscience adequately account for the scientist behind the experiment, whose mind engages nature by drawing inferences and reasoning with inquisitiveness and intentionality. There is, after all, a Crick behind the hypothesis. C.S. Lewis considered naturalism to be self-refuting because it is inconsistent with the validity of reasoning, on which all possible knowledge depends. If mental processes were dictated solely by a deterministic biophysical chain of causation in the brain, then the scientist would have no reason to believe that scientific insights into nature are true and trustworthy rather than just a reflection of the way the brain happens to work. Attempts to explain reason naturalistically end up explaining it away.

Not only must the reasoning mind in some way stand apart from nature to comprehend nature, but the mind that considers science encounters, knowingly or not, signs of a creative Mind behind nature (Psalm 19:1; Rom. 1:20).
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There is a larger view of human nature than is dreamt of in the philosophy of naturalism. Judeo-Christian teaching bases human dignity on the understanding that humankind is created in the image and likeness of God (Gen. 1:26). This *imago Dei*, which all men and women bear, is not a scientific notion and thus cannot be defined by physical, genetic, or cognitive criteria alone. From a biblical perspective, every human being has value beyond measure (Matt. 18:14; 25:40; 2 Pet. 3:9). The Hebrew Scriptures declare (e.g., 2 Chron. 7:14; Psalm 105:4; Jer. 29:13) and the New Testament affirms (e.g., Matt. 11:28-30; John 3:16; Rev. 3:20), that human beings have the special capacity to enter into a personal relationship with God. This larger view accommodates all that science reveals about human nature. That the human brain is a vast assembly of 100 billion neurons exchanging signals through 160 trillion synapses comes as no surprise to the biblical perspective on humanity as “fearfully and wonderfully made” (Psalm 139:14). To the scientific account the larger view adds hope exceeding anything technology can deliver (John 11:25; 1 Cor. 15:22, 51-57; Col. 1:27).

This larger view promises that science can never disprove the existence of God. There is no area of brain function off limits to neuroscience, provided the experiments are conducted ethically. Scientific discoveries have hardly put to rest the dialectic between science and faith. On the contrary, they reinvigorate it. Thinking about the brain with all the mind deepens the scientific appraisal. In so doing, it is important to be attentive to unstated philosophical presuppositions regarding the nature of humanity and reality. Rather than question whether science has replaced religion, a better question to ask is, what should be the right relationship of one to the other?

The story of neuroscience is punctuated with reminders that the reality of God is not dependent on human thought, as if His sovereign provision and guidance were the result of human striving, or faith the product of sufficient effort to imagine Him clearly. There is assurance in His grace and rest in His presence (Psalms 23, 46:10).

The human brain is at once wondrous and wanting. In all of creation nothing more intricate is known. Yet its thoughts are imperfect and its behavior gravely flawed. The mind is not yet in its true form. For the renewing of the mind, Jesus Christ is the answer.

The subject of neuroscience – the human brain – is at once wondrous and wanting. In all of creation, nothing more intricate is known. Yet its thoughts are imperfect and its behavior gravely flawed. The mind is not yet in its true form. The renewing of the mind requires communion with the mind of God (Isa. 1:18; Rom. 12:2), whose thoughts the Scriptures indicate are vast and profound (Psalms 92:5, 139:17) and utterly unlike our own (Isaiah 55:8-9).

It is unnecessary to ask what kind of science can apprehend the mind of God, as if that were possible. For God, in His mercy, through His Son has bridged the unfathomable divide and invites all people to draw near to Him (Rom. 10:6-10). The mind of faith
looks to what science has not yet seen (Heb. 11:1). Herein lies the hope of seeing God face to face (1 Cor. 13:12). 

References
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15 Churchland, pp. 127-199.
Human beings are almost obsessive innovators. Homo sapiens (knower) is by nature Homo faber (fabricator). Thank God He has made us so. Life without what Michael Novak has called “the fire of invention” would be nasty, bloody, and brutish. Medicine and biotechnology are two spheres where innovation is especially rewarded. So it is no surprise that we contemplate the possibility of human biological enhancements.

After all, we attempt enhancement in many different ways, especially for our children: diet, exercise, music lessons, tutoring, athletics, and even cosmetic surgery. But for many people, there is something deeply troubling about enhancing human beings through biomedical technologies, whether through reproductive, genetic, neurological, or prosthetic technologies. For the sake of my argument, I will call this clutch of technologies, “Human Bioenhancement Technologies” (HBTs). By “bioenhancement” I mean that these technologies improve human biological function beyond species-typical norms.

**Therapy versus enhancement**

Ethical reflection about these technologies requires that we make some distinction between therapy and enhancement. Therapies would include medical interventions to restore human functioning to species-typical norms. So, kidney dialysis, lasik surgery, and angioplasty are therapies, but adding twenty IQ points to someone who already has a normal IQ would be an enhancement.

Both proponents and critics of HBTs have argued, however, that the line between therapy and enhancement is vanishingly thin. But it may not be as faint as some imagine. I was once in a conversation with a prominent fertility specialist who used preimplanta-
tion genetic diagnosis (PGD) to help couples have children without genetically-linked diseases. He told of a couple who came to him requesting that he assist them using PGD to have a child who would have perfect musical pitch. Since they were both orchestral musicians, they wanted a child to follow in their footsteps. He refused. He said he could not say exactly why, but his intuition was that it was unethical.

I think we have fairly reliable intuitions about most examples of enhancement. Let’s test our intuitions. Would you consider the following cases therapies or enhancements?

A woman is told that the baby she is carrying has fetal hydrocephalus. She opts to have surgical intra-ventricular decompression for the fetus. Therapy or enhancement?

The Pentagon pressures Congress to pass legislation requiring all children to be genetically altered to be able to tolerate a greater range of temperature exposure in order to survive future biological warfare. Therapy or enhancement?

A pre-teen basketball player wants to alter herself genetically so she will continue to grow through her college years in order to improve her chances of playing in the pros. Therapy or enhancement?

A medical student uses modafinil to help him stay alert longer so he can pass his medical board examinations. Therapy or enhancement?

Just because we cannot always make finely tuned distinctions does not mean distinctions are impossible. Just because a bright yellow line may not be able to be drawn does not mean no line can be drawn.

We should resist human bioenhancement technologies for a number of reasons, including their inconsistency with the goals of medicine, their violation of the principle of justice, and their complicity with cultural stereotypes.

The goals of medicine

HBTs should be resisted, first, because they are inconsistent with the goals of medicine. Edmund Pellegrino, MD, has made much of the notion that the first goal of medicine is healing for the “patient’s good.” The principle of medical beneficence assumes either that a patient is enjoying homeostasis, and the role of the physician is to assist him or her to maintain or optimize normal functioning, or that a patient is suffering diminished capacity due to illness or disease, and medicine’s role it to help restore as much normal function as possible. This aim of medicine is as old as the Hippocratic Oath. Whether we call it healing, wellness, or shalom, the goals of medicine are restorative and preventive.

Only recently have we begun to imagine medicine as a way to move beyond therapy. Medicine is seen less today as a profession and more as a commercial service. Physicians are not seen as professionals, they are merely body plumbers (no offense to plumbers). Consumerism thrives on giving the customer what he or she desires. While HBTs are not consistent with the traditional aims of medicine, they are very consistent with desire-satisfaction where, as ethicist Carl Elliot so elegantly puts it, “American medicine meets the American dream.” So now consumers employ doctors to make them “better than well.”

The principle of justice

Another reason to reject HBTs is the principle of justice. Having recently witnessed the Olympic games in Beijing, and heard the hoopla over doping in the Tour de France, we should be sensitive to the ways even the hint of enhancements threaten the fairness of competition. By analogy, technologically enhanced IQ, speed, dexterity, hearing, musical ability, etc., would create injustices, at least in cultures where those qualities are valued. The enhanced individual potentially would have unfair advantage over others in employment or life, just as blood-doping and steroids create advantages over other athletes.

Furthermore, in a nation like the U.S. with such massive healthcare costs, and in a world with such massive healthcare needs, enhancing already wealthy Westerners while so many individuals lack access to basic therapeutic medicine, seems unjust. In fact, most of the world’s people do not want enhancements, they want basic healthcare.
The problem of cultural complicity

Georgetown philosopher Margaret Little has argued that enhancements contribute to cultural differences that lead to personal dissatisfaction and even stigmatization. For instance, Western culture’s valorization of the Barbie-doll figure leads to body dysmorphic disorder among American teenage girls. Some Asian girls are having cosmetic surgery to make their eyes rounder and less almond-shaped in order to fit the Western ideal. For a culture to legitimize enhancement is to be complicit in these pathologies. And this would seem especially heinous after spending untold social capital, tax-dollars, and educational resources trying to convince our culture that persons with disabilities should be respected equally as those without them.

For these and other reasons, HBTs seem like a very dubious investment of time and scarce resources. Only those already well-off can afford the luxury of enhancements. The sick need a physician.†

For additional information:


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QUESTION: Should this severely brain-damaged man with a poor prognosis continue to receive painful and repeated cardioversions?

Cary, a 52-year-old former construction worker with history of drug and alcohol abuse, had a witnessed cardiac arrest at a detox center. He was transported to the emergency department with ventricular tachycardia (a life-threatening rapid heart rate), was cardioverted repeatedly with electroshocks, and was placed on a respirator. He did not immediately awaken because of significant brain damage from lack of oxygen. Echocardiography showed severe irreversible cardiac muscle damage such that the cardiology consultant predicted a cardiac life expectancy of less than one year.

After several days the patient demonstrated minimal response to pain; he had awakened from a vegetative state to a minimally conscious state. Over the next few weeks, repeated electric shocks to the heart were required (as frequently as three times a day), and the patient began grimacing with facial expressions that could be interpreted as severe pain. (There was not time to give an analgesic prior to giving the electric shocks.) The hospital staff was quite uncomfortable administering this seemingly painful therapy without patient consent. In addition, they were frustrated that his family members declined to be present when the shocks were administered. The staff requested an ethics consultation, asking the above question.

The patient had not completed a written advance directive. By state law, his mother became his legal healthcare proxy. She consulted regularly with her other son, George, who was quite religious and very assertive. They demanded full medical support for Cary and expected the prayers of their church would lead to restoration of his health. In addition, George distrusted doctors since his own son had been diagnosed with a fatal heart condition at age two. His son subsequently thrived after receiving a heart transplant, and George attributed this to the prayers of the church. Cary had joined a different church while married to his second wife, but he soon dropped out after his divorce. Because his mother and brother felt that Cary was “unsaved,” they insisted he be supported until they could speak with him and be sure that he was “at peace with the Lord.”

ASSESSMENT:

This case presents a patient with loss of mental capacity who requires painful multiple daily electrical shocks to sustain life with no reasonable hope of long-term survival. His mother and brother want him kept alive until he can convert to Christianity. The medical staff feels that this is inappropriate.

DISCUSSION:

When a previously competent patient loses the capacity to make his own treatment decisions, those decisions should be made by a legally designated surrogate or by someone who best knows the patient’s values and wishes. This surrogate should base treatment decisions on what she believes the patient would choose (substituted judgment), or if this is unknown, based on what she believes to be in his best interests.

In this case, since the patient had no advance directive and no wife or children, his mother became his legal proxy. She officially made healthcare decisions, but she relied heavily on her other son. In the absence of written documents, they made decisions based on what they thought would be in the patient’s best interests. The staff questioned their judgment since the patient’s facial
expressions made it appear he was in severe pain at the
time of the repeated cardioversions and it seemed very
unlikely that his proxies’ goal could be achieved. Though
facial expressions can be difficult to interpret, they
caused the staff considerable angst in applying the treat-
ment without the patient’s consent.

The mother likely sensed failure and a burden of guilt
for her son’s rejection of religion and his immoral life
style. Her hope for his religious conversion almost cer-
tainly determined her decisions for continued aggressive
medical treatment in the face of medical failure.

**RELIGIOUS PERSPECTIVES:**

While most patients would prefer not to survive indefi-
nitely in a minimally conscious state with debilitating
heart disease and the burdens of electrical shocks, all
healthcare professionals (including Christians) must
avoid allowing their own values and emotions to domi-
nate patient or family decision-making. They should sup-
port patient or proxy decisions, including those based on
religious beliefs such as the sanctity of temporal life and
future eternal life.

This patient’s mother and brother were expected to
make a substituted judgment, or failing that, to represent
a “best interest” standard for Cary’s physical well-being.
Their request clearly represented their own values, but
did not seem consistent with the patient’s previous
choices and lived values. *Primum non nocere,* do no
harm, has been considered the core of morality and is
assumed to apply to physical health. Lo notes that “when
benefits and burdens are evenly balanced, physicians
should err on the side of not intervening.”

According to the proxies’ religious faith, salvation is
received through repentance to God and faith in the Lord
Jesus Christ. Because of the almost certain permanent
inability of this patient to acknowledge repentance and
make a faith profession, the noble stated goals of the
mother were not reasonably attainable and would be
considered by many to thus be inappropriate.

Continuing cardioversions created significant conflicts
of conscience for the staff and violated the principle of
proportionality, where the burden of therapy exceeded
any perceived benefit. Some involved professionals who
are believers might feel these actions represented failure
to practice “neighbor love” or the “Golden Rule.” It
would not be possible for physicians to pursue those
goals without violating their commitment to do no harm.

**RECOMMENDATIONS:**

1) Based on the proxies’ assessment of the patient’s best
interests, it is ethically permissible to temporarily con-
tinue to honor their requests while still focusing on the
patient’s comfort. However, physicians and consultants
should continue discussions with the patient’s family to
clarify his confusing medical conditions and the impli-
cations of his permanently impaired mental capacity
and inability to make a valid confession of faith.

2) The team might seek a spiritual confidant (e.g., the
proxies’ pastor or the patient’s former pastor) who
might function as a religious mediator.

3) If the physicians cannot establish mutual agreement
about care of the patient, after following guidelines
outlined by the institution, care could be transferred to
another physician or another facility.

*End of clinical ethics consultant’s report*

**FOLLOW-UP:**

The patient’s mental status showed some improvement
over the next six months such that he seemed to have
awareness of the presence of other persons in his room.
His episodes of tachycardia continued, but became less
frequent. Four and one half months after admission, an
implantable cardioverter-defibrillator was surgically
placed prior to transfer to a nursing facility.

The patient’s mother and brother were repeatedly
asked to have further discussions with the attending
physicians and ethics consultant, and their pastor or
other spiritual advisors were invited to talk with them.
These requests for meetings were declined. The physi-
cians considered transfer of care, but their fear of legal
sanctions prevented their doing this.

After the patient was moved to a nursing home, his
mother frequently visited. The patient would occasional-
ly smile when asked about his favorite college football
team, but showed no significant cognitive improvement.
He had two hospitalizations at a community hospital for
heart failure during his six month nursing home stay, and
he died eleven months after his initial cardiac arrest. His
mother died three months later of an undisclosed illness.


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