CMDA *Position* STATEMENTS

Based on scientific, moral and biblical principles

Christian Medical & Dental Associations®
Changing Hearts in Healthcare
# Table of Contents

TABLE OF CONTENTS ......................................................................................................................... 0

ABORTION ..................................................................................................................................................... 4

ABUSE OF HUMAN LIFE .............................................................................................................................. 10

ADVANCE DIRECTIVES ............................................................................................................................... 11

AIDS .............................................................................................................................................................. 18

ALLOCATION OF MEDICAL RESOURCES ............................................................................................... 24

ALTERNATIVE/COMPLIMENTARY THERAPY ......................................................................................... 34

ANTI-PROGESTATIONAL AGENTS (RU-486) ........................................................................................... 35

ARTIFICIALLY-ADMINISTERED NUTRITION AND HYDRATION (ANH) .................................................. 37

ASSISTED REPRODUCTIVE TECHNOLOGY ......................................................................................... 41

BABY DOE .................................................................................................................................................... 45

THE BEGINNING OF HUMAN LIFE .......................................................................................................... 48

THE BEGINNING OF HUMAN LIFE, ADDENDUM I: CONCEPTION AND FERTILIZATION: DEFINING ETHICALLY RELEVANT TERMS ............................................................................................... 51

BIBLICAL MODEL FOR MEDICAL ETHICS ............................................................................................... 54

CHRISTIAN DENTIST’S OATH ..................................................................................................................... 59

CHRISTIAN PHYSICIAN’S OATH .................................................................................................................. 61

CHRISTIAN RESPONSE TO ADVERSE OUTCOMES ARISING FROM MEDICAL ERROR ...................... 65

CONFLICTS OF INTEREST ......................................................................................................................... 67

DEATH ........................................................................................................................................................... 71

DISABLED PERSONS ................................................................................................................................. 73

DOCTOR & PHARMACEUTICAL/MEDICAL DEVICE INDUSTRY RELATIONSHIPS ................................. 78

DOUBLE EFFECT ........................................................................................................................................ 82

EUGENICS AND ENHANCEMENT ............................................................................................................ 83

EUTHANASIA ................................................................................................................................................. 89

FETAL TISSUE FOR EXPERIMENTATION AND TRANSPLANTATION .................................................... 95

GENETIC INFORMATION AND MANIPULATION TECHNOLOGIES .................................................. 100

HEALTHCARE DELIVERY ......................................................................................................................... 102

HEALTHCARE EDUCATION AND THE CHRISTIAN FAITH .................................................................. 107
Abortion

1. We oppose the practice of abortion and urge the active development and employment of alternatives.

2. The practice of abortion is contrary to:
   • Respect for the sanctity of human life, as taught in the revealed, written Word of God.
   • Traditional, historical, and Judeo-Christian medical ethics.

3. We believe that biblical Christianity affirms certain basic principles which dictate against interruption of human gestation; namely:
   • The ultimate sovereignty of a loving God, the Creator of all life.
   • The great value of human life transcending that of the quality of life.
   • The moral responsibility of human sexuality.

4. While we recognize the right of physicians and patients to follow the dictates of individual conscience before God, we affirm the final authority of Scripture, which teaches the sanctity of human life.

Approved by the House of Delegates
Passed with 59 approvals, 3 opposed, 1 abstention

Revised by the House of Representatives
Passed with 52 approvals and 1 abstention
May 2, 2013, Ridgecrest, North Carolina.

Explanation

Abortion, although widely practiced, was considered immoral and illegal in most western societies until this generation. In the United States, state laws, hospital policies, and professional codes clearly prohibited the practice because it destroyed a developing human being. The social ferment of the 1960's brought about increased emphasis on individual rights, including women's rights. Many women's rights activists sought legalization of abortion, initially to help women who were victims of rape or incest and women who were carrying deformed babies, as well as to eliminate the dangers of illegal abortion. Later, the goal of the advocates became abortion-on-demand for any reason at all. The U.S. Supreme Court's Roe v. Wade decision in 1973 struck down all state laws that restricted abortion. With time, the issue has become increasingly contentious and even violent, and positions have become polarized. The designations have changed from pro-abortion vs. anti-abortion to pro-choice vs. pro-life, but the issue refuses to go away.

Early Christian response to the pro-abortion (or pro-choice) activism was mixed. Roman Catholics were consistent and steadfast in their opposition to abortion for any reason except to save the life of the mother. Protestants were divided. Most liberal denominations and individuals were in favor of lessening restrictions on abortion and took strong pro-choice positions. Some have recently retreated somewhat and decry casual abortion, but most still believe it is a woman's right to terminate an early unwanted pregnancy. Early in the debate, evangelicals tended to ignore the issue, fearing that it was part of the "social gospel" which would detract from their primary goal of sharing the gospel. Following the lead of several prominent conservative Christian voices, most have subsequently adopted a position very close to that of the Roman Catholic Church. Many have become involved in abortion alternatives (e.g., Crisis Pregnancy Centers), some have become involved in abortion protests (e.g., Operation Rescue), and some have become involved in legislative activism.

Abortion was the first issue tackled by the Ethics Commission of the C.M.S. After several drafts and revisions, the position statement on Abortion was passed by the House of Delegates in 1985 following
major debate by the delegates. Subsequent statements were passed regarding the Use of Fetal Tissue for Experimentation and Transplantation (1989) and the use of Anti-Progestational Agents: RU-486 (1991).

The wording of these statements reflects a strong sanctity of life perspective. This perspective is based on scripture which indicates that the fetus was created by God and seen by Him (Psalm 139:13-16), considered worthy to be called by name (Isaiah 49:1, 5), and set apart for specific tasks (Jeremiah 1:4-5). Other Old Testament passages which affirm the personhood of the unborn include Job 3:3-4; Psalm 95:6-7, 100:3, 119:73; Isaiah 44:22. The encounter between Mary and Elizabeth recorded in Luke 1:41-45 implies that even three months before birth John was fulfilling his prophetic role, and early in gestation Jesus was already a person worthy of honor.

There is, however, some variety of interpretation by conservative Christians of how this clear scriptural principle of the sanctity of life should be applied today. While most are close to the absolute stance of the Roman Catholic Church, a few would not forbid abortion in all situations. For instance the positions taken by Jones and Almquist in CMDS Journal articles abstracted in this resource find some instances of abortion less problematic than others. Others believe strongly that abortion is always wrong for the Christian, but are unwilling to seek legislative or judicial measures which proscribe the procedure for the nation as a whole. Unfortunately, some who firmly believe that scripture absolutely forbids all abortion use the stance taken by others on abortion as a litmus test of orthodoxy.

In 1991, the CMDS Ethics Commission considered a recommendation to re-write the current statement on Abortion because scripture does not explicitly prohibit abortion as is suggested in item 2 (a). It was felt by some members that the current wording might cause non-Christians to question the credibility of the CMDS statement. After long discussion, and because of the difficulty reaching consensus on the original statement, it was decided to leave the statement intact.

The secular and Christian literature on abortion is voluminous. The suggested readings which follow are not meant to be exhaustive, but were chosen in an attempt to support the CMDS position, although some do display a broader perspective.

Abstracts

Jones DG. Abortion: Thoughts on a perplexing issue. CMDS Journal Spring 1983; XIV(1):4-6

The author claims that both extreme "pro-life" and "pro-choice" positions are inadequate; they are both absolute, and they both fail to take account of all factors. He argues that the fetus is part of a continuum which commenced prior to fertilization and will not end at birth. He states, "Once a fetus has been conceived, that fetus must be regarded with seriousness and concern. Under normal circumstances, it has a right to full development." Wantedness and convenience are not morally relevant. However, he denies that the fetus has an absolute right to life. He argues that abortion may be justified (a) to preserve the physical health of the mother, (b) in extreme circumstances to preserve the mental health of the mother, (c) when pregnancy results from rape or incest, (d) when the fetus is so severely abnormal that non-existence might be considered a benefit to the fetus. He argues against the abortion of individuals with less severe anomalies, stating that the emotional or financial burden to others is not sufficient justification to deny life to genetically defective individuals. He closes by urging compassion for individuals confronted with such difficult decisions.

Shaw CT. The Death of Kleine. CMDS Journal, Summer 1983; XIV(2):29-31

The author narrates the fateful perspective of events in the womb, beginning as the fertilized egg tumbles down the fallopian tube. This is not a blob of tissue, but a distinct individual who grows and develops and at 12 weeks of gestation discovers that he has a twin occupying the womb with him. The narrative is interspersed with brief thoughts and emotions which might be experienced by parents who are overjoyed with the pregnancy, or those of parents who are greatly distressed by the prospect of having a baby. The narrative is suddenly and prematurely interrupted when abortion claims these two lives.

Hughes EM. The issue is life. CMDS Journal, Winter 1983; XIV(4):pp 18-23

The author laments that physicians have participated in millions of abortions and that abortion is considered to be immoral by a smaller percentage of physicians than the general public. While some decry the polarization of the issue, he declares that there can be no middle ground just as there was no compromise possible on the issue of slavery.
He quotes numerous biblical passages and cites several biblical scholars to build a strong case for the sanctity of unborn life. He then discusses the meaning of "person" and the misuse of the concepts of "potentiality" and embryonic twinning. He makes a clear case for the individuality and personhood of the zygote and goes on to propose that the law should be changed to protect all innocent humans. He counters arguments made by those who would make exceptions for rape, incest or fetal abnormalities. Because health professionals are stewards of life, he urges us to become involved in education, legislative activity and crisis pregnancy centers.

**Ney PG. We wrestle with death. CMDS Journal, Spring 1984; XV(1):25-27**

The author begins by calling abortion "the greatest sin humanity has ever committed." He believes that anti-life forces have caused several distortions: (a) the hope of survival of the species has become a fear of over-population, (b) sex has been changed from source of species survival into a search for pleasure, (c) the parent/child bond is strained by the sequellae of unresolved grief following abortion, (d) some mothers likewise have an aversion to touching their healthy children, (e) the normal restraint of parental rage at their children has been lessened, (f) some parents have less sensitivity to their baby's needs because of their belief that the unborn is not a person, and (g) some fathers refuse to become attached to the unborn for fear that he or she might not survive. He believes that these distortions can lead to more child abuse, less inclination to conditioned child protection, and a fear of ridicule for speaking on behalf of the unborn. The net effect, according to the author, is an endangerment of the human species.

**Schiedermayer DL. Abortion: Manasseh's legacy...and ours. CMDS Journal, Winter 1987;XVIII(1):5-9**

The matter of first importance in the ongoing abortion debate, according to the author, is the status of the fetus rather than the procedure of abortion. He makes a strong scripture-based argument for the sanctity of fetal life. In tabular form as well in the text, he defines and characterizes five positions which attempt to balance fetal rights and maternal rights: total reproductive freedom, abortion on demand, balanced rights, the right to life, and the absolute right to life.

While a majority of U.S. citizens favor some form of legalized abortion, many (or most?) do not favor allowing abortion to be available under all circumstances. He then delineates several new medical developments which are likely to enhance the public recognition of the status of the fetus. He encourages Christians to focus on the status of the fetus in order to minimize some of the effects of Roe v. Wade.

**Clark DK. Is the sanctity of life principle relevant today? CMDS Journal, Fall 1988; XIX(3):10-15**

The "alleged inflexibility of the absolutistic Sanctity of Life view has intimidated some Christians into accepting a Quality of Life view." After this opening, the author quotes Joseph Fletcher's argument that the absolute view fails to resolve the extreme cases, particularly that of severely handicapped infants. He then cites Dan Brock's argument that the absolutist position fails in the killing/letting die distinction and "leads inevitably to a position where all life must be saved at all costs."

The author rebuts these claims by stating that evangelical ethicists (he quotes Charles Kraft and Arthur Holmes and cites others) can maintain an absolutist ethic but use quality of life factors in making decisions about the application of the absolute principle. He contends that Fletcher has confused principalism and legalism. He notes that scripture contains no word for "absolute" and then he offers two meanings of the word, universal and exceptionless. He claims that most biblical norms are universal, but need not be exceptionless, and only a few such as the commands to love God and neighbor are exceptionless.

**CMDS Journal, Summer 1990; XIX(2):4-10 Four articles on Operation Rescue**

Hirsh MR. Commitment to sacrifice: What Operation Rescue is doing.

Fern DR. Why I participate.

Randall JS. Why I do not participate.

Frame R. An objective evaluation

Operation Rescue (O.R.) is described as a peaceful and non-violent attempt to bring to an end to the "holocaust" of abortion. Its motivation is scriptural (Proverbs 24:11) and its example is Christ. The first article chronicles the history of O.R. and describes police and judicial mistreatment of protesters. The author addresses the question of why there is dissension about involvement among Christians, and concludes that apathy must be replaced by a willingness to sacrifice.
One rescuer writes that he is involved because O.R. has been an extremely effective means of raising the conscience of America, and because social change rarely occurs without conflict or challenge. He states that physicians have abandoned their professional responsibility, and he encourages them to become knowledgeable, to get involved, and to refuse to take part in abortions.

A non-participant believes that not all are called to the same efforts, and that there are many other ways to support the cause of life. He encourages strength through unity.

"...as abortion has divided society at large, so have approaches to the problem divided the believing community" says one observer. Some favor political compromise, others maintain a belief in uncompromising abolition of abortion. Some oppose O.R. thinking it is a poor strategy to engender more public opposition, others say image is a non-issue. Although he feels the jury is still out on the effectiveness of O.R.'s approach, the author is convinced that the O.R. movement is not justified in claiming their motivation is purely principle and unconcerned with image. He believes that their non-violent strategy obscures an underlying "just war" stance.

The author begins by lamenting that many who are opposed to abortion are not willing to undertake other 'pro-life' causes. He defends a scriptural portrayal of prenatal human life and identity. He questions, however, the position taken by many that human life begins at the moment of fertilization. Instead he supports the view that implantation is a more biologically tenable, and a more pragmatically useful (vis a vis methods of contraception), position.

Readers responses. No end to 'Beginning of Life'. CMDS Journal, Summer 1990; XXI(2):17-20
Eight earnest responses to Dr. Almquist's article, most disagreeing, a few supporting his view.

Forsythe CD. Abortion is not a 'necessary evil': Why Americans oppose abortion but want to keep it legal. Christianity Today May 241999:63-4
The author discusses 4 myths which have led many Americans to believe that abortion is a necessary evil and points out the serious implications for future public policy brought about by this distorted thinking.

Bibliography
A compilation of scholarly and well-reasoned writings on the medical, legal, and social issues early in the abortion debate.

A beautiful photographic presentation of prenatal life.

The author, after discussing definitions, concepts and 'biblical bearings', concludes that the unborn are sufficiently like us that they must be considered human beings and we are therefore morally responsible for what happens to them.

One of the first strong statements against abortion (plus euthanasia and infanticide) by respected evangelical voices. Well presented from a biblical and historical perspective.

An expose of the deceptive argumentation and statistics used by pro-abortion advocates in the 1960's and 70's to advance their cause. The author was an abortion advocate and practitioner until philosophical and moral reasoning led him to conclude that abortion was wrong.

This book gives scientific information in lay language about the intellectual and emotional development of the unborn child.

This historical review shows that the abortion debate is not a twentieth century problem.

After laying a framework for Christian ethics taken from the biblical narrative of the flood, the author delineates four principles he deduces: (1) our understanding of scientific data must be made within the context of a created order, (2) all life has value, and there are restrictions on the taking of life, (3) persons and animals are different, and (4) there is an absolute prohibition against shedding innocent human life. He then discusses the divine image created within humans using several Old Testament and New Testament passages.

The authors argue that the fetus has the same moral status as a newborn, and thus should be regarded as a person. They go on to say that this does not preclude justifiable killing of the fetus, at least to save the life of the mother.

This one page summary of the 1988-89 study sessions of the Board of Directors of the Italian Catholic University's Center for bioethics highlights biological, philosophical, legal, psychological, ethical, and theological aspects of the question.

The author points out the misuse of numbers by both sides in the debate.

A factual review of the many problems of teenage pregnancy and abortion.

Put into historical perspective, the author maintains that the fourth century collection of first century Jewish-Christian writings is indeed against abortion.

An in-depth review of the new technologies which allow parents and physicians to "eradicate illness in a whole new way ". The author stresses that these new capabilities have produced subtle quality-of-life standards and not so subtle ways of discouraging birth of those who do not measure up.

The author concludes "An embryo's personhood rests then in his being, not in his acts or functions or in what happens to him."

The author gives clear scientific data on the issue of prenatal testing which can be used by physicians and parents-to-be who come from a pro-life perspective.

A well-reasoned and well-articulated defense of its title.

The author discusses the history of modern bioethics and public policy, especially in regard to the emphasis on personhood and autonomy. He concludes that abortion is the issue that will not die because of its central focus on personhood and autonomy.

This paper concludes "...to be a human person is to possess an essential human nature. The unborn are individual human substances, possessing an essentially human nature; therefore they are human persons. Functional definitions of personhood are arbitrary, metaphysically inadequate and ethically problematic."
This book includes five chapters which discuss abortion from various perspectives:

#13 Smith SJ - Post-abortion syndrome: Fact or fiction
#14 Roberge LF - Abortifacient vaccines: Technological update
#15 Beckwith FJ - From personhood to bodily autonomy: The shifting legal focus in the abortion debate
#16 O Mathuna DP - The Bible and abortion: What of the 'Image of God '?
#17 Pohl CD - Abortion: Responsibility and moral betrayal.

The author maintains that the statistics cannot believed, but more important, the fetus’ right to protection should not depend on such arguments, but is based on the recognition that he or she is a human being distinct from the mother.
Abuse of Human Life

Abuse of human life assualts the dignity of a person as a bearer of the image of God. Human abuse is an offense against God. Abuse may be physical, psychological, or emotional. Furthermore, there is a spiritual dimension to abuse. The resulting harm may be permanent, reparable, or only partially reparable. While not all harm is the result of abuse, abuse results in harm.

Abuse arises from pride, greed, lust, hatred, ignorance, or indifference. Abuse may be intentional or unintentional; it may result from inappropriate acts of commission or omission.\(^1\)

General conditions of human abuse may be directed against people in many ways. For example:

- Persecution or genocide of people sharing a common ethnic, political, racial or religious identity.
- Misallocation or maldistribution of resources causing inadequate relief, starvation, or death.
- Human trafficking for purposes of servitude or sexual exploitation, such as prostitution, predation, and pornography.
- Coerced bodily mutilation, e.g. female circumcision, dismemberment.
- Unjust treatment of prisoners.
- Coerced retrieval of gametes, organs, or embryos.
- Child abuse, spousal abuse, elder abuse and other forms of relational abuse.

Individual health care professionals engaged in the care of a person who is in an abusive situation have substantial attendant responsibilities in addition to providing appropriate medical care. They should affirm the victim’s worth as a person loved by God. Insofar as possible, they should assist in the reparation of the abusive situation, in the removal of the individual from the situation if there is threat of imminent harm, and in the rehabilitation of the abused individual. This almost always will involve reporting to authorities so that the perpetrator can be dealt with appropriately.

CMDA condemns human abuse. Abuse harms not only the victims but also degrades all humanity. As Christians, we recognize that evil is part of the human condition. We are thankful that God is able to redeem the results of evil to accomplish his glory. He often uses the health care professional in that process.

Approved by the House of Representatives
Passed Unanimously
June 22, 2007, Orlando, Florida

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\(^{1}\) Acts of omission may be acts of neglect. Not all acts of neglect rise to the level of abuse.
Advance Directives

Whereas modern medicine has made available technologies that can prolong life, medical science alone cannot answer questions of whether life-sustaining technologies should be used in particular circumstances or whether such technologies are consistent with patients’ goals of care, values, and beliefs about health, life, and death. Therefore, patients should have the opportunity, while they have capacity, to indicate their desires about the use or nonuse of specific treatment modalities and to designate a surrogate (sometimes called healthcare proxy or agent) to make decisions on their behalf if they become incapacitated.

Definitions:

1. Advance Care Planning: the ongoing process whereby the patient, in conversation with family and healthcare professionals, receives information about the types of life-sustaining treatments that are available, shares personal values, and makes decisions about medical care the patient would want to receive if no longer able to speak for himself or herself. Advance care planning may lead to completing a written advance directive.

2. Advance Directive (or Advance Medical Directive): a patient’s medical directive, which may be a discussion, a written statement, or an audio or video recording, specifying what medical actions should be taken for the patient if, because of incapacity, the patient is no longer able to make decisions for himself or herself. An advance directive is a legal document. An advance directive has inherent limitations; as a static document, it may not anticipate all developing clinical scenarios as medical circumstances change, and it may not reflect the nuances of a patient’s preferences or choices in every potential context.

Types of advance directives include:

   a. Durable Power of Attorney for Health Care: a legal document that authorizes someone the patient trusts to be a surrogate decision-maker, that is, to make medical decisions on behalf of the patient in the event that the patient becomes incapacitated.

   b. Living will: a written statement detailing a person’s desires regarding his or her medical treatment in circumstances in which he or she is no longer able to express informed consent, especially an advance directive.

   c. AND (Allow Natural Death): a positive medical term defining the use of life-extending measures that emphasize comfort rather than life extension.

   d. DNR (Do Not Resuscitate): a physician’s order, placed with the patient’s or surrogate’s consent, directing the withholding of cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS) in the event of cardiac or circulatory arrest. DNR means that electrical therapy, chest compressions, external cardiac pacing, or any medication intended to reverse cardiac arrest will not be provided to an unresponsive pulseless patient.

   e. DNI (Do Not Intubate): a physician’s order, placed with the patient’s or surrogate’s consent, specifying the withholding of endotracheal intubation and ventilatory support during cardiac arrest or non-arrest circumstances.

   f. POLST (Physician Orders for Life-Sustaining Treatment): actionable physician orders, signed also by the patient or surrogate, that support other forms of advance directives and are transferrable (implementable) across healthcare settings and the home. These vary in terminology and application from state to state, including signature by APRN or PA rather than physicians only, some examples being:

   i. POST (Physician Orders for Scope of Treatment)
   ii. MOST (Medical Orders for Scope of Treatment)
iii. MOLST (Medical Orders for Life-Sustaining Treatment)
iv. DNR/COLST (Do Not Resuscitate Order / Clinician Orders for Life-Sustaining Treatment)
v. TPOPP (Transportable Physician Orders for Patient Preferences)
g. VSED (Voluntarily Stopping Eating and Drinking): the decision of a patient who has decisional capacity to stop eating and drinking by mouth for the purpose of hastening death in the setting of unrelieved suffering. It may include a directive not to be hospitalized.

In formulating and applying advance directives, the following areas should be considered:

A. Biblical
1. God who gave us life is ultimately sovereign over the timing of our death.
   a. There is an appointed time for death (Gen 6:3; Eccl 3:1-2; Psalms 89:48, 116:15, 139:16).
   b. God is able to intervene in human affairs using natural or supernatural means. He frequently chooses to accomplish his purposes through human hands or medical technology, but he is not limited by those means.
   c. God may allow suffering at the end of life to accomplish his inscrutable purposes. An advance directive should not be interpreted as seizing that control from God (Job; 1 Peter 4:19; Romans 5:3-5; 2 Corinthians 12:9).
   d. The whole counsel of Scripture, as expressed preeminently in the healing ministry of Jesus Christ, endorses the merciful relief of suffering in anticipation of the final defeat of evil, when Christ will wipe away every tear and make all things new (Revelation 21:4-5).
   e. Death for the Christian is not failure but victory through Christ (Romans 6:8, 14:7-9; 1 Corinthians 15:54-56; 2 Corinthians 5:8; Philippians 1:21-23).

2. We as beings created in the image of God have moral responsibility. Scripture provides guidance on how Christians should view the end of their lives, which is important as a basis for making good decisions regarding healthcare choices.
   a. We are stewards of our bodies, our health and our resources, and therefore we are responsible to God for our lifestyle and healthcare choices (1 Cor 3:16,17, 6:19-20).
   b. Scripture provides a moral basis for making healthcare decisions on behalf of others (Mark 12:28-34; Luke 10:25-37; Phil 2:4; Gal 6:2; 1 Tim 5:8).
   c. Our inevitable decline in health is never fully within our control (John 21:18; 2 Cor 4:16).
   d. There is in Scripture a tension between viewing death as an enemy and as a defeated enemy through Christ. Death is our enemy (1 Cor 15:26,57; Phil 1:21-26). However, death is not the ultimate evil. As Christians we are freed from the fear of death (Heb 2:15).

B. Biological
   Aging, illness, and death are inevitable.

C. Social
1. The expanding powers of medical technology to extend life have contributed to cultural anxiety over the reality of natural death while also presenting patients, their families, and healthcare professionals with difficult decisions.

2. There are many reasons why advance care planning conversations do not occur:
   a. discomfort in discussing death,
   b. lack of appreciation of importance,
   c. lack of understanding of terminology and options,
   d. a sometimes overwhelming number of potential decisions to be made,
   e. breakdown in communication because of unresolved family conflict,
   f. the belief that God will direct the time of death, so we dare not intervene,
   g. assumption that the medical system will do what is right, and
   h. patients’ inability to reflect on or express their values to their surrogates.

3. Decreased interpersonal connectedness, geographical separation of families, divorce, and greater social isolation have contributed to a shift to emphasizing individual autonomy in lieu of authorizing a trusted surrogate decision-maker.

D. Medical

1. CPR is unique among medical procedures in that it is the default, not requiring a patient’s permission. Choosing to forego CPR by electing a DNR is one of the most important decisions a patient and his or her physician can make. If this discussion has not taken place, initiating CPR on a patient who would not desire it can cause considerable end-of-life suffering.

2. Healthcare professionals and patients’ surrogates are frequently faced with difficult end-of-life treatment decisions on behalf of patients who do not have an advance directive or who have not communicated their goals of care.

3. When patients opt not to communicate their preferences, once incapacitated, others will decide for them. The ultimate decision-maker may be someone the patient would not have chosen: it may be someone unfamiliar with the patient, or it may not even be a family member; it may be someone whose values the patient would not embrace.

4. The complexities of end-of-life medical choices necessitate naming a surrogate who can speak on behalf of the incapacitated patient as medical circumstances change.

5. Using a patient’s advance directive to limit interventions at the end of life can relieve moral distress of the surrogate decision-maker.

6. POLST orders are actionable across medical settings; as such, they have the benefit of decreasing patients’ moral distress by removing the need to ask patients repeatedly about their end-of-life decisions as care settings change.

7. A limitation of POLST orders is that they are not designed to accommodate context-specific medical decision-making. Additionally, in some states a POLST could be void if it contradicts a pre-existing advance directive. A broad directive to decline resuscitation does not take into account changing clinical circumstances in which, for example, a brief course of mechanical ventilation or cardioversion might enable the patient to return to his or her previous state of health.

E. Ethical

Implementing Advance Directives

1. Advance directives are an important aspect of ethical care. It is imperative for patients and their physicians to discuss goals of care in an unhurried, uninterrupted, and thorough manner. Out of respect for the patient’s dignity, it is essential that the patient understand the potential benefits and burdens of aggressive end-of-life treatment before decisions are made.
2. The benefits and burdens of CPR will vary with the clinical context and, therefore, should be reviewed with the patient or surrogate as the disease context changes. For example, CPR performed after a primary cardiac event in an ICU will have far greater benefit and less burden than when attempted outside of the hospital or when the cardiac arrest is caused by a noncardiac process.

3. The patient who has an advance directive has the obligation to communicate it to the potential surrogate and to medical caregivers.

4. The surrogate who is chosen must be willing and able to speak on behalf of the patient and to make difficult decisions when necessary.

5. The designated surrogate is obligated, within legal constraints that may vary by jurisdiction, to follow:
   a. a “substituted judgment” standard: what he or she thinks the patient would choose if able, or, if that is not possible,
   b. a “best interest” standard: what a reasonable person in a similar situation would choose.

**Treatment and Nontreatment Decisions**

6. Whereas suffering can produce strength of character (Romans 5:4), no patient is obligated to forego analgesic interventions. Medical professionals should offer any palliation possible to relieve their patients’ pain and suffering, to the exclusion of intentionally hastening death.

7. When natural death approaches, the option of withholding or withdrawing treatment should always be considered.

8. Patients have the right to refuse any medical treatment. Honoring a patient’s advance directive for nontreatment does not equate to euthanasia.

9. A suicide attempt is not an indication for medical nonintervention. A request by an individual (or surrogate) for discontinuation of life-sustaining treatment shortly after surviving a suicide attempt should not be automatically honored. In these situations time may be needed to allow the patient to transition beyond the coerced state of depression and despair that led to suicidal ideation in order to engage in informed consent about treatment options. Once the medical evaluation is complete, the patient is no longer actively suicidal, and the patient or surrogate has had an opportunity to receive adequate information to make an informed and uncoerced decision, it may be appropriate to carry out a refusal, expressed at the time or through an advance directive, of ongoing treatment of the underlying disease or the medical consequences of the attempted suicide. To discontinue therapy prior to such an evaluation risks making the physician or healthcare team complicit with suicide rather than allowing natural death.

10. A decision to withdraw a medical treatment should not be interpreted as withdrawal of care. Even when nothing more can be done medically to treat a patient’s illness, there is still much that can be done for the patient. While treatments may be discontinued, care should always remain.

11. A DNR status does not mean “do not treat.”

12. Medical technology is inherently expensive, but treatment decisions should not be based primarily on economic considerations.

13. A patient with an advance directive may be a potential organ donor, but treatment decisions should not be based primarily on preserving transplantable organ viability.

14. When medical indications are unclear or the patient’s prior wishes are uncertain, a medically appropriate time-limited intervention may be an ethical alternative to committing prematurely to an ongoing treatment or nontreatment decision.

15. Whereas the intent of an advance directive is to honor the patient’s autonomy, autonomy is not an absolute principle. Healthcare professionals also have responsibilities not to
harm but rather to do good, as well as to listen, to educate, and to provide compassionate care. Making a nontreatment decision in accordance with an advance directive that did not take into account a current unforeseen clinical context, or making a default treatment decision for a patient who did not understand an advance directive document well enough to fill it out, is not necessarily to honor the patient’s autonomy.

16. Not all treatment requests, at the time of care or in an advance directive, are ethically appropriate. In situations where the patient’s request violates the healthcare professional’s moral or religious values, then the healthcare professional should discuss this with the patient and allow transfer of care if the conflict cannot be resolved. (See CMDA position statements on: Assisted Suicide, Euthanasia, Right of Conscience in Health Care)

**VSED (Voluntarily Stopping Eating and Drinking)**

17. Patients have the right to refuse oral eating or drinking and to change their mind.

18. Whether patients should be allowed to request physician assistance in VSED through an advance directive has been a subject of controversy. The decision whether to offer palliation to symptoms of dehydration or starvation needs to be made in the immediate context consistent with the physician’s right of conscience.

19. An ethical dilemma may arise when a cognitively impaired patient who requests food or drink has previously signed a VSED advance directive requesting that healthcare professionals withhold spoon feeding and orally administered hydration. In these situations, it is ethically appropriate to honor the advance directive in regard to medical interventions such as intravenous fluid or tube feedings. However, it is ethically impermissible to withhold ordinary food and water to the patient who requests them, as these represent normal human care and interaction and are not considered medical treatment. Healthcare professionals have the right to offer spoon-fed nutrition and orally administered fluids to all patients who desire them and to whom they can be provided safely. A previously stated desire for VSED should not overrule a conscious patient’s expressed desire for oral feedings. (See CMDA position statements on Artificially Administered Nutrition and Hydration; Double Effect; Euthanasia and Assisted Suicide)

**POLST (Physician Orders for Life-Sustaining Treatment)**

20. Patients may elect to sign a POLST document as an advance directive in the event of serious illness with limited life expectancy. POLST forms should be filled out only after a meaningful discussion with the patient and family or surrogate. The discussion should be documented in the medical record. These documents are most appropriate for those patients who are terminally ill, are likely to have multiple or frequent interactions with the healthcare system, and have significant chronic or life-limiting illness.

21. Standing orders dictating future treatment decisions are ethically appropriate only if the patient’s preferences are stable over time and across foreseeable clinical contexts. Some forms require review and renewal at least on an annual basis.

22. Whereas POLST is appropriate in regard to CPR, decisions about the use or nonuse of fluids and nutrition and about time-limited treatment trials are better addressed through the patient’s advance directive or discussion of goals of care with the patient’s surrogate than through the automatically invoked POLST form.

23. It is important that physicians whose practice involves end-of-life considerations and consultations be aware of the extent to which these orders are legally binding.

24. Many iterations of POLST orders are exceptionally detailed and complex, and it is incumbent upon healthcare professionals to ensure that the patients and their surrogates have an adequate understanding of the implications of the orders, to the end that the vulnerable are not placed at risk.
25. Efforts to provide comfort care and pain management are always appropriate, and most variations of POLST address this imperative.

Conclusion

- The role of the physician is to affirm human life, relieve suffering, and give compassionate, competent care as long as the patient lives. The physician as well as the patient will be held accountable by God, the giver and taker of life.
- Advance directives are biblically, medically, and ethically appropriate. Advance directives should be recommended to all adult patients regardless of health and reviewed and updated periodically.
- An essential part of an advance directive is the patient’s discussion with designated family or other close associates and the healthcare team about the patient’s values and wishes.
- Healthcare professionals should assist patients with advance care planning in accordance with patients’ beliefs, values, and preferences, particularly when they are clearly and consistently expressed.
- Conversations about death, dying, and end-of-life medical care should be a routine part of church ministry, focusing not just on eternal destiny, but also on how Christians’ end-of-life decisions should be consistent with their belief that death has been defeated through Jesus Christ.
- Advance directives should never be used as a means to physician-assisted suicide or euthanasia.
- Healthcare professionals should honor their patients’ medically appropriate advance directives and recognize this as an opportunity to respect their dignity as made in the image of God.

Approved by the CMDA House of Delegates
Passed Unanimously
May 2, 2019
Ridgecrest

References


AIDS

Acquired immunodeficiency syndrome (AIDS) caused by the human immunodeficiency virus (HIV) is a growing epidemic that may surpass the ravages of any plague in human history.

We extend compassion to all who have acquired this disease by whatever means. We urge the provision of medical care for them to the same degree that patients with other life-threatening diseases receive it.

Christian physicians and dentists, following the example of Christ, should care for HIV-infected persons even at the risk of their own lives.

We encourage all health care workers to do the same. In keeping with its historical precedents (e.g., the establishment of hospitals and orphanages), we urge the Church to become involved with the development of new health care ministries to provide compassionate care for persons with AIDS. They need the hope and peace that only the Gospel of Jesus Christ can give them.

We call for public health policies that balance patient confidentiality with protection of the uninfected. We urge screening of high-risk groups and sexual contact tracing of persons who are HIV-positive for both treatment and prevention of further transmission of infection. We encourage all health care workers to take reasonable precautions in caring for all patients.

Failure to inform one's sexual partner or any other person who may be exposed that one is HIV-positive is morally reprehensible, as is discrimination against an identified HIV-positive person. We believe that the interests of the uninfected have priority over the autonomy and confidentiality of patients who are HIV-positive and persist in high risk behavior. Physicians, dentists, and public health officials have a duty to warn in such life-threatening situations.

CMDA reaffirms the sanctity of marriage and deplores non-marital sexual intercourse, homosexual practices, and IV drug use, which account for the vast majority of AIDS cases.

Family life teaching and sexual education are God-given responsibilities of parents. The Church's task is to assist both parents and youth in understanding their sexuality in the context of biblical values. Sexual education in these and all other settings should include risk behavior information and instruction on protective techniques to inhibit the spread of AIDS and all other sexually transmitted diseases. Education and protective techniques alone, however, will not stop the spread of AIDS.

Our society needs to understand and acknowledge that there are compelling emotional, philosophical, medical, sociological and historical reasons for practicing abstinence before marriage and for fidelity within marriage. Since God has designed sexual intercourse for monogamous heterosexual marriage alone, and since this form of sexual practice will ultimately help to solve this problem, the Christian Medical & Dental Associations call our world to affirm biblical sexual morals.

Approved by the House of Delegates
Passed unanimously

Explanation
Background

The CMDS does not have a position statement on diabetes, heart disease, or any other single disease process except AIDS. Why is this condition so unique that Christian clinicians need to give it special consideration?

HIV disease is unique. It has the transmission characteristics of syphilis and a natural history similar to tuberculosis; it carries with it the prognosis of bubonic plague and the stigma of leprosy. When the disease was first described and its epidemiology was being worked out in the early 1980’s, the devastation it caused led to fear, judgment, hostility, avoidance, and discrimination regarding employment, access to medical care, housing, insurability, and other areas. Some Christians felt that the epidemic was God s judgment on those with immoral lifestyles. Some physicians and dentists chose not to treat patients with AIDS. Ethical questions arose about screening, confidentiality of test results, quarantine, access to treatment, HIV positive healthcare professionals, hurried access to research results and/or research drugs, etc.

Some supporters of and activists for the homosexual community labored extensively to ensure non-discrimination and urge non-judgment. These social and political activists were joined by many Christians who felt compassion for individuals with AIDS. This social/political movement encouraged acceptance of homosexual individuals, and directly or indirectly also encouraged acceptance of the homosexual lifestyle. Some of the non-discrimination policies and laws which resulted actually granted favored status to those infected with the HIV.

It was in this context that the CMDS undertook in 1988 to draft a position statement which could truly follow the old sermon theme about loving the sinner while hating the sin. The statement attempts to reaffirm the moral obligation of physicians and dentists to treat patients infected with the HIV, and to encourage the provision of compassionate care in the context of the gospel. It attempts a balanced approach to testing and confidentiality. At the same time, it reaffirms its understanding of and position on biblical sexual morals.

Christian Perspective

The Bible is very helpful in establishing a moral framework which provides parameters for treating persons with AIDS. Particularly relevant is Jesus encounter with the ten people with leprosy in Luke 17:11-19, one of whom was a Samaritan. Lepers in the time of Jesus bore much resemblance to persons with AIDS today—they were seriously ill and they were ostracized. Then, Jews looked down on Samaritans, just as today many people look down on those who take IV drugs or engage in homosexual behavior. When these kinds of people contract leprosy (then) or AIDS (now), they are especially despised.

Against this backdrop it is striking that Jesus not only relates to and heals people with unclean diseases, but that he heals them all without regard for whether or not they fall into a doubly-despised sub-group. Moreover, none of the ten appears to be a person of faith before the healing; yet one appears to come to faith in response to Jesus loving care. Surprisingly—but perhaps not so surprisingly after all—it is the Samaritan, the particularly despised one, who responds. Those most rejected by society can often be the most receptive to God’s love expressed through medical and other forms of care.

Jesus makes it clear that he wanted all to come to faith, not just to physical health. Yet he healed all ten, irrespective of their openness toward God. Had those with leprosy been involved in sinful behavior, Jesus undoubtedly also would have told them to stop engaging in it after he saved their lives—as he did with the woman caught in adultery (John 8:11). So it is appropriate to uphold and communicate the importance of Christian faith and morality, even though the provision of care is not to depend on a patient’s acceptance of either.

Abstracts

Kelly D. A biblical perspective on AIDS. CMDS Journal Fall 1989; XX(3):12-16
A pastor and theologian looks at and reflects on the AIDS epidemic. He first addresses a theology of life which emphasizes the infinite value of human life because it is created by God in his own image, and the divine plan of the marital and sexual relationship. He goes on to discuss a theology of disease and death. Although all disease and disintegration can be traced to the root cause of original sin, and some diseases may be a direct punishment from God, very often we can see no direct connection between specific sin and specific disease. He draws an analogy between the lowered voice of the church for failing to sound a warning about the consequences of sin to the lowered resistance of the body’s immune system to infection with the AIDS virus. He goes on to make several observations about the involvement of innocents in plagues and disasters.

The author concludes with a theology of redemption focusing on God’s atonement and reconciliation and Man’s forgiveness and transformation. He calls Christians to a costly compassion while holding to high godly standards of life and conduct.


A professor of ethics and theology expresses some concern about the favored legal status accorded persons with HIV disease, facilitated in some instances by Christians who encourage compassion, but go even further and encourage non-judgmental acceptance of the causative lifestyle. He discusses the moral challenge, and concludes that it is to hate the sin while showing compassion and concern for the sinner while offering the possibility of forgiveness and salvation.

In discussing the medical challenge of AIDS, the author warns that the physical and emotional misery of the disease, its uniformly fatal prognosis, the burgeoning costs of terminal care, as well as unreasonable fear of AIDS may combine to encourage the acceptance of induced death; i.e. physician-assisted suicide or euthanasia. In addition, he asks whether AIDS is related to homosexuality in a specific way, and he doubts that advice on AIDS prevention can be effective without addressing the issue of moral behavior.

Regarding the spiritual challenge presented by this disease, he reaffirms the covenant relationship of one man with one woman as part of the divine creation. He concludes that AIDS may be a warning to return to God’s ways, but he fears that it may be used as a pretext for ignoring those teachings.

Baker CJ. The child with AIDS. Today’s Christian Doctor 1996; XXVII (1):29-33

A clinical researcher on pediatric AIDS gives information on maternal-fetal HIV transmission, the natural history and symptoms of HIV infection in children, and risk of transmission to healthcare professionals. She gives up-to-date information on research in prevention of HIV disease in children. In discussing ethical issues, she briefly presents the utilitarian position for termination of HIV infected fetuses or newborns, but instead offers the Christian view of non-judgmental ministry to infected individuals.

The author concludes the article with her own personal testimony of moving from existential hopelessness and despair to the foot of the cross. It was there she found hope and the answer to the issue of when the innocent suffer. Motivated by His love, we must seek to minister to Christ Himself by caring for the sick, including those victims of AIDS.

Bibliography


This early professional position paper articulates seven specific position statements along with the rationale for each. Included are the obligation to treat, the need for education, non-discrimination in testing and reporting, encouragement of research, and others.

Schiedermayer DL. Choices in plague time. Christianity Today 8/7/87; 31:20-22

In this personal account of his experience with the AIDS epidemic, the author relates how his first encounter with this deadly plague forced him to choose whether he would desert, persecute, or choose to care for those afflicted with AIDS. Drawing a parallel between the desertion and persecution of historical plague victims and that of modern-day AIDS patients, he asserts that the consequences of such maltreatment only heighten the effects of plague. On the contrary, he notes that historical exceptions in which persons have chosen to care for plague and AIDS victims have resulted in positive consequences
for society as a whole. He concludes by urging Christians to extend compassion to persons afflicted by AIDS in hopes that the terror of this plague will diminish.

**Emanuel EJ. Do physicians have an obligation to treat patients with AIDS?** New England Journal of Medicine 1988;318(25):1686-1690

Taking a strong stand for the internal morality of medicine, the author answers the title question with a yes. He goes on to discuss situations of excessive risk, those with questionable benefits, obligations to other patients, and obligations to self and family.

**Sherer R. Physician use of the HIV antibody test: The need for consent, counseling, confidentiality, and caution.** JAMA 1988;259(2):264-265

Starting with the potential harm which can result from HIV testing and the inappropriate release of results, the author encourages anonymous testing of individuals at risk, as well as adequate pretest and posttest counseling and confidentiality.

**Bergamo F, Greely JH. AIDS in a dental office - two views.** CMDS Journal Fall 1989; XX(3):28-29

Two practicing dentists address practical implications of the AIDS epidemic. One relates a personal encounter with an established patient who now has the disease, and how his office staff's response required him to take new steps to provide treatment. The other articulates legal requirements and professional standards about treating patients with AIDS, but calls Christians to a higher standard.

**Pellegrino ED. Ethics.** JAMA 1990;263(19):2641-2642

In the annual JAMA Contempo issue, Dr. Pellegrino devotes this op-ed piece to the many difficult ethical dilemmas posed by the HIV epidemic. He asks questions about access to treatment, obligation to treat, responsibilities of patients, cost of care, use of experimental drugs, efforts at prevention, and many others.

**Giesel EH. AIDS and the obligation to treat: A personal journey.** CMDS Journal Spring 1990; XXI(1):14-16

An internist relates her experience with a non-compliant and uncooperative AIDS patient whose behavior placed her and others at risk. Her response of personal concern and frustration is balanced by her Christian motivation. Her conclusion is that Christian physicians have a professional obligation to accept that risk.


Addressing the impact of AIDS on the world, church, family, and the individual Christian, the authors consider the nature and growth of the AIDS epidemic, the response of society to this disease, and the call to Christians to minister to those who are afflicted. They encourage members of the Christian community to consider becoming a Samaritan alongside the many others already working to bind up the wounds of our nation caused by this epidemic—to offer compassion, healing, and ultimately eternal life through Christ and propose models of ministry for doing so.


This book illustrates the power of God in the face of adversity, calls us to examine our relationships with our own family members, and challenges us as Christians to respond to the AIDS epidemic as Christ would have us.

**Lo B, Steinbrook R. Health care workers infected with the human immunodeficiency virus.** JAMA 1992;267(8):1100-1105

The authors review the history of the controversial 1991 guidelines proposed by the CDC and the AMA and their subsequent revisions. They suggest that disregarding the guidelines will further erode public trust, and they encourage physicians and dentists to respond more effectively to public fears about HIV transmission. The challenge is to protect patients while respecting the privacy and livelihood of health care workers.

Noting that the AIDS epidemic has witnessed scientific, medical, and economic changes since the time of its inception, the authors assert that a biblically and theologically based response to this epidemic remains both appropriate and essential. They urge Christians to develop and engage in ministries which are designed to reach all persons affected by AIDS, not merely those who are afflicted with the disease. Drawing on the various roles that Jesus fulfilled during his earthly ministry, they challenge members of the Christian community to adopt the role of servants in extending compassion to AIDS victims whom society may regard as sinners or outcasts.

Grenz SJ. Why reach out to persons with AIDS? Direction 1993; 22(1):63-72

Drawing on the biblical account in which Jesus healed a man with leprosy (Mark 1:40-42), the author asserts that as Christians, we are called to minister to persons with AIDS and that we are to do so with the compassion of Christ. He cites biblical passages which illuminate the nature of God, the character of Christ, and the calling of the Church in challenging Christians to care selflessly for those who suffer from AIDS.


Focusing on the prospect of early treatment of AIDS patients which has been made possible by research advances, the author maintains that the common debate over issues of patient confidentiality and patient autonomy have gained a new urgency since frequent testing is essential for such early treatment. He raises issues such as the patient's obligation to undergo treatment, the physician's duty to encourage treatment, and resource allocation. Though he admits that these issues are not yet resolved, he is optimistic that the prospect of early treatment will replace fatalistic resignation of physicians and patients to the AIDS epidemic.


In these opening remarks to the VIII International Conference on AIDS/III STD World Congress in July 1992, the author contends that the insufficiency of our response to the AIDS epidemic thus far can be traced to our misunderstanding of AIDS itself. He urges the health care community to abandon the perception of AIDS as a separate, unique, and isolated health problem in favor of viewing it as a disease which is deeply [and] fundamentally about people and society. He is optimistic that members of the health care community, by adopting this new understanding of AIDS, will be empowered to confront the societal ills which have diminished our ability to respond effectively to the AIDS epidemic.


A missionary during the early AIDS epidemic in Uganda addresses facts (the epidemic, the forecast, the virus, bad behavior, God, testing, treatment, prevention), and feelings (moral outrage, blind compassion), about the AIDS problem, and he filters them through faith to conclude with practical suggestions for a Christian response. The appendix gives more information about AIDS in a concise question and answer format, then uses scriptural quotations to answer five important questions about God s plan for sex and marriage, Christian response to the disease, comfort and salvation for the affected individual.

Harris J, Holm S. Is there a moral obligation not to infect others? British Medical Journal 1995; 311:1215-1217

The authors state that there is a strong prima facie obligation not to harm others by making them ill where this is avoidable. They go on to state, however, that the reasonableness of expecting people to live up to this obligation depends on society reciprocating in the form of providing protection and compensation.

This book is a personal and honest account of the secret burden of having HIV disease. The career changes, the social isolation, the depression, and the victories are clearly portrayed. They can be an encouragement to Christian physicians, clergy, neighbors.


A Christian infectious disease specialist gives details of the HIV infection and then encourages ministering without fear. He gives concrete suggestions about showing care and compassion. His conclusion is that, because of God’s incomprehensible mercy and grace to us as broken individuals, we should accept His transforming grace to obediently minister to others.

**Kaldjian LC, Jekel JF, Friedland G. End-of-life decisions in HIV-positive patients: The role of spiritual beliefs. AIDS 1998;12;103-7**

This personal survey of 90 patients hospitalized with AIDS concludes that spiritual beliefs and religious practices appear to play a role in end-of-life decisions. Discussions about end-of-life decisions may be facilitated by a patient’s belief in a forgiving God and impeded by a patient's interpretation of HIV infection as a punishment.
Allocation of Medical Resources

As Christian physicians and dentists we recognize that increasing treatment capabilities and increasing treatment costs, as well as societal priorities for the allocation of dollars, make it difficult to provide all people with all services which they might need (or perceive they need). Therefore, as individual practitioners, as a profession and as a society, we are often faced with difficult allocation decisions.

The scriptural principle of justice requires us to treat patients without favoritism or discrimination. The scriptural principle of stewardship makes us, individually and corporately, accountable for our decisions about the provision of medical and dental care. The scriptural principles of love and compassion require that we place the interests of our patients and of society before our own selfish interests. Recognition of the finitude of human life, along with the higher calling of eternal life with Jesus, should help Christian healthcare professionals resist the disproportionate expenditure of funds and resources in an effort to postpone inevitable death. Christian healthcare professionals, however, must never intentionally hasten the moment of natural death, which is under the control of a sovereign God. (see Ethics Statement*)

Christian doctors have a responsibility in helping to decide who will receive available health care resources. To refuse that responsibility will not prevent allocation decisions, but will instead leave those choices to institutions and individuals with purely utilitarian or materialistic motives. If this happens, allocations may generally shift toward people who have wealth or other forms of privilege, which is not the biblical way to value human life.

International Concerns:
We must be sensitive to the unmet health care needs of most of the world compared to the position of great privilege we enjoy in the United States. As Christian doctors we must seek to address the suffering of the international community through our personal actions and through our influence in public policy decisions.

Public Policy Concerns:
Society must evaluate its total resources and be certain that adequate dollars are made available for the health care needs of its people. (see Ethics Statement**) This involves the understanding that choices must be made between the value of health care and the competing values of lifestyle, entertainment, defense, education etc. Society must minimize waste caused by unnecessary administrative and malpractice costs. Waste can also occur in expenditures for ineffective or unproved therapies or by funding perceived, rather than true, healthcare needs.

Society must also make decisions regarding the allocation of resources to individual patients but should not place patients in the situation of choosing less effective care because of costs. These decisions must always be made with compassion and recognizing the inestimable value of human life. The choice between similarly beneficial therapies may be made on the basis of cost in order to maximize resources. Limits on therapeutic and diagnostic procedures may need to be based on cost and outcome. Outcome assessments based on "Quality of Life" determinations are problematic. We need to remember God's great love for all individuals and the great value He places on each individual life regardless of the world's valuation of that life. Purely utilitarian considerations should not determine the allocation of absolutely scarce, lifesaving resources (e.g. transplantable organs). All humans are equal in the eyes of God.
Society must recognize the value of research in continuing to improve the healthcare of its people, and must therefore allocate adequate funding for promising areas of research.

**Professional Practice Concerns:**
Christian doctors should earnestly examine their lives and practices and prayerfully seek God's guidance about their charges for professional services. They must be careful not to offer unnecessary diagnostic and therapeutic interventions. They should be actively involved in the provision of professional care for the poor and uninsured. Doctors should offer the best care available and inform their patients if that care isn't covered by their insurance plan. Whenever equally beneficial therapies are available the doctor should offer the less expensive therapy in order to benefit others who might use the resources.

The practice of medicine at the level of the individual doctor is primarily an exercise in mercy. Society, because of limited resources, introduces the concept of justice. We as Christian doctors must strive in our practices and in our society to model the person of Christ, and His grace.

* See Statement titled "Physician-Assisted Suicide"
** See Statement titled "Health Care Delivery"

*Approved by the House of Delegates*
*Passed with 64 approvals, 4 opposed, and 1 abstention*
*May 1, 1999. Toronto, Ontario.*

**Explanation**

"Rationing" has always been a dirty word in the practice of medicine. As healthcare professionals and as citizens we have been very reluctant to admit or even consider that some of our neighbors are restricted from healthcare which they may need. However, the increased cost of healthcare, increasing numbers of citizens without health insurance, and increasing disparity between the rich and the poor have forced us to recognize that rationing is part of our current healthcare system.

The issue has been hotly debated for many years in the public policy arena, the literature of medicine and ethics, and in doctors' lounges, but not so much in our pulpits or Sunday School classes. There are many basic questions, most of which have not yet achieved societal consensus. Is healthcare a right or a privilege? What constitutes a decent minimum of healthcare? How does individual choice, e.g. those regarding lifestyle or the purchase of insurance, factor into the issue of whether an individual deserves a particular treatment modality? Are rationing decisions always matters of public policy, or do such decisions also occur in the ICU, the hospital, and in the office practice of medicine and dentistry? Is there, or can there be, a clear distinction between futility (withholding non-beneficial therapy) and rationing (withholding potentially beneficial therapy)?

**Secular Perspective**

Experts in medical and dental ethics have given considerable thought to these questions and have published voluminously. The principles which clash in these discussions are the professional's duty to beneficence (i.e. doing what is good for the patient), the individual patient's right to autonomy (i.e. self-determination) and society's obligation to justice (i.e. to treat like patient's alike). There is general agreement that minority patients and poor patients, and especially poor minority patients, have too often been treated unjustly in our society.

Most of the reasoning used in discussions aimed at correcting this injustice is clearly utilitarian, i.e. trying to achieve the greatest good for the greatest number. And this has some merit. When there is not enough to go around, how can we determine how to be good stewards of our resources? By trying to do the best
we can with our limited resources - and this involves looking at the anticipated consequences of professional and policy decisions.

Others have voiced a virtue ethics perspective which relies on the integrity and fairness of the individual practitioner.

**Christian Perspective**

For the most part, Christians have been late in entering this modern discussion. This is ironic since it was the example of Jesus which interjected the concept of compassion into Hippocratic medicine, and it was religiously motivated individuals who established the first hospitals and who volunteered to provide medical and dental service on the mission field. However, modern Christian healthcare professionals have been less responsive to the needs around us today, and we have often been unbiblical when we have responded.

Tragically, Christian healthcare professionals have not been immune to the consumerist mentality of modern western society. Too many Christian physicians and dentists have focused on accumulation of personal wealth and have forsaken their biblical mandate to service.

Some Christians have also been quite judgmental in pointing fingers at individual patients or groups of patients whose sinful lifestyle choices have resulted in the need for intensive and/or expensive therapies, or at those who may have contributed to their poverty by poor choices or lack of ambition. And truly, all of us must be prepared to live with the consequences of our sinful choices. However, Jesus in his healing ministry did not discriminate against the down-trodden. In fact he appeared to give preference to the poor and to sinners.

Scripture does teach us about serving and caring for the less fortunate. In addition to the secular principles of medical ethics, Christian professionals and laypersons alike have other principles to guide us in these difficult discussions, e.g. compassion (Luke 7:11-15), service, contentment (Heb 13:5), the Imago Dei (Gen 1:27), and dominion (Gen 1:28). And a Christian understanding of stewardship is broader than the secular in that it involves an accountability to God. In addition, the biblical concept of justice is broadened to include mercy and grace.

Individual CMDA members, and the association as a professional organization, have tried to teach and model these biblical principles in our practices and in debate on public policy issues. This approach is indeed critical in a discussion of the allocation of medical resources.

In 1997, our association (then the CMDS) cooperated with several other Christian professional organizations in sponsoring a continuing education conference entitled "The Changing Face of Health Care". The proceedings of that conference were published by Eerdmans in 1998 as a book of the same title with a subtitle of "A Christian Appraisal of Managed Care, Resource Allocation, and Patient-Caregiver Relationship." Some of these tough questions are addressed in depth by Christian clinicians and scholars.

**CMDA Position Statement**

The Ethics Commission struggled with this issue for a long time before bringing a draft to the House of Delegates. Commission members felt it was important to emphasize biblical principles, to recognize rationing decisions on an international scale, and to differentiate between issues of public policy and those of individual practitioners. The statement became official policy on May 1999.

**Abstracts**

**Introductory Articles**


"The discovery that health status is affected by personal life-styles and apparently voluntary health risks poses new problems. It has potential impact on clinical practice, health insurance, and theories of health and disease. Five major problems need attention. First, are these health-risk behaviors really voluntary? Five responses are explored: several other models (the medical, psychological, social structural, and multicausal models) all challenge the assumption of voluntary behavior. Second, are some sufficiently in
the public interest that they ought to be subsidized? Third, does justice require that persons bear the costs of truly voluntary health risks? Fourth, what policies should apply to cost-saving, health-risk behavior? Finally, does the voluntary health-risks theme make life too rational and calculating? These issues must be dealt with in future health planning and clinical decision making."


In this article, the author notices the trend of increasing health costs and envisions the accompanying difficult allocation decisions. He proposes five suggestions "regarding steps that the medical profession, together with the public, might take that should at least reduce the area of conflict. (1) Assess new technologies, procedures, and therapies much more carefully before introducing them into practice, so that their benefits and costs are known. (2) Educate the medical profession and the public to accept medical decisions that are based on probabilities of success or failure and to stop gambling expensive and scarce resources on long shots. (3) Remove fiscal incentives from the medical decisions-making process. (4) Allocate more support national for medical research. (5) Introduce more preventive medicine into clinical practice."


"The problem of health care distribution in the United States demands immediate action. Many different solutions have been proposed to slow rising health care costs and to improve access to care for the poor and uninsured. Debate among proponents of these various proposals might be advanced if a common language were adopted with regard to certain key terms instead of the various meanings currently assigned to these terms. For this reason, we propose and defend the following three definitions: (1) rationing is the societal toleration of inequitable access to health services acknowledged to be necessary by reference to necessary-care guidelines; (2) health care needs are desires for services that have been reasonably well demonstrated to provide significant net benefit for patients with specified clinical conditions; and (3) basic benefit plans are insurance packages that provide for all and only acknowledged health care needs, again by reference to appropriate clinical guidelines."


"How can health plans make fair determinations about when 'experimental' (and costly) treatments such as high dose chemotherapy with autologous bone marrow transplantation should be covered despite lack of clear clinical consensus about their benefits? Different models for managing 'last chance' therapies evolving in some health plans offer promising examples of how issues of fairness and legitimacy in decision making can be addressed."


In an environment where the insurance maze gets longer, the paperwork thicker and the premiums more expensive, there is an alternative in the form of the Christian Brotherhood Network. Based on Gal. 6:2, the Christian Brotherhood is a network of families who help each other defray the costs of a major medical event. In this article, the author compares government insurance programs with the Christian Brotherhood philosophy. She concludes, "Insurance actually was God's idea. As the apostle Paul writes in 2 Corinthians 8:13-14a: 'Our desire is not that others may be relieved while you are hard pressed, but that there might be equality. At the present time, your plenty will supply what they need, so that in turn their plenty will supply what you need."


In this article, the author states that the narrow way we define the phrase healthcare delivery system "impoverishes our learning and dramatically limits our ability to foster health." Instead, he advocates "a different way of thinking about health care," a way in which we realize that each person has his/her own unique health system, "comprising a unique array of personal and public resources, connected in idiosyncratic patterns, and oriented to goals that are our own." He concludes, "If we are to maximize the return on our societal investments in health, we must be willing to consider investments in a much wider
array of resources than we have in the past. We must also be willing to compare the 'health return' on investments in new medical technology, more doctors, and more elaborate hospitals with the health return on investments in information technology, community education resources, better nutrition, enhanced exercise and recreation resources, and better transportation systems. If health derives from many resources in addition to those in the 'healthcare delivery system,' then we must consider those other resources as worthy candidates for our investments in health."

**Justification for Rationing**


Reforming the American health care system, argues this prominent author, takes more than just cost containment. Pointing out that American health policies have not worked thus far, Callahan urges the re-examination of our values and our fear of rationing in order to achieve an economically sound system. "Whether we like modifying our basic values or not, it seems impossible to achieve equity and efficiency without doing so. Having a minimal level of adequate care available to all means that if such care is to be affordable, it must be combined with limits on choices, progress, and profit. Setting limits means we cannot have everything we want or dream of. The demand for priorities arises when we try to live with both decent minimal care and limits to care. At that point we must decide what it is about health care that advances us most as a society and as individuals. We have bet that we could have it all. That bet is not paying off. There remains no reason, however, that we cannot have a great deal. We do not necessarily have to limit decent health care in any serious, drastic fashion. What we do need to do is to restrain our demands for unlimited medical progress, maximal choice, perfect health, and profits and income. This is not the same as good health care."


"American doctors in the 1990s are being asked to serve as 'double agents,' weighing competing allegiances to patients' medical needs against the monetary costs to society. This situation is a reaction to rapid cost increases for medical services, themselves the result of the haphazard development since the 1920s of an inherently inflationary, open-ended system for funding and delivering health care. The answer to an inefficient system, however, is not to stint on care, but rather to restructure the system to remove the inflationary pressures. As long as we are spending enormous resources on an inherently inefficient and inflationary system we cannot justify asking doctors to withhold beneficial care to save money for third-party payers. Doing so serves a largely political agenda and endangers the patient-centered ethic that is central to medicine."


"The arguments against doctors as 'double agents' that are presented by Marcia Angell in the preceding article do not defeat the core justification for rationing some relatively high-expense, low-benefit care, and they do not enable us to conclude that clinicians should be barred from any active, substantive role in decisions to limit that care. They do, however, reveal several important conditions that need to govern cost-conscious medical practice in order to preserve an ethic of fidelity to patients: insurers' profits and providers' incomes must be fair, providers must inform patients of any economic reasons that lead to the forgoing of care, and 'direct incentive' arrangements must not be used to contain costs."


In this article, the author proposes 11 principles to guide the debate over cost and allocation. "Ideally, there should be national agreement on a single set of principles…My hope is that health care organizations will debate each of the principles and either will agree with the ones I have proposed or will develop better ones."

The Principles:
1. The financial resources available to provide health care to a population are limited
2. Because financial resources are limited, when deciding about the appropriate use of treatments it is both valid and important to consider the financial costs of the treatments.
3. Because financial resources are limited it is necessary to set priorities
4. A consequence of priority setting is that it will not be possible to cover from shared resources every treatment that might have some benefit.
5. The objective of health care is to maximize the health of the population served, subject to the available resources
6. The priority a treatment should receive should not depend on whether the particular individuals who would receive the treatment are our personal patients.
7. Determining the priority of a treatment will require estimating the magnitudes of its benefits, harms, and costs.
8. To the greatest extent possible, estimates of benefits, harms, and costs should be bases on empirical evidence. A corollary is that when empirical evidence contradicts subjective judgments, empirical evidence should take priority.
9. Before it should be promoted for use, a treatment should satisfy three criteria:
   There should be convincing evidence that, compared with no treatment, the treatment is effective in improving health outcomes.
   Compared with no treatment, its beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
   Compared with the next best alternative treatment, the treatment should represent a good use of resources in the sense that it satisfies principle No. 5.
10. When making judgments about benefits, harms, and costs, to the greatest extent possible, the judgments should reflect the preferences of the individuals who will actually receive the treatments.
11. When determining whether a treatment satisfies the criteria of principle No. 9, the burden of proof should be on those who want to promote the use of the treatment.

Justice and Equality in Allocation


In this article the author deals with two questions that are associated with debate on the right to a decent minimum of health care: (1) "Is there a more extensive right than the right to a decent minimum of health care?" (2) "What is included in the decent minimum to which there is a right?" He examines various arguments attempting to establish the right to a decent minimum of health care.


This paper explores the implications of Roman Catholic teachings on social justice and rights to health care. It argues that contemporary societies, such as those in North American and Western Europe, have an obligation to provide health care to their citizens as a matter or right. Moral considerations provide a basis for evaluating concerns about the role of equality when determining health care entitlements and giving some precision to the widespread belief that the right to health care requires equal entitlement to health care benefits.


"Can proposing a policy of equal access to health care be justified on Christian grounds? The notion of a 'Christian justification' with regard to Christians' political activity is explored in relation to the New Testament texts. The less demanding policy of granting a 'right to (basic) health care', the meaning of Jesus' healing activities, early Christian welfare schemes, and Christian grounds for the ascription of 'rights' are each discussed. As a result, with some stretching of the neighbor-love and missionary imperatives it is proposed that a basic health care policy can be legitimized. With regard to equal access to health care, however, all attempts to derive an equalizing imperative from the spiritual 'equality among humans'or by way of the 'love your neighbor as yourself' imperative are shown to fail. Particular attention is given to whether 'attending to the least of my brothers' needs'obliges Christians to satisfy those needs optimally, as well as to the personal involvement aspect of the love-commandment in its simultaneously spiritual and temporal orientations."

"A frenetic search for equality lies at the center of much secular and even 'Christian' bioethics. In a secular world, if one does not believe in God, if this life is one's whole existence, it would seem that one could not settle for less than equal approbation, especially equality before the risks of suffering and death, which medicine promises to ameliorate. Yet, the concern for equality in health care is puzzling. After a modest level of access to health care there is little difference in average life expectancy. Are concerns for equality in health care even vaguely Christian? The pursuit of Christian perfection has never been correctly equated with state-imposed egalitarianism. Furthermore, an all-encompassing, secular, egalitarian health care system may provide equal access to significantly immoral medical treatments. In contrast to secular thought, the call of Christianity is a call to holiness, not a call to an egalitarianism that superficially resonates with certain elements of Christian thought."


"This paper examines the arguments presented by the Roman Catholic Bishops in their 1993 Pastoral Resolution, Comprehensive Health Care Reform: Protecting Human life, Promoting Human Dignity, Pursuing the Common Good, concerning health care reform. Focusing on the meaning of equality in health care and traditional Roman Catholic doctrine, it is argued that the Bishops fail to grasp the force of the differences among persons, the value of the market, and traditional scholastic arguments concerning obligatory and extraordinary health care. To attempt to equalize the distribution of health care would be ruinous. A more traditional understanding of Christian thought reveals an acceptance of inequality in health care distribution and a bias against using the secular state to coerce a solution to such concerns for social justice."


"Equality is a concept that is often used in health care discussions about the allocation of resources and the design of health care system. In secular discussions and debates the concept of equality is highly controverted and can take on many different specifications. One might think that Christians hold a common understanding of equality. A more careful study, though, makes it quite clear that equality is just as controversial among different Christian communities as it is in the secular world."

Ethics and Rationing


As rationing has become increasingly debated, age has been proposed as a criterion for withholding medical care. The author repeats arguments from Daniels, Veatch and Callahan about rationing by age and rebuts them by stating "no more than 1 or 2 percent of the national health care expenditures for the elderly is devoted to high-cost hospital admissions. For substantial savings, we must withhold routine medical care from the elderly." He proposes another rationing hypothesis- that "medical care that extends life devoid of human qualities should not be undertaken, but this principle should apply equally to patients of all ages, not only to the elderly." He concludes by saying "society must not insulate itself from the agony of each decision to forgo beneficial treatment as it is experienced by patients, families and caregivers."


Rationing is usually thought to demand a high ethical cost, but in this article, the author argues that the cost is not as high as commonly supposed. He explores four costs: "the sacrifice of physician loyalty, the substitution of misleading and discriminatory numerical measurements of medicine's human benefit for more sensitive qualitative judgements, the unfair bite that rationing is likely to take first out of poor people's care before it affects wealthier patients, and the general substitution of public, group standards about life and health for the values and decisions of individuals." He concludes, "Some dimensions of rationing will always remain morally suspect, but rationing's fundamental conflict with respect for the individual patient-subscriber is not as severe or intractable as most people assume."

"Much recent analysis of health care insurance reform emphasizes economic and policy issues. In contrast, this article examines health policy issues from the viewpoint of medical ethics. The critical ethical 'problem' in health care today is that ability to pay determines the availability and quality of care. This article discusses three types of proposed solutions: health care insurance reform, health care financing reform, and health care cost reform. It sketches an ethical framework for evaluating health policy and presents seven specific propositions that an ethical analysis of health care reform proposals raises. This article concludes that remedying the unethical treatment of certain classes of patients requires both health care financing reform and health care cost reform; health care insurance reform will not suffice."

Kilner, John F. "The Ethical Allocation of Health Resources: Contributions from the Christian Community." Discernment Spring 1993; 2 (1); 2+.  
Allocation of health resources is not just an economic problem, the author states. "Where matters like happiness, justice, freedom and life are concerned, religious communities and traditions are among the best sources of insight available. The Christian community serves the nation as well as God by voicing its views publicly." In this article, Kilner warns against relying too heavily on utilitarian "greatest good for the greatest number" mantra. Instead, he names allocation criteria that "are much closer to embodying biblical understandings of God's love than are more utilitarian criteria."

In this article, Kowal, a practicing family physician, and Hekman, a health care consultant, detail their positions on managed care. Kowal notes some of the problems with managed care contracts, such as the gag rule clause, that have prevented her from signing thus far. Hekman responds lightly to some of Kowal's concerns while writing from a big picture standpoint. He clearly lays out the need for managed care and the opportunity Christian physicians have to "participate in making the U.S. health care system better." Kowal, on the other hand, concludes "Jesus would not have me sign the contracts as they exist today."

"A Christian analysis of the moral conflicts that exist among physicians and health care institutions requires a detailed treatment of ethical issues in managed care. To be viable, managed care, as with any system of health care, must be economically sound and morally defensible. While managed care is per se a morally neutral concept, as it is currently practiced in the United States, it is morally dubious at best, and in many instances is antithetical to a Catholic Christian's ethics of health care. The moral status of any system of managed care ought to be judged with respect to its congruence with Gospel teachings about the care of the sick, Papal Encyclicals, and the documents of the Second Vatican Council. In this essay, I look at the important conceptual or definitional issues of managed care, assess these concerns over against the source and content of a Catholic ethic of health care, and outline the necessary moral requirements of any licit system of health care."

American society is afraid of rationing, yet is it something we already do? The authors describe four scenarios based on their own experience or those of others. "In each case, a physician decides in favor of a treatment choice that he or she believes to be both less effective and less expensive...to illustrate that compromises in clinical care are pervasive, varied and often disguised." After a discussion about each rationale portrayed in the scenarios, the authors conclude that debate should move "beyond the loaded question of whether rationing is acceptable to the more constructive question what kinds of compromise are justified. The goal, in the end, is to help physicians learn to practice medicine more effectively when compromise is inevitable."

Rationing, the author argues, is not in keeping with the historic and religious heritage of medicine. Rather, a decline in the moral imperatives of health care practice, that were developed starting with Hippocrates and then integrated into the Judeo-Christian tradition, has made rationing seem like the inevitable choice.
However, "there are indeed at least three kinds of policies that should be tried before anyone should even contemplate rationing health care as necessary: (1) Altering practices that drive up the cost of health care; (2) Promoting moral development and spiritual renewal; (3) Preserving and renewing the moral structure guiding health care." The author concludes, "Christians should affirm and live out the moral responsibilities that sustain the moral structure of health care. We should not allow ourselves to be trapped into the utilitarian reasoning that sanctions the rationing of health care for the sake of saving or making money, or for any other reason."


The author begins by describing a proposal that a hospital CEO made to his chief of orthopedic surgery regarding lowering the cost of hip-replacement surgery by substituting a less durable prosthesis for patients who they judged would not live 10 years or more. After discussing the various aspects of this case and the state of rationing by doctors, Levinsky concludes, "society has the right to ration care, provided that the limitation of appropriate, effective care is openly revealed...the key to the doctor's role as patient advocate is telling patients the truth. Without the uncompromising commitment of doctors to be honest with their patients about the reasons for offering or withholding specific medical care, patients may be deprived of the opportunity to seek other options."

Letters to the Editor regarding this article can be found in the 6 Aug 1998; 339 (6) issue of NEJM.


In this article, a widely respected ethicist tackles the subject of managed care and its moral implications. After stating the dual ideals of "economic feasibility and moral defensibility", Pellegrino goes on to outline the conflicting values of managed care and Christianity. He concludes "Christians and other people of good will concerned about a just ministry and distribution of health care services must turn away from managed care as it exists today."

Bedside Allocation


"In the preceding article, Mehlman and Massey examine possible legal responses to the issues that confront physicians faced with treating patients who have insufficient financial resources. This commentary explores the same issues from the perspective of ethics, including a comparison of the way law and ethics interpret the physicians-patient relationship, the ethical obligations of physicians that are inherent in that relationship, and the propriety of Mehlman and Massey's legal and ethical proposals to ameliorate physicians' conflicting obligations in providing or withholding care on grounds of conservation of society's resources."


"Under increasing pressure to contain medical costs, physicians find themselves wondering whether it is ever proper to ration health care at the bedside. Opinion about this is divided, but one thing is clear: Whether physicians should ration at the bedside or not, they ought to be able to recognize when they are doing so. This paper describes three conditions that must be met for a physician's action to qualify as bedside rationing. The physician must 1) withhold, withdraw, or fail to recommend a service that, in the physician's best clinical judgement, is in the patient's best medical interests; 2) act primarily to promote the financial interests of someone other than the patient (including an organization, society at large, and the physician himself or herself); and 3) have control over the use of the beneficial service. This paper presents a series of cases that illustrate and elaborate on the importance of these three conditions. Physicians can use these conditions to identify instances of bedside rationing; leaders of the medical profession, ethicists, and policymakers can use them as a starting point for discussions about when, if ever, physicians should ration at the bedside."

Annotated Bibliography

In this article, the author strives to "specify the kind of justification that would have to be provided for any coercive life-style reform measure."


In this article, the author discusses public health policy, autonomy and government.


"This article examines evolution of the British and American physician's role in filtering clinical need from patient 'demand' for health services, and in setting relative priorities among patient needs. It then raises questions about the significance of this change to the physician-patient relationship."


In this article, the author discusses "contributive justice...fairness to the large number of people whose financial contributions comprise the resource pool from which individual needs are then served."


This article details the financial aspects Canadian health care system and the problems that have come with decreasing federal funding.
Alternative/Complimentary Therapy

Alternative / complementary therapies have gained national prominence. We recognize the growing use of and request for these modalities by our patients. While some have been shown to be beneficial in certain clinical situations, we as Christian physicians and dentists have scientific, moral, and spiritual concerns about some of these therapies.

Some of these therapies raise concerns because they are not based on sound scientific principles and/or may not have been tested adequately for safety and efficacy.

Some of these therapies raise moral concerns because they may result in a harmful delay of diagnosis or treatment and may waste the limited resources available for medical care.* In the extreme, some therapies are outright fraud and quackery and are therefore morally reprehensible.

Some of these therapies raise spiritual concerns. Any therapy based on principles contrary to the teaching of Scripture is spiritually dangerous and should be condemned.

We recognize that general wide-sweeping statements regarding the appropriate use of alternative medicine are difficult. Each therapy should be investigated thoroughly with careful attention to the scientific evidence, moral implications, and spiritual beliefs underlying them. ** ***

* See statement on “Allocation of Medical Resources” in Ethic Statements from the Christian Medical & Dental Associations.

** See Basic Questions on Alternative Medicine: What is Good and What is Not?, GP Stewart, WR Cutrer, TJ Demy, et al, (Grand Rapids: Kregel Publications, 1998). This booklet was the primary resource for the substance of this statement.


Passed by the House of Delegates
Passed unanimously.
Anti-Progestational Agents (RU-486)

RU-486 and other anti-progestational agents were developed as abortifacients. Additionally, they may have other potential applications which remain to be demonstrated.

While abortion is currently legal, it remains an issue of intense moral and ethical debate. We believe it violates the biblical principle of the sanctity of human life. RU-486, when used as an abortifacient, is thus morally unacceptable. The result of both surgical abortion and RU-486 is the destruction of a defenseless life. The apparent ease and simplicity of pharmacological abortion further trivializes the value of life.

Some suggest that potential applications of RU-486 exist which justify further clinical investigation. Because its investigation for other uses will further threaten the unborn, we oppose such introduction of RU-486 and all similar abortifacients into the U.S. We do not oppose its development for non-abortifacient uses in jurisdictions where the rights of the unborn are protected.

If additional data suggest that there is a significant therapeutic benefit for these agents in life-threatening disease, we would support their compassionate use as restricted investigational agents. If they are demonstrated to have a unique therapeutic benefit for treatment of life-threatening disease, we would reconsider our position on their introduction into the U.S. We would, however, insist that there be strict control of distribution.

We believe that introduction of RU-486 into the U.S. at this time is not justified because our society has not yet exercised its moral capacity to protect the unborn.

Approved by the CMDA House of Delegates
Passed unanimously

Explanation:

The 1989 and 1990 publication in U.S. medical journals of results from large European studies of mifepristone as an early abortifacient fanned the cooling flames of the polarized public abortion debate. Political and legal efforts to prevent its introduction by those who opposed abortion were met with cries of 'foul' from abortion advocates. The ensuing 'discussion' further polarized the players and eliminated any opportunity for rational discussion.

Abortion advocates wanted it to be made available without U.S. studies normally required by the FDA. They promoted potential non-abortion uses as sufficient reason to overturn attempts at blocking its introduction. And in regard to its abortifacient use, they maintained that it would allow earlier abortions making it an ethically preferred method since; they felt the personhood of the early fetus was less contentious than it was in later pregnancy.

Anti-abortion groups feared that readily available early abortions would cause individuals faced with an unwanted pregnancy to have even less apprehension about a "termination of pregnancy".

35
The CMDS Ethics Commission in 1991, based on its earlier statement on abortion, took a strong stand in opposition to the introduction of anti-progestational agents at that time, but left the door open for further reflection should new data shift the balance of the discussion.
Artificially-Administered Nutrition and Hydration (ANH)

A frequent ethical dilemma in contemporary medical practice is whether or not to employ artificial means to provide nutrition or hydration in certain clinical situations. Legal precedents on this question do not always resolve the ethical dilemma or accord with Christian ethics. CMDA offers the following ethical guidelines to assist Christians in these difficult and often emotionally laden decisions. The following domains must be considered:

BIBLICAL

1. All human beings at every stage of life are made in God’s image, and their inherent dignity must be treated with respect (Genesis 1:25-26). This applies in three ways:
   a. All persons or their surrogates should be given the opportunity to make their own medical decisions in an informed manner as possible. Their unique values must be considered before the medical team gives their recommendations.
   b. The intentional taking of human life is wrong (Genesis 9:5-6; Exodus 20:13).
   c. Christians specifically (Matthew 25:35-40; James 2:15-17), and healthcare professionals in general, have a special obligation to protect the vulnerable.
2. Offering oral food and fluids for all people capable of being safely nourished or comforted by them, and assisting when necessary, is a moral requirement (Matthew 25:31-45).
3. All people are responsible to God for the care of their bodies, and healthcare professionals are responsible to God for the care of their patients. As Christians we understand that our bodies fundamentally belong to God; they are not our own (1 Corinthians 6:20).
4. We are to treat all people as we would want to be treated ourselves (Luke 6:31).
5. Technology should not be used only to prolong the dying process when death is imminent. There is “a time to die” (Ecclesiastes 3:2).
6. Death for a believer will lead to an eternal future in God’s presence, where ultimate healing and fulfillment await (2 Corinthians 5:8; John 3:16, 6:40, 11:25-26, and 17:3).
7. Medical decisions must be made prayerfully and carefully. When faced with serious illness, patients may seek consultation with spiritual leaders, recognizing that God is the ultimate healer and source of wisdom (Exodus 15:26; James 1:5, 5:14).
8. Illness often provides a context in which the following biblical principles are in tension:
   a. God sovereignly uses the difficult experiences of life to accomplish his inscrutable purposes (Job; 1 Peter 4:19; Romans 8:28; 2 Corinthians 12:9).
   b. God desires his people to enjoy his gifts and to experience health and rest (Psalm 127:2; Matthew 11:28-29; Hebrews 4:11).

MEDICAL

1. Loving patient care should aim to minimize discomfort at the end of life. Dying without ANH need not be painful and in some situations can promote comfort.
   a. Nutrition: In the active stages of dying, as the body systems begin to shut down, the alimentary tract deteriorates to where it cannot process food, and forced feeding can cause discomfort and bloating. As a person can typically live for weeks without food, absence of nutrition in the short term does not equate with causing death.
   b. Hydration: In the otherwise healthy patient with reversible dehydration, deprivation of fluids causes symptoms of discomfort that may include thirst, fatigue, headache, rapid heart rate, agitation, and confusion. By contrast, most natural deaths occur with some degree of dehydration, which serves a purpose in preventing the discomfort of fluid overload. As the heart becomes weaker, if not for progressive dehydration, fluid would back up in the lungs, causing respiratory distress, or elsewhere in the body, causing excessive swelling of the
tissues. In the dying patient, dehydration causes discomfort only if the lips and tongue are allowed to dry.

2. Complications of ANH.
   a. Tube feedings may increase the risk of pneumonia from aspiration of stomach contents.
   b. Tube feedings and medications administered through the tube may cause diarrhea, increasing the possibility of developing skin breakdown or bedsores, and infections, especially in an already debilitated patient.
   c. Patients with feeding tubes will, not infrequently, either willfully or in a state of confusion, pull at the feeding tube, causing damage to the skin at the insertion site or dislodging the tube. Prevention of harm may require otherwise unnecessary physical restraints or sedating medications.
   d. The surgical procedure of inserting a percutaneous gastrostomy (feeding) tube can occasionally lead to bowel perforation or other serious complications.
   e. Complications of TPN include those associated with the central venous catheter, such as blood vessel perforation or collapsed lung; local or blood stream infection; and complications associated with the feeding itself, such as fluid overload, electrolyte disturbances, labile blood glucose, liver dysfunction, or gall bladder disease.

3. Disease context
   a. Cancer: End stage cancer often increases the metabolic requirements of the body beyond the nutrition attainable by oral means. When the cancer has progressed to this stage, the patient may experience considerable pain, and ANH may only prolong dying.
   b. Severe neurologic impairment: This frequently has an indeterminate prognosis rendering decision-making problematic. It requires a careful evaluation of the probability of improvement, the burdens and benefits of medical intervention, and a judgment of how much the patient can endure while awaiting the hoped-for improvement.
   c. Dementia: If a patient survives to the late stages of dementia, the ability to swallow food and fluids by mouth may be impaired or lost. ANH has been shown in rigorous scientific studies to improve neither comfort nor the length of life and may, in fact, shorten it (see Appendix).

ETHICAL

1. There is no ethical distinction between withdrawing and withholding ANH. However, the psychological impact may be different if withdrawal or withholding is perceived to have been the cause of death.
2. If there is uncertainty about the wisdom of employing ANH, a time-limited trial may be considered.
3. Any medical intervention should be undertaken only after a careful assessment of the expected benefit vs. the potential burden.
4. The decision whether to implement or withdraw ANH is based on a consideration of medical circumstances, values, and expertise, and involves the patient or designated surrogate in partnership with the healthcare team.
5. It is best that all stakeholders strive for consensus.

SOCIAL

1. Eating is a social function. Even for compromised patients unable to feed themselves, being fed by others provides some of the best opportunities they have for meaningful human contact and pleasure.
2. People suffering from advanced dementia frequently remain sentient and social.

CMDA endorses ethical guidelines in four categories
1. **Strong indications**: Situations where the use of ANH is strongly indicated and it would be unethical for a medical team to decline to recommend it or deny its implementation. Examples of these situations would be:
   a. A patient with inability to take oral fluids and nutrition for anatomic or functional reasons with a high probability of reversing in a timely manner.
   b. A patient who is in a stable condition with a disease that is not deemed to be progressive or terminal and the patient or surrogate desires life prolongation (e.g., an individual born unable to swallow but who is otherwise viable, or the victim of trauma or cancer who has had curative surgery but cannot take oral feedings).
   c. A patient with a newly-diagnosed but not imminently fatal severe brain impairment in the absence of other life-threatening comorbidities.
   d. Gastrointestinal tract failure or the medical need for total bowel rest may justify the use of TPN in some contexts not otherwise terminal.
   e. An otherwise terminal patient who requests short term ANH, fully informed of the risk being taken, to allow him or her to experience an important life event.

2. **Allowable indications**: Situations where the use of ANH is morally neutral and the patient or surrogate should be encouraged to make the best decision possible after the medical team has provided as much education as necessary. Examples of these situations would be:
   a. A patient with severe, progressive neurologic impairment who otherwise desires that life be prolonged (e.g., end-stage amyotrophic lateral sclerosis).
   b. Conditions that would not be terminal if ANH were provided but, in the opinion of either the patient or surrogate, there is uncertainty whether the anticipated benefits versus burdens justify the intervention.

3. **Not recommended but allowable**: Situations where the use of ANH may not be recommended in all instances but, depending on the clinical context, would be morally licit, assuming the patient or surrogate has been informed of the benefits and potential complications and requests that it be initiated or continued. Examples of these situations would be:
   a. A patient who has a disease state, such as a major neurologic disability, where, after several months of support and observation, the prognosis for recovery of consciousness or communication remains poor or indeterminate. In cases where ANH is withdrawn or withheld, oral fluids should still be offered to the patient who expresses thirst.
   b. A patient whose surrogate requests overruling the patient’s advance directive and medical team’s recommendation against ANH because of the particular or changing clinical context.
   c. Placement of a PEG in a patient who is able but compromised in the ability to take oral feeding as a convenient substitute for the sometimes time-consuming process of oral feeding, for ease of medication administration, or to satisfy eligibility criteria for transfer from an acute care setting to an appropriate level of short-term nursing care, long-term care, or a rehabilitation facility. ANH decisions in such cases should consider the potential benefits versus risks and burdens of available feeding options, the capacity of caregivers to administer feedings, and prudent stewardship of medical and financial resources, always in regard to the best interest of the patient.

4. **Unallowable indications**: Situations where it is unethical to employ ANH. Examples of these situations would include:
   a. Using ANH in a patient against the patient’s or surrogate’s expressed wishes, either extemporaneously or as indicated in an advance directive and agreed to by the surrogate. There may be particular medical contexts in which a surrogate may overrule an advance directive that requests ANH on the basis of substituted judgment if the surrogate knows the patient would not want it in the present context.
   b. Compelling a medical professional to be involved in the insertion of a feeding tube or access for TPN in violation of his or her conscience. In this situation the requesting medical
professional must be willing to transfer the care of the patient to another who will provide the service. (See CMDA statement on Healthcare Right of Conscience)
c. Using ANH in a situation where it is biologically futile, as in a patient declared to be brain dead. An exception would be the brain dead pregnant patient in which the purpose of ANH is to preserve viable fetal life; ANH in this circumstance is not futile for the life in the womb.
d. Using ANH in an attempt to delay the death of an imminently dying patient (except in the context in 1.e. above).

CMDA recognizes that ANH is a controversial issue with indistinct moral boundaries. Disagreements should be handled in the spirit of Christian love, showing respect to all.

Unanimously approved by the House of Representatives
April 21, 2016
Ridgecrest, North Carolina

1 ANH may be given enterically through a nasogastric (NG) tube. Alternatively, a percutaneous gastrostomy tube (PEG) may be inserted endoscopically so that a feeding tube is passed through the abdominal wall. Total parenteral nutrition (TPN) is administered through a large bore catheter inserted into a central vein in the chest. Hydration (water plus electrolytes) may be given with nutrition in any of these ways or alone through a peripheral intravenous catheter or, less commonly, through a catheter inserted subcutaneously.
**Assisted Reproductive Technology**

As Christians, reflection on assisted reproductive technologies (ART) must begin with recognition that each individual, beginning at fertilization, is a unique creation with special worth to God.

Additionally, marriage and the family are the basic social units designed by God. Marriage is a man and a woman making an exclusive commitment for love, companionship, intimacy, spiritual union, and, in most cases, procreation. Children are a gift and responsibility from God to the family. Parents are entrusted with providing and modeling love, nurture, protection and spiritual training.

In addition to natural conception and birth, married couples may choose adoption or seek assisted reproductive technology, especially when they are unable to have children naturally. Adoption emulates God's adoption of us as spiritual children. Many assisted reproductive technologies may be an appropriate expression of mankind's God-given creativity and stewardship. A husband and wife who suffer from infertility should pray together for God's wisdom (James 1:5). They should be encouraged to seek godly counsel and guidance when considering these technologies.

However, while we are sensitive to the heartbreak of infertility, certain assisted reproductive technologies present direct and indirect dangers to sanctity of human life and the family. As technology permits further divergence from normal physiologic reproduction, it can lead to perplexing moral dilemmas. Not every technological procedure is morally justified and some technologies may be justified only in certain circumstances. The moral and medical complexities of assisted reproductive technologies require full disclosure both of the medical options available and their ethical implications.

These principles should guide the development and use of assisted reproductive technologies:
- Fertilization resulting from the union of a wife's egg and her husband's sperm is the biblical design.
- Individual human life begins at fertilization.
- God holds us morally responsible for our reproductive choices.
- ART should not result in embryo loss greater than natural occurrence. This can be achieved with current knowledge and technology.

**CMDA finds the following consistent with God's design for reproduction:**
- Medical and surgical intervention to assist reproduction (e.g., ovulation-inducing drugs or correcting anatomic abnormalities hindering fertility)
- Artificial insemination by husband (AIH)
- Adoption (including embryo adoption)
- In-vitro fertilization (IVF) with wife's egg and husband's sperm, with subsequent: a. Embryo Transfer to wife’s uterus b. Zygote intrafallopian transfer (ZIFT) to wife’s fallopian tube c. Gamete intrafallopian transfer (GIFT) to wife’s fallopian tube
- Cryopreservation of sperm or eggs

**CMDA considers that the following may be morally problematic:**
• Introduction of a third party, for example:
  o Artificial insemination by donor (AID)
  o The use of donor egg or donor sperm for:
    ▪ In-vitro fertilization
    ▪ Gamete Intrafallopian Transfer
    ▪ Zygote Intrafallopian Transfer
  o Gestational Surrogacy (third party carries child produced by wife’s egg and husband’s sperm)

• Cryopreservation of Embryos

CMDA opposes the following procedures as inconsistent with God's design for the family:
• Discarding or destroying embryos
• Uterine transfer of excessive numbers of embryos
• Selective abortion (i.e., embryo reduction)
• Destructive experimentation with embryos
• True surrogacy (third party provides the egg and gestation)
• Routine use of Pre-implantation Genetic Diagnosis
• Pre-implantation Genetic Diagnosis done with the intent of discarding or destroying embryos.

Conclusion

CMDA affirms the need for continued moral scrutiny of developing reproductive technology. We recognize that as physicians we must use our technological capacity within the limits of God's design.

Approved by the House of Representatives
Passed with 37 approvals, 2 opposed, 2 abstentions
April 29, 2010. Ridgecrest, North Carolina

1See CMDA Statement: The Non-Traditional Family and Use of Adoption of Reproductive Technologies
2Example of appropriate gestational surrogacy: The wife of a couple that has frozen embryos has a change in health status (e.g., loss of her uterus or a major medical problem) that prohibits her from providing gestation. Rather than have their embryos adopted (another acceptable alternative), the couple may choose a gestational surrogate to provide birth to their child.

3GUIDELINES FOR CRYOPRESERVATION OF EMBRYOS:

1. Cryopreservation of embryos should be done with the sole intent of future transfer to the genetic mother.
2. The number of embryos produced should be limited to eliminate cryopreservation of excessive numbers of embryos.
3. There should be agreement that all frozen embryos will be eventually transferred back to the genetic mother. Should it become impossible to transfer the frozen embryos to the genetic mother, embryo adoption or gestational surrogacy should be pursued.
Background Document for CMDA’s Statement on Artificial Reproductive Technology

Infertility has long been a source of anguish for some married couples (e.g., I Samuel 1). The Bible presents infertility as a condition in which God may choose to intervene (e.g. Hannah, Sarah, Rebecca, Manoah, Elizabeth). God has also granted mankind the ability to gain knowledge and develop technologies to treat our maladies, including infertility. Medical treatment for infertility first became available over 100 years ago with the introduction of artificial insemination, but these practices did not become widely available until the 1960's.

An increase in the incidence of infertility in the modern era has been associated with social factors such as voluntarily delayed child-bearing, the use of contraceptives, and multiple sexual partners with the consequent transmission of diseases which impair fertility. Current estimates are that one out of six couples experience infertility.

Before the 1970's adoption was the common solution for couples facing infertility - a solution encouraged and lauded by society. Some have argued that the decriminalization of abortion in 1973 made it more difficult for infertile couples to find adoptable babies, thus magnifying the anguish of this affliction.

A better understanding of reproductive physiology combined with advances in medical technology led to the development of several methods of assisted reproductive technology (ART). Most notable of these methods involved in vitro fertilization (IVF), the union of sperm and egg outside of the womb (in vitro = in glass). The birth of Louise Brown in England in 1978 (the first IVF baby) heralded a new era in the treatment of infertility. IVF quickly became a growth industry.

As oft occurs, science and medicine adopted new technology with little consideration for ethical/moral appropriateness. As history has demonstrated, just because technology is available does not mean that it is morally justified to use it.

Paradoxically, the advent of IVF has increased the anguish for some infertile couples. Because these technologies are now available (to those who can afford them), couples must make choices about whether to undergo such assistance, how many cycles to attempt, etc. Such additional choices can cause turmoil - socially, financially, relationally, and morally.

Moral/Ethical Questions

Assisted Reproductive Technology (ART) has raised many ethical questions: Is infertility a disease? Is there a ‘right’ to conceive, or to have a baby? What is a family? What is the moral status of gametes (unfertilized egg and sperm), of pre-implanted embryo, and of implanted embryo? The advance of technologies that made these become practical questions occurred at a time when many societies around the world were legalizing the termination of pregnancy as a choice.

In response, the Ethics Commission of the Christian Medical and Dental Society (now Christian Medical & Dental Associations – CMDA) addressed the issue in an Ethical Statement on IN VITRO FERTILIZATION in 1983. Considerable discussion subsequently took place prior to proposal and acceptance of the more nuanced and detailed statement on REPRODUCTIVE TECHNOLOGY adopted in 1990. There was agreement on the biblical principles articulated in the preamble of the 1990 statement, but there was not total agreement on the practical application of these principles, as reflected in the body of the statement. The conclusion encourages “continued moral scrutiny” of this still-developing field. The Ethical Statement has subsequently been refined, most recently in 2010. This document provides background for the Ethical Statement.

Biblical Principles

Reflection on ART possibilities by Christians should begin by recalling the sanctity of human life. Each individual is a unique creation with special worth to God. In addition, God is sovereign. He has ultimate control over who will conceive and bear a child. At the same time, we are stewards of our bodies and our resources. We will be held accountable for how we use the gifts He has given us. Children resulting from that union are a gift from God. Also, Scripture demonstrates God’s approval of adoption by the fact that believers are adopted into His family by their redemption in Christ Jesus (Romans 8:23).
Concerns

One moral concern of Christians regarding ART is the multitude of embryos which do not develop to maturity. While there is a natural attrition of embryos in both natural reproduction and in ART, the specific concern regards the decisions made in the ART process that result in intentional loss of embryos. Disturbing is the number of embryos (early human life) discarded in the process. Also disturbing are the embryos that remain frozen and not implanted as a result of ART. While some debate their moral status, there is nothing scientifically or biblically that denies that these embryos are unique human beings, simply at an early stage of development. Therefore, CMDA has taken the position that human life is to be honored and protected from its beginning at fertilization – whether that fertilization occurs within the mother’s body or in the laboratory.

As mentioned above, normal human reproduction results in the natural loss of a many embryos. After fertilization some embryos do not continue to develop. While the precise loss-rate is not known, it is estimated to be greater than 50%. Artificial reproductive technologies will also result in loss of many embryos. It is CMDA’s opinion that ART procedures should not be chosen that knowing result in a loss-rate of embryos greater than that estimated to occur naturally.

There are other ethical debates beyond the scope of this paper. One example regards the grading of IVF embryos as a determinate for implantation. While we may gain knowledge that guides us to know that certain embryos have no chance of further development (and therefore implantation would be futile), when there is doubt, deference should be given to providing an opportunity for continued development for each embryo.

Future technologies will raise new dilemmas, as well as provide some ethically acceptable solutions. But for Christians, decisions to accept or apply these technologies must first be determined by biblical instruction. While there will be grey areas requiring discernment guided by prayer and godly counsel, decisions that result in destruction of early human life are not morally acceptable.
Baby Doe

This resolution was adopted following the decision of the Indiana Supreme Court in the case of a Down's Syndrome neonate in Bloomington, Indiana:

RESOLVED that the Christian Medical Society strongly opposes the decision allowing for the death of "Baby Doe" and urges that this Court decision not be seen as either legal or moral precedent for the future. The right of privacy does not allow for parents to decide the death of such infants.

Approved by the House of Delegates
Passed with a vote of 41 for and 12 opposed
May 7, 1982. Dallas, Texas.

Explanation

Background

On April 9, 1982, an infant was born in Bloomington, IN with both Down syndrome and a tracheoesophageal fistula. Although closure of the fairly small fistula had a better than 90% chance of success, the parents chose to decline consent for the corrective surgery for "Baby Doe". This choice was made based on a gloomy prognosis for the Down syndrome presented to them by one of the physicians involved. Other physicians and hospital administrators went to court to challenge the parents' right to make such a decision. The judge upheld the parents right, and two appeals of the court decision failed. The infant died on April 15. In retrospect, most commentators believe this was a poor decision from a medical, legal, and ethical perspective.

Intense public discussion led quickly to federal government intervention to prevent such decisions in the future. The establishment of mandatory signs posted in hospital nurseries warning about discrimination against handicapped newborns, a hot-line to report suspected abuse to Washington, and responding investigative teams created an adversarial atmosphere. Procedural skirmishes and legal challenges to the federal regulations did little to ease the tension. Subsequent compromises between the government and professional bodies led to the current "Baby Doe" regulations which were implemented in 1984 as an amendment to the Child Abuse and Treatment Act. These regulations specify that treatment may not be withheld from children unless (a) they are chronically and irreversibly comatose, (b) treatment would merely prolong dying or otherwise be futile, or (c) treatment would be virtually futile in terms of survival and would be inhumane. Debate continues about the interpretation, applicability, and enforceability of the regulations.

CMDS Position

The CMDS responded quickly to the Bloomington, Indiana judicial decision with strong opposition. They have not visited the issue of handicapped newborns further.

Abstracts

"Baby Doe and the Concept of Grace" by Tom Elkins and Douglas Brown - Christian Medical Society Journal Vol XVIII, no 3; Summer 1987, pp 5-9

After a review of the controversy surrounding the "Baby Doe Regulations", the authors explore the possibility of growth through the various phases of the grief process which follows the birth of an infant with severe handicaps. They then discuss the universal handicaps of human limitations. Our response should be one of grace which leads to hope, and from hope to joy, and from joy to love of others as Christ loved us. However, the authors contend that we have trouble understanding the concept of grace. They encourage us to minister to "the least of these", all vulnerable and disenfranchised patients, including handicapped newborns.
"Life and Death and the Handicapped Newborn" by C. Everett Koop - Ethics & Medicine 1987;3(3):39-44
The Surgeon General tells of his experience as a pediatric surgeon in caring for children who were born with severe handicaps. He includes quotations from several after they had grown to adulthood about the joys of life, even with their residual disabilities. He criticizes the British "Lorber criteria" for treatment/non-treatment decisions in children born with spina bifida. After a detailed narration of the Bloomington, IN "Baby Doe" case, he tells of his own growing role in advocacy for handicapped newborns. He concludes by stating that "...all aspects of medical ethics are dwarfed by the question: 'How are we to care for those who cannot---in one way or every way---care for themselves?'"

Drawing on John Rawls, the author argues that decisions about the care of handicapped infants, at best, represent imperfect procedural justice, based on two claims. First, there is an independent standard of just/right outcome: the infant's best interests. He asserts that life is a primary good and a precondition for other goods and, therefore, there should be a rebuttable presumption in favor of treatment. This presumption may be rebutted if the infant will not survive, be unable to interact, or be overwhelmed by pain and suffering. Second, there is no procedure that can guarantee a just/right outcome. Childress argues that the best possible procedure involved a lexical ordering of proxy decision-makers: parents, physicians and other professionals, ethics committees, and the courts. Proxies should be disqualified if they act contrary to the child's best interests. He believes it may prudent to require ethics committees to review each non-treatment decision. He also argues for increasing societal financial support for the care of handicapped children.

Bibliography

The author sympathetically criticizes the decision of parents and physicians not to treat a newborn with Down syndrome and duodenal atresia by redescribing the dilemma they faced in a manner that places greater emphasis on moral obligations, relative independence from immediate desires, and on respect for human life.

McCormick RA. To save or let die: the dilemma of modern medicine. JAMA 1974;229(2):172-176
The author argues that the Judeo-Christian tradition's affirmation that life is a basic good to be preserved as the condition for human relationships suggests the following guidelines for the treatment of handicapped newborns: if an infant does not possess the potential for human relationships or if that potential "would be, because of the condition of the individual, totally subordinated to the mere effort for survival" the infant need not be treated.

After proposing in an earlier chapter his "medical indications policy" (in contrast to Robert Veatch's "reasonable man standard and Richard McCormick's personal intersubjectivity/ minimal personal relatedness standard), Ramsey argues that withholding medical care from handicapped newborns is a species of injustice. He concludes by considering whether there are exceptions to the duty to treat non-dying incompetent patients. He argues that we must always treat them, but there are exceptions once they are dying.

Meilander G. If this baby could choose... Linacre Quarterly 1982;49(2):313-321
The author argues for the superiority of a medical indications policy to a reasonable person standard or a substituted judgment standard for making decisions about the care of defective newborns, but he is concerned about the possibility of restricting medical indications to physiologic criteria.

After reviewing the context in which treatment decisions are made, the Commission advances an ethical framework for decision-making that focuses on an evaluation of the benefits and burdens from the infant's
own perspective and on internal hospital review of non-treatment decisions. This chapter is a rich bibliographic resource.

The authors argue that the justifications that the Reagan administration advances for the "Baby Doe Guidelines," the sanctity of human life and justice, are inconsistent and incoherent. They suggest that all human life is not of equal worth, a view that is more fully developed in their chapter "Should the Baby Live?: The Problem of Handicapped Infants" in Studies in Bioethics, (Peter Singer, ed.); Oxford University Press, 1985.

The inaugural issue of this journal has four sections which (1) explores the ethical and moral issues that surround the withholding of medically indicated treatment from handicapped infants and addresses the legitimacy of approaching these issues from a traditional civil rights analysis, (2) describes a f-year experiment at the University of Oklahoma involving non-treatment of some infants with spina bifida, (3) discusses the applicability of two federal statutes to the withholding of treatment from handicapped infants, and (4) gives an overview of the legislative action amending the Child Abuse Act.

The authors offer an interpretation of the Child Abuse Amendments of 1984 and a criticism of its enforcement mechanisms while describing the Amendment's development and interpretation.
The Beginning of Human Life

The Bible affirms that God is the Lord and giver of all life.\textsuperscript{1} Human beings are uniquely made in God’s image,\textsuperscript{2} and each individual human being is infinitely precious to God and made for an eternal destiny.\textsuperscript{3} The Christian attitude toward human life is thus one of reverence\textsuperscript{4} from the moment of fertilization to death.

\textbf{Definition of human life}

1. A living human being is a self-directed\textsuperscript{5}, integrated organism\textsuperscript{6} that possesses the genetic endowment of the species Homo sapiens\textsuperscript{7} who has the inherent active biological disposition (active capacity and potency)\textsuperscript{8} for ordered growth and development\textsuperscript{9} in a continuous and seamless maturation process, with the potential to express secondary characteristics such as rationality, self-awareness, communication, and relationship with God, other human beings, and the environment.

2. Thus, a human being, despite the expression of different and more mature secondary characteristics, has genetic and ontological identity and continuity throughout all stages of development from fertilization until death.

3. A human embryo is not a potential human being, but a human being with potential.

\textbf{Biological basis for the beginning of human life}

1. The life of a human being begins at the moment of fertilization (fusion of sperm and egg)\textsuperscript{10}. “Conception” is a term used for the beginning of biological human life and has been variously defined in the medical and scientific literature as the moment of fertilization (union or fusion of sperm and egg), syngamy (the last crossing-over of the maternal and paternal chromosomes at the end of fertilization), full embryonic gene expression between the fourth and eighth cellular division\textsuperscript{11}, implantation, or development of the primitive streak. Scientifically and biblically, conception is most appropriately defined as fertilization. The activation of an egg by the penetration of a sperm\textsuperscript{12} triggers the transition to active organismal existence.

2. It is artificial and arbitrary to use other proposed biological “markers” (such as implantation, development of a primitive streak, absence of potential for twinning, brain activity, heartbeat, quickening, viability, or birth and beyond) to define the beginning of human life.

\textbf{Biblical basis for the beginning of human life}

1. Procreation is acknowledged in the Bible to be the gift of God.\textsuperscript{13}

2. The mandate for human procreation in Genesis 1:27-28 and 9:1,7 implies that the God-ordained means of filling the earth with human beings made in His image is the proper reproductive expression of human sexuality in marriage. Human beings do not merely reproduce “after their kind”; they beget or procreate beings that, like themselves, are in the image of God. (see CMDA Statement on Reproductive Technology)

3. Human beings are created as ensouled bodies or embodied souls\textsuperscript{14} (Genesis 2:7). Together the physical and spiritual aspects of human beings bear the single image of God and constitute the single essential nature of human life.\textsuperscript{15} A biological view of human life beginning at fertilization is therefore consistent with the Biblical view of human life.
4. From fertilization on, God relates to the unborn in a personal manner. Between fertilization and birth, which are regularly linked in Biblical language, God continues His activity in the unfolding and continuous development of the fetus.

5. The Bible assumes a personal and moral continuity through fertilization, birth, and maturation.

6. The Bible, the Church in all its formative Creeds and Ecumenical Councils, and the witness of the Holy Spirit attest to the beginning of the incarnation, wherein the second person of the Trinity took upon himself human nature, being conceived (“conceived” is to be understood as “fertilization,” see The Beginning of Human Life, Addendum I: Conception and Fertilization: Defining Ethically Relevant Terms) by the power of the Holy Spirit in the womb of the Virgin Mary. The uniqueness of the event and its mode does not affect its relevance to the question of the beginning of human life. From conception the Son of God is incarnate, his human nature made like us in every way. It follows that authentic human existence begins at conception or fertilization.

The Moral Worth of Human Life

1. The moral worth of a human being is absolute and does not consist in possessing certain capacities or qualities—e.g., self-consciousness, self-awareness, autonomy, rationality, ability to feel pain or pleasure, level of development, relational ability—that confer a socially-defined status of “personhood” (a quality added to being). A human being consists in the entire natural history of the embodied self. A human being is a person.

2. The moral worth of a human being at all stages of development consists not merely in a) the possession of human chromosomes nor b) the fact that he or she may someday grow and develop into a more mature human individual. In fact, he or she already is the same individual being who may gradually develop into a more mature human individual.

Conclusions

1. Every individual from fertilization is known by God, is under His providential care, is morally accountable, and possesses the very image of God the creator.

2. Since human life begins at fertilization, the full moral worth afforded to every human being is equally afforded from fertilization onward throughout development. Vague notions of “personhood” or social utility have no place in decisions regarding the worth, dignity, or rights of any human being.

3. Because all human beings derive their inherent worth and the right to life from being made in the image of God, standing in relation to God as their personal Creator, a human being’s value and worth is constant, whether strong or weak, conscious or unconscious, healthy or handicapped, socially “useful” or “useless,” wanted or unwanted.

4. A human being’s life may not be sacrificed for the economic or political welfare or convenience of other individuals or society. Indeed, society itself is to be judged by its protection of and the solicitude it shows for the weakest of its members.
5. Human life, grounded in its divine origin and in the image of God, is the basis of all other human rights, natural and legal, and the foundation of civilized society.

Passed by the CMDA House of Representatives
June 16, 2006. Irvine, California.

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1 This is attested to by the whole of the Decalogue (not only the Sixth Commandment; Fifth Commandment in the Catholic and Lutheran traditions) and by the incarnation.
2 Early zygote dependence on maternal genetic material does not argue against this, since the role and integration of this information into the organism’s development are determined by the organism itself.
3 The term “organism” is a biological concept that refers to the functional unity of the organism, specifically the functions of integration, control, and behavior (and in this case, development) of the organism as a whole, whether single cellular, multi-cellular, multi-tissue, or multi-organ. Implicit in this concept is the primacy of the functional unity of the organism as a whole and not merely the sum of the function of its parts. This definition is also univocal and can be applied to all forms of living organisms.
4 Genetic identity with the species Homo sapiens alone is a necessary, but not sufficient, criteria for defining a human being.
5 Both human genetic identity and active potential and capacity (an inherent disposition for development) define a unique human being. While somatic cells have genetic identity to human beings (they have a latent potency and capacity such as exists in all raw materials), they do not possess an inherent active biological disposition (active potency and capacity) for further development into a unique human being. Somatic cell nuclear transfer (cloning) artificially confers such an active potency and capacity on a cell with genetic identity resulting in a unique human being.
6 Hydatiform moles (the result of abnormal fusions between egg and sperm) and teratomas (arising from the abnormal parthenogenic division of germ cells) lack ordered growth and development.
7 Some scientists and theologians note that it is only at the end of the process of fertilization (the joining of the male and female chromosomes at syngamy) that a substantive change has taken place resulting in a new, unique, living, individual human person. According to this view, the substantive change inherent in the human diploid single-cell zygote is not yet present at the moment of fertilization (union or fusion of sperm and egg) or during the pronuclear stage of fertilization. However, these cells do contain within themselves the organizing principle for the self-development and self-maintenance of the full human organism.
8 Some scientists and theologians note that it is only at the end of the process of fertilization (the joining of the male and female chromosomes at syngamy) that a substantive change has taken place resulting in a new, unique, living, individual human person. According to this view, the substantive change inherent in the human diploid single-cell zygote is not yet present at the moment of fertilization (union or fusion of sperm and egg) or during the pronuclear stage of fertilization. However, these cells do contain within themselves the organizing principle for the self-development and self-maintenance of the full human organism.
9 Up until this stage maternal mRNAs support all or most of the biosynthetic activities of the early embryo
10 Or the equivalent event in nuclear transfer/cloning
11 Up until this stage maternal mRNAs support all or most of the biosynthetic activities of the early embryo
12 Or the equivalent event in nuclear transfer/cloning
13 Gen 4:1; Psa 127:3
14 “nephesh”
15 Some Christians hold that Scripture describes human beings as composed of distinct parts, either body and soul (dichotomy), or body, soul, and spirit (trichotomy). CMDA is aware of this viewpoint but feels that the issue in clinical medicine should be approached viewing a human being as a functional unity. The body soul distinction could provide a rationale to those who would disrespect human life is the “higher” (implying soul) functions of “personhood” or “rationality” are not present.
16 Job 10:8-11; Jer 1:5; Psa 139:13-16 (“golem” meaning “embryo,” i.e., first few weeks of gestation)
17 Isa 7:14
18 Psa 51:5; Psa 119:13-16
19 Apostolic, Nicean-Constantinopolitan, and Athanasian
20 Nicea (325 AD), Constantinople (381 AD), Ephesus (431 AD), and Chalcedon (451 AD)
21 Luke 1:31; Matt 1:20 (where the term “genmao” stands unambiguously for conception)
22 Heb 2:17
23 Matt 25:40; James 1:27
The Beginning of Human Life, Addendum I:
Conception and Fertilization: Defining Ethically Relevant Terms

Summary

Scientifically CMDA understands that human life begins at fertilization (See CMDA Statement: The Beginning of Human Life). The Bible states that human life begins at the absolute “beginning or inception” using the term “conception.” Because the term “conception” has been variably (re)defined in the current scientific, medical, and bioethics literature, Christians may become confused over the Church’s creedal, doctrinal, biblical, liturgical, traditional, and cultural language of, “Life begins at/with conception.” CMDA affirms that it is appropriate to maintain the traditional biblical and creedal language of the Church without accommodation, remaining biologically precise and accurate, with the understanding that “conception” refers to the absolute “beginning or inception” of life, which is determined scientifically and upheld by CMDA to be fertilization.

Argument

Questions of morality and ethics are frequently questions of language and definition. The terms “conception” and “fertilization” are central and critical terms in any definition of the beginning of life. In traditional ways of speaking conception was assumed to be synonymous with fertilization and, as used in traditional orthodox Christian language, marked the very beginning of individual human life. This is no longer the case. Presently these terms are being used in different ways by different organizations for the purpose of promoting certain ethical agendas. In particular, the previously univocal term “conception” is now open to multiple definitions and interpretations. For instance, the American College of Obstetrics and Gynecology has now (re)defined conception as “implantation.” The scientific and medical literature no longer defines conception in a manner consistent with Biblical and traditional use of this term in reference to the beginning of human life. The current CMDA Position Statement on The Beginning of Human Life correctly and precisely defines the biological beginning of individual human life as fertilization. Recognizing that a multiplicity of competing definitions may generate some confusion, there nonetheless remain good reasons for the Christian community to retain the language, “Life begins at/with conception” (understanding that the use of the term “conception” means “beginning” which is at the point of “fertilization”).

Traditional Language of the Christian Church

The traditional language of Conservative and Evangelical Protestants, Orthodox, and Roman Catholic believers has always been, “Life begins at/with conception” (Cf. Evangelium Vitae). This has traditionally meant “beginning” and was assumed to be at the moment of fertilization.

Creedal Language of the Christian Church

The strongest argument in the CMDA Statement on The Beginning of Life, and for any Christian, is the incarnation (Isa 7:14; Mat 1:20; Luk 1:31). The foundational language for this doctrine is that of the historic ecumenical Christian creeds, primarily the received text of the Apostolic Creed in which the term “conceived by the Holy Spirit (Ghost)” is used throughout in all English translations to designate the inception, or beginning, of the incarnation of our Lord and Savior Jesus Christ. The use of the term “conceived” in these passages is not to be confused
with current scientific and medical definitions but is to be understood as referring to the absolute “beginning or inception” which is scientifically defined as fertilization.

**Biblical Language**

In all predominant English translations of the Bible (KJV, NKJV, RSV, NRSV, NAS, NIV, NAB) the terms “conception” and “conceived” are employed to translate Hebrew and Greek words that have the specific connotation of “beginning of life” or the “inception of life.” “Conception” or “conceived” are used to translate the Hebrew hrh (“harah”) and either the Greek gennaw (“gennao” in Mat 1:20, which can mean “conceive,” “beget,” “to father,” but unambiguously “to conceive” in this context;⁵ Cf. also John 8:41; 9:34 and the translation in BGD: “you were altogether conceived in sin”⁶) or sullamba,nw (“sylambano” Gen 4:1; 30:7 in LXX, and Luke 1:24, 31, 36; figuratively in Jas 1:15, which can mean “to seize,” as with child, or “conceive”⁷). Harah is used in Gen 4:1; 16:4,5; 19:36; 25:21; 30:7; 38:18, etc. (and see especially Isa 7:14; LXX: gastri. e[xei, “conceive” or “become pregnant” ) and its semantic domain is consistent with the traditional use of the term “conception” meaning “to beget,” “to become the parent of,” “to cause something to come into existence,” “to conceive.”⁸ It’s also important to appreciate this term’s use within the redemptive-historical language of YHWH’s “conception” of a people before “giving birth” to them in actual history (Cf. Num 11:12). In particular, Hos 9:11 implies that conception (!Ayr'h “herayon” a unique, single, one-time event, not a process or state of being; the inception of pregnancy; result of sexual intercourse, etc.) is to be distinguished from and precedes the state of being pregnant (!j,B,ÞmiW “yum-baten” “from,” “of,” or “on account of the womb”; “state of being pregnant”) or of giving birth (dl;y” “yalad” “bear, bring forth, beget”; “to birth”).

On the other hand, Psalm 5:7 uses the terms lyx (“chul” “writhe in pain” or “birth pains associated with labor and giving birth”) and ~xy (“yacham” “conceive,” used only in this instance in the Bible with respect to human conception or becoming pregnant by an act of sexual intercourse, otherwise used in respect to animals in heat). “Three words are used in relation to the birth process: harah “conceive,” yalad “bear, give birth” and chul “to labor in giving birth.” Another word for conceive is yacham, used more, however, of animals in heat (but cf. Ps 51:7). The first describes the inception and the latter two the termination of the process.”⁹ Recognizing that these Hebrew and Greek terms were not used in the context of a modern biological understanding of human reproduction, the term “conceive” (or “conception”) is consistently used to translate those Hebrew and Greek terms that have the specific connotation of “the very earliest beginning,” “inception,” or “the very bringing into existence.” Consequently, “conception” and its cognates, as they are understood in the context of these passages, refer to the biological point of fertilization.

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³It is sometimes alleged that the phraseology of Isa 7:14 is found in Ugaritic texts (UT 16: nos. 77, 11.5, 7), and that it is only a formula announcing the arrival of a royal heir to be born naturally. In the Ugaritic passage the verb hry “be pregnant” is not used at all, while the text does speak of a virgin (bllt) who will later bear a child naturally. Interestingly, the Ugaritic line in poetic parallelism uses the word for “virgin” cognate to the Hebrew hm‘ (q.v. of Isa 7:14. The case in Isa 7:14 is different. In this verse the prophet speaks of a pregnant virgin, using the participle (or adj.) of harah. The announcement is similar to Gen 16:11 addressed to Hagar who had conceived and was pregnant. As far as the grammar goes, this could refer to a pregnant virgin either contemporary
or in the future, but the reference to virginity shows that the pregnancy is miraculous. See HG Stigers, “hrh” in RL Harris GL Archer BK Waltke (Eds.) Theological Wordbook of the Old Testament (TWOT), Volume 1 (Chicago: Moody Press, 1980), p. 223.

4The “received” form of the Apostles’ Creed (ultimate text of the Western Creed from Priminius, A.D. 750, but dating back to Rome circa A.D. 340) reads in Latin as “qui conceptus est de Spiritu Sancto, natus ex Maria virgine” and in Greek as “to, n sulihfge, nta e, k pneu, matoj agi, ou, gennhqe, nta ek Mari, aj thj parqe, nou” (“who was conceived by the Holy Ghost/Spirit and born of the Virgin Mary”). These texts are taken from the Psalterium Graecum et Romanum, erroneously ascribed to Pope Gregory the Great, first published from a MS. preserved in the library of Corpus Christi College, Cambridge, by Archbishop Usher: De Romanae Ecclesiae Symbolo Apostolico vetere, London, 1647. An old Roman form given by Rufinus (Forma Vetus, A.D. 390) reads as, “qui natus est de Spiritu Sancto et Maria virgine” (“was born by the Holy Ghost of the Virgin Mary”) and an African form (Symbolum Augustini Hippo Regius, Africa Circ. A.D. 400) reads, “qui natus est per Spiritum Sanctum ex virgine Maria.” The earliest Greek form, probably used as a baptismal confession (St. Irenaeus, A.D. 200), reads, “to, n sarkwqe, nta thj hmete, ras swthriaj a, nqrwpoj e, ge, neto” (“was incarnate as our Savior, and became man”), while the text of Marcellus, Professio Fidei Marcelli Anycrani (A.D. 336-341), reads, “to, n gennhqe, nta e, k pneu, matoj agi, ou kai. Mari, aj thj parqe, nou” (“was born by the Holy Ghost of the Virgin Mary”). Sources found in: Philip Schaff (Ed.), The Creeds of Christendom, With a History and Critical Notes, Volume II: The Greek and Latin Creeds with Translations (Grand Rapids: Baker Book House, 1990 reprint of the 1931 edition).


6BGD, p. 155.


9HG Stiger in TWOT, p. 223.
**Biblical Model for Medical Ethics**

Christians believe in the divine inspiration, integrity, and final authority of the Bible as the Word of God. This is our starting point for Christian medical and dental ethics. In affirming the authority of Scripture, we follow the command and example of the Lord Jesus Christ, in whom all authority in heaven and earth is vested.

We believe that in His Word, God has graciously provided us with the principles necessary to make difficult ethical decisions. Ethical concepts which are not specifically taught in Scripture can be derived from principles which are found there.

In addition, our ethical perspectives are guided by the Holy Spirit and enriched by the teachings of Christian tradition, moral reasoning, and clinical experience. The circumstances of each case must be considered to discover the moral issues raised, but we do not accept such philosophies as ethical relativism, situational ethics, or utilitarianism.

Neither do we follow mindless legalism. Our Lord stated that the weightier matters of the law are justice, mercy, and faith in God.

Biblical ethics is concerned with motives as well as actions, with process as well as outcome. The integrity of moral decisions rests on the prudent use of biblical principles. We acknowledge, however, that sincere Christians may differ in their interpretation and application of these principles.

Patients or their advocates, families, and clinicians are morally responsible for their own actions. We, as physicians and dentists, are ultimately responsible to God as we care for the health of our fellow human beings.

*Approved by the House of Delegates*
*Passed with 63 approvals, 3 opposed, 1 abstention*

**Explanation**

The discipline of medical ethics is quite new considering the age of the profession. It was not much before the 1960's that theologians began to ask physicians the should we...? questions. In the ensuing years, several schools or methods of medical ethics have evolved, including Principilism, Casuistry, Virtue Ethics, Narrative Ethics, and others. Although theological voices were instrumental in the inception of the field, they have been largely supplanted by secular voices from the disciplines of philosophy, law, and medicine. Verhey and Lammers lament the loss of this theological perspective, and they invite us toward a future in which religious traditions and theological voices will be restored to a prominent role in medical ethics.

Although proposed and adopted before that invitation, it was in this spirit that the Ethics Commission wrote the statement on a Biblical Model for Medical Ethics. It posits that the Bible is the proper starting point for discussions of ethical issues in medicine and dentistry. In addition to the stated and derived principles which can be found in scripture, the statement encourages reliance on the Holy Spirit, with help from Christian tradition, moral reasoning, and clinical experience. The CMDS statement recognizes human fallibility and some areas of ethical uncertainty in our limited human perspective.

54
Abstracts

Christian Ethics from Universal Principles


The author draws a clear distinction between how the Christian and the non-Christian should determine what is right. He questions the approach presented in the October 1983 Bioethics Newsletter of the Christian Medical Society to search for universal principles. He uses the watershed of biblical inspiration and authority to give four reasons why Christians should not use a method which derives ethical principles from universal sources: (1) its unbiblical starting point, (2) its failure as an authority to be obeyed, (3) its failure to solve the problem of an objective and absolute standard, and (4) its definition of morality that differs from the biblical concept. He uses the issues of euthanasia, abortion, and truth telling as examples of situations where biblical teaching gives clear answers while universal principles do not.

He concludes Together with the evangelical Christian community in general, CMS is experiencing growth and expansion, for which we can praise God. If we are to have any full and lasting impact as Christians on our culture we must be able clearly to discern truth within the pluralism of that culture. Failure to discern may arise from a lack of biblical knowledge, biblical interpretation, or practical application. Christians in general, and we as Christian physicians, would do well to be consciously aware that there are only two human moral states, namely darkness and light. We may speak and act as though there were more, but the Bible recognizes and describes only two, as we have seen. We cannot take this conflict any less lightly than does God Himself. Thus, we have to answer this question: Is a search for universal principles of medical ethics consistently and fully in accord with God s word? I believe that universal principles fail to be biblical and also fail in practice. For evangelical Christians, and the statement of Belief of CMS makes us evangelical, anything that is not biblical is not Christian.

Such a conclusion is not to say universal principles of medical ethics are worthless. Every such principle must be measured against and derive its authority from Scripture. A universal principle, therefore, can be said to be universal only in so far as Scripture applies to all men everywhere. CMS desires to become increasingly biblical in every way, including in our ethics. We must be careful that--in Dr. Schaeffer s analogy--we do not flow in a direction that will take us far from biblical truth that is both clear and authoritative in its ethical principles.

A Reply [to Payne, above]
Lewis Penhall Bird. CMDS Journal Summer 1985; XVI(3):31

...While Holy Scripture provides final authority, it is not the only authoritative voice to heed. The author points out that Paul cited secular authorities in his argumentation at the Court of Areopagus. Both the residual remnants of Imago Dei along with the benefits of common grace provide numerous non-Christian minds with insight, perspective, and quotable quotes which we neglect to our peril. He goes on to point out the difference between universal principles, which are derived from God s general revelation, and absolute principles which proceed from His special revelation

Compassion and Cynicism in the Hospital

The author states that cynicism is the tendency to doubt the value of high ideals. He cites another author who posits that cynicism is a way to get needed distance from troubling situations in medical school and in the hospital. But Schiedermayer believes the problem is more basic, that health care professionals become cynical to deny wounds and withdraw from decay. He suggests that we confront the reality of wounds and decay and respond with compassion as Jesus did by binding wounds and preparing the dying for burial.

Honor Thy Patient

The author begins by telling how his grandfather s fatal diagnosis was withheld from him in the 1960’s. He gives a brief history of the legal doctrine of informed consent and describes its elements. He quotes from
Katz’s book, The Silent World of Doctor and Patient, as evidence that physicians resist the concept, and expands on why this is so. Using the biblical teaching of free will regarding our souls, he justifies the importance of informed consent regarding our bodies. He then describes Siegler’s concept of the doctor-patient accommodation as shared information and mutual consent and gives examples of how applying this concept allows us to respectfully treat patients as human beings.

**Biblical Revelation and Medical Decisions,**

In this discussion of the interface between medical decision-making and biblical revelation, the author first considers how God’s revelation in general is to be interpreted and then focuses his attention on how principles for decision-making in medicine are to be garnered from Scripture. He contends that ... divine commands have a crucial bearing on the whole duty of man and that they therefore must certainly be considered when addressing issues in medical decision-making. The author asserts that the Bible is the standard of God’s revelation against which all other directives believed to be from God must be checked. In addition, he maintains that the Bible in its totality must be considered when extrapolating guidelines for what constitutes a moral medicine. That is, prayers, historical narratives, and parables, etc., in addition to explicit commands, must be evaluated in determining the biblical dictates for medicine. The author concludes with a discussion of basic assumptions about the nature of medicine.

**Informed Consent & Prayer: Medical Ethics Need Not Be Separated From Faith**

The author begins by telling of two cases which are clinically similar, but where there is a difference between first-world ethics where the focus is on pre-operative informed consent and third-world faith where the focus is on pre-operative prayer. Both are important items of communication, but prayer differs from informed consent in its object and its expectations. In the informed consent process, the patient is putting herself in the hands of the doctor, while in the prayer process, she is putting herself in the hands of God. Both reassure the patient that she is being respected as a person because she is being involved. He concludes that Medical ethics need not be separated from faith, whether we live in the first or the third world.


Moral strangerhood is due in part to competing worldviews. The profession of nursing is experiencing a paradigm shift which creates ethical dilemmas for both Christian nurses and Christian patients. Nursing’s new focus on spirituality and spiritual care presents itself as broadly defining a desired state or patient outcome -- spiritual integrity -- supposed to be applicable to all patients of all faiths. Analysis of nursing’s definition of spirituality reveals assumptions and values consistent with an Easter/New Age worldview which may cause hostility towards Christian patients stereotyped as dogmatic or noncompliant.

**Bibliography**

**Articles**


In response to the ignoring of the Christian viewpoint by secular philosophers, the author describes Christian ethics in philosophical terminology as a deontological system which can stand against many of the arguments currently used to decry it in philosophical texts.

**Horner JS. Christian ethics - an irrelevance or the salvation of medicine? Journal of Medical Ethics 1994;20:133-4**

This guest editorial criticizes the major intrusion of utilitarian thinking into modern medicine. He concludes that the Christian church has adopted and treasured many of the essential Hippocratic standards, and they should not be vilified for doing so.

**Winslow GR. Christians and bioethics: Can the Bible help? Dialogue 1994;7(1):5-8**

The author presents a Christian framework for bioethical decisions.
Journals

Today's Christian Doctor (formerly Christian Medical and Dental Society Journal), David Biebel, editor. This journal of the CMDS is published six times a year. It frequently includes articles written by members and non-members which address issues of concern from a bioethics standpoint. While it is the official organ of the CMDS, all text represents the opinion of the author and does not necessarily reflect the official position of the CMDS.

Ethics and Medicine, C. Benjamin Mitchell, editor. Jointly sponsored by the Center for Bioethics and Human Dignity, Bannockburn IL (USA) and the Centre for Bioethics and Public Policy, London (UK). U.S. editorial address is Trinity Evangelical Divinity School, 2065 Half Day Road, Deerfield, IL 60015. Its editorial policy is that it seeks to develop a Christian mind on the complex and fundamental challenges posed to society by the break-up of the Hippocratic consensus and technological advances in medical science.

Journal of Biblical Ethics in Medicine, Hilton P. Terrell, editor. Published four times a year by Biblical Medical Ethics, Inc., P.O. Box 13231, Florence, SC 29501. It s stated purposes are: to recognize the authority of the inerrant, infallible Word of God over the practice of medicine; to uncover and advocate the Biblical principles upon which medicine must rest; to encourage physicians and patients to undertake the prevention and treatment of illness in accordance with Scripture; to challenge existing ideologies which teach the autonomy of man or the sufficiency of reason; to disestablish the mechanical view of man or any other view of man that fails to acknowledge accountability to God; and, to affirm God s provision of mercy through Biblical medicine as a secondary agency.

Christian Bioethics: Non-Ecumenical Studies in Medical Morality, H. Tristam Engelhardt, editor. This journal is published three times a year by Swets & Zeitlinger, P.O. Box 825, 2160SZ Lisse, The Netherlands. Aims and Scope: ...a non-ecumenical, interdenominational journal, exploring the content-full commitments of the Christian faiths with regard to the meaning of human life, sexuality, suffering, illness, and death within the context of medicine and health care. The Journal seeks to be fresh, novel, and controversial by taking the content of Christianity seriously, while critically assessing how different Christian faiths and different policies authentically realize that content with respect to bioethical issues. This non-ecumenical approach to Christian bioethics, guided by the usual secular scholarly standards, offers a forum for the extended and vigorous exploration of issues at the interface of theology, moral theory, and health care.

Books

Payne FE. Biblical Medical Ethics: The Christian and the Practice of Medicine. Milford, MI: Mott Media, 1985; 267 pages

One of the first published by a conservative Christian physician (and former member of the CMDS Ethics Commission), this book contains 13 chapters, including such topics as theism or naturalism, the credibility of science, empirical uncertainties, the theology of medicine, the role of the church in health care, as well as chapters devoted to such clinical topics as abortion, psychotherapy, euthanasia, and others. It includes a large number of references, both scriptural and others.


This anthology contains the work of over 50 authors from diverse theological (Christian and Jewish) traditions. Each of the 19 chapters has a short introduction by the editors, followed by several readings from different authors. It has become a classic reference work.


This shorter work (72 pages of text plus appendices and references) written by a theologian looks at three perspectives (normative, existential, and spiritual) of issues in and approaches to medical ethics.

This second book by Dr. Payne includes chapters on population control, birth control, artificial insemination, in vitro fertilization, genetic engineering, and the ethics of life and death.


This book by two physicians and a pastor (all past members of the CMDS Ethics Commission) includes an introduction, 8 chapters on specific clinical topics (reproductive technology, abortion, handicapped newborns, consent, AIDS, long-term care, artificially administered fluids and nutrition, euthanasia, terminal care), and a concluding chapter which encourages support from churches and pastors as Christians confront difficult medical decisions. It includes references for further reading and questions for group discussion at the end of each chapter.


This book by two Christian philosophers gives calm answers to tough questions on abortion (Part One - 125 pp) and euthanasia (Part Two - 75 pp) and includes 190 pages of appendices and references.


This book by a theologian (and Director of the Center for Bioethics and Human Dignity) proposes a God-centered, reality bounded, love-impelled ethic to approach these difficult issues. It is a scholarly work (over 600 references) which is divided into three parts titled Living Ethically, Ending Patients Lives, and Allocating Vital Resources.


Two evangelical theologians address several of the typical issues in medical ethics (abortion, euthanasia, birth control, genetic engineering) plus some issues of social ethics (homosexuality, sexual morality, divorce, war, capital punishment). It includes 60 pages of notes and references plus detailed topical and scriptural indices.


This encyclical letter on abortion, euthanasia, and the death penalty clearly articulates the consistent position of the Roman Catholic Church on these issues beginning with a statement on the incomparable worth of the human person.


Fourteen CMDS members have each done a video and contributed a chapter to this book which is divided into three sections (Ethical Issues at the Beginning of Life, Ethical Issues During Life, and Ethical Issues at the End of Life).


This multi-authored book contains 23 chapters in four sections on The Practice of Medicine, The Ethical Underpinnings of Medicine, the Evolving Abortion Crisis, and The Expanding Bioethics Agenda.


This scholarly work gives an in-depth review of contemporary secular approached to bioethics and compares and contrasts them to a biblical approach. Though academically sound, it is both readable and understandable by those interested in solidifying the Christian underpinnings of their thoughts on and approach to the important issues in bioethics today.
Christian Dentist's Oath

With gratitude to God, faith in Christ Jesus, and dependence on the Holy Spirit, I publicly profess my intent to practice dentistry according to the highest Biblical and professional standards for the glory of God.

With humility, I will seek to increase my skills, and I will respect those who teach me and who broaden my knowledge. In turn, I will freely impart my knowledge and wisdom to others.

With God's help, I will love those who come to me for healing and comfort. I will honor and care for each patient as a person made in the image of God, striving to put aside selfish interests.

With God's guidance, I will endeavor to be a good steward of my skills and of society's resources. I will convey God's love in my relationships with family, friends, and community. I will aspire to reflect God's loving kindness in caring for those in need.

With God's grace, I will live according to this profession.

Approved by the House of Delegates

Amended by the House of Delegates

Explanation

The modern dental profession has developed in the Hippocratic tradition. Dental professionals have a long history of interest in and concern for matters of ethics in the practice of dentistry (1), and they often look to the Hippocratic Oath as a standard for conduct. (2) The first American Dental Association Code was adopted in 1866. Major changes were made in 1922 and again in 1951 when it became the Principles of Ethics and Code of Professional Conduct. This 1951 document has undergone periodic revisions, the most recent being in 1992. (3)

The professions of medicine and dentistry have many common features in training and practice, and also share the fundamental precept of seeking the best interests of the patient. This commonality led to the inclusion of dental students and clinicians in the Christian Medical Society, and the subsequent name change to the Christian Medical and Dental Society. These shared professional features and, more importantly, the shared faith in Jesus Christ led the Ethics Commission to propose a Christian Dentist's Oath which closely parallels the Christian Physician's Oath. It was adopted by the CMDS House of Delegates in 1991.


Abstracts

Physicians and dentists share similar scientific backgrounds, pursue similar treatment goals, and confront similar moral dilemmas in the day-to-day care of patients. An ethic for practicing professionals must focus on the act of clinical decision-making with and in the interest of the patient. Clinical ethics offers a useful and practical way for medical and dental professionals to integrate clinical experience with teaching, research, and practice activities. Because of their technical knowledge and involvement with patients, physicians and dentists are in the best position to practice and teach clinical ethics.


The author, a philosopher who has worked extensively in dental ethics, begins with three assumptions: (a) to be a member of a profession means that one has undertaken certain obligations; (b) dentistry is a profession; (c) the content of a profession is the product of a dialogue between the profession and the larger community, and this dialogue is subtle, complex and ongoing.

He then presents seven categories of professional obligation for dentists: (1) the chief client is the patient; (2) the relationship between professional and patient—four models are offered and discussed, the Commercial Model, the Guild Model, the Agent Model, and the Interactive Model; (3) a hierarchy of central values—life and general health, oral health, autonomy, preferred pattern of practice on the part of the dentist, aesthetic considerations, considerations of cost and efficiency; (4) competence; (5) the priority of the client’s wellbeing, including sacrifices the dentist should be willing to make; (6) relations with co-professionals; and (7) relations between the profession and the larger community.

Bibliography

The April 1985 issue of the Journal of Dental Education (vol 49, no 4) was devoted to ethical issues in dentistry and includes 7 articles plus a large bibliography.

The Fall 1990 issue of the Journal of the American Dental Association (vol 57, no 3) includes 7 articles on ethical issues in contemporary dentistry.


This book on dental ethics has 24 contributors and is divided into three sections. The first establishes a ethical framework using principlism. The second addresses several specific clinical issues faced by practicing dentists. The third includes long case studies. The book concludes with appendices with the ADA Principles of Ethics and Code of Professional Conduct (1992 update) and an extensive bibliography with over 650 references.


This book is co-authored by a dentist and a philosopher. It also has three sections on "Ethical Questions: Theory and Principles", "General Principles in Dental Ethics", and "Case Studies of Special Problems".

Christian Physician’s Oath

With gratitude to God, faith in Christ Jesus, and dependence on the Holy Spirit, I publicly profess my intent to practice medicine for the glory of God.

With humility, I will seek to increase my skills. I will respect those who teach me and who broaden my knowledge. In turn, I will freely impart my knowledge and wisdom to others.

With God's help, I will love those who come to me for healing and comfort. I will honor and care for each patient as a person made in the image of God, putting aside selfish interests, remaining pure and chaste at all times.

With God's guidance, I will endeavor to be a good steward of my skills and of society's resources. I will convey God's love in my relationships with family, friends, and community. I will aspire to reflect God's mercy in caring for the lonely, the poor, the suffering, and the dying.

With God’s direction, I will respect the sanctity of human life. I will care for all my patients, rejecting those interventions that either intentionally destroy or actively end human life, including the unborn, the weak and vulnerable, and the terminally ill.

With God's grace, I will live according to this profession.

Updated by the House of Representatives
Passed unanimously

Approved by the House of Delegates
Passed with 63 approvals, 3 opposed, 1 abstention

Explanation

In antiquity, a man who wanted to learn the art of medicine was often required to swear an oath containing important principles and precepts before beginning his study, usually as an apprentice. The Oath of Hippocrates is one such ancient vow. It may have been composed by a group of Pythagorean physicians rather than by Hippocrates of Cos. While the history of the Hippocratic Oath is still the subject of scholarly debate, it is clear that the precepts of the Oath gradually became the guiding principles of the majority of educated physicians, and this ethos was accepted as the standard for centuries, because it is consistent with monotheistic religion and the dignity of people made in the image of God.

In this century, it became increasingly common for the faculties of medical schools to administer an oath to their graduates. While several modifications and adaptations of the classical Hippocratic Oath are still in use, very few graduating physicians swear the actual words or precepts of that ancient standard. Some maintain that the Hippocratic Oath is out of date and no longer applies. Much medical practice, in fact, ignores it. A limited number of physicians maintain that the ancient precepts are still valid, although some of the specific proscriptions or prescriptions may not make sense today. Because of these differing perceptions of the importance and/or validity of the classical Hippocratic Oath, many new oaths have been written and used in modern times. A recent analysis of oath usage and content showed an increasing rate of the use of oaths throughout this century, but a steady decrease in the content items which were present in the classical Hippocratic Oath.
Some Christians are uncomfortable swearing an oath by the ancient Greek gods. Others believe the precepts of the classical Hippocratic Oath are still valid and the swearing of this traditional vow is very important, so they are willing to swear this oath because of its clear declaration of the transcendent nature of the healing relationship, understanding that the object of their vow is the one true God.

The Ethics Commission of the Christian Medical and Dental Society proposed a Christian Physician's Oath in 1990, which was subsequently adopted by the house of Delegates in 1991. The goal was to retain the valid principles and precepts of medical tradition, and to re-frame them in a Christian context. It was the hope that this oath would be adopted and sworn by practicing physicians and would also be administered by CMDS chapters at medical schools to Christian students as they graduate.

Abstracts

"Restoring the Covenant" Tom Elkins and Douglas Brown. CMDS Journal Spring 1987; XVIII(2):16-20

The authors begin by quoting the Hippocratic Oath and they describe it as portraying a "covenant image of the medical professional" with commitment to integrity, mercy, justice, sensitivity and trust. They give examples of unequal treatment of pregnant patients based on their insurance or economic status and express concern about physicians who are motivated by self-interest. They also describe the self-interest of patients and lawyers and the consequent malpractice crisis. Using quotes from Paul Tournier and William May, they lament the fact that the growth of these self-interests has changed the altruistic covenant relationship into a legalistic contractual one which focuses on rights and obligations. They define covenant as "two parties bound to a common agreement" and they demonstrate the use of this concept in scripture as a way to provide security between those parties, even unequal parties.

They then apply this scriptural picture of covenant to the practice of medicine saying it includes "the trust and patience of friendship. Each party of the covenant shares respect and mutual need. Each party is committed for better or worse. Each party acts for the other's interests. Each party has latitude to express disappointment with their own or the other party's performance. Each party can be admonished and even constructively disciplined. Each party maintains a sense of gratitude, even in unfavorable or confusing circumstances." They close with a call to "help deepen the character of health care by nourishing the covenant roles of friend and servant."


The author refers back to Socrates and Hippocrates (and quotes a large portion of the Hippocratic Oath) as he maintains that truth is timeless. Science is important in our culture, but science depends on ethical integrity. The moral basis of medical science is the recognition of a "real right and a real wrong" which is wholly consistent with theism. Hippocrates recognized this as he dealt with questions of medical practice such as abortion. Such ethical realism leads to a humility and a reverence for life which ultimately leads to a reverence for persons. For these reasons, the spiritual life of the medical scientist is more important than his technical ability.


Background: Oaths have been administered to medical students for a long time, but the oaths used and the content of those oaths have changed with time.

Methods: We surveyed the deans of all 157 allopathic and osteopathic schools of medicine in the U.S. and Canada to assess current practices regarding oath administration, and compared this data to results from similar surveys done in 1928, 1958, 1978, and 1989. We did a content analysis of oaths currently used and compared the results with content items of the original Hippocratic Oath.

Results: There has been a progressive and marked increase in percentage of schools administering an oath over the past 65 years. The graduates of 98% of the 150 responding schools took an oath in 1993 while only 26% of schools administered an oath in 1928. We determined that only one school used the
text of the classical Hippocratic Oath, but 68 reported they used other “versions” of the traditional oath. When we examined the contents of all oaths in current use, we discovered that although 100% and 86% respectively still pledge a commitment to patients and to teaching, only 43% vow to be accountable for their actions, only 14% include a prohibition against euthanasia, only 11% invoke a deity, only 8% forewear abortion, and only 3% retain a proscription against sexual contact with patients.

Conclusions: There has been a steady increase in the use of professional oaths at the time of graduation from medical school during this century. At the same time, there has been a decrease in the number of content items found in the original Hippocratic Oath.

Bibliography


Of the several translations of the classical Hippocratic Oath available, Edelstein’s is considered by many to be the most scholarly and accurate. He was the most authoritative historian to posit that the Oath was not written by Hippocrates of Cos, but by a group of Pythagoreans, some of whom may have been physicians.


Kass, a conservative Jewish scholar, has written this thorough analysis of the Oath (as translated by Edelstein). He believes the Oath expresses the core values of medicine which have been accepted for centuries, and only recently questioned. He recognizes and reinforces the transcendent nature of the professional relationship. He divides the Oath for the sake of analysis into the following sections: the oath itself, conduct regarding teachers and students, treatment (ends and means; limits on ends and means), decorum, and closing prayer.

Bird LP, Barlow J, eds. Codes of Medical Ethics, Oaths & Prayers: An Anthology. Richardson, TX: the Christian Medical and Dental Society, 1989

This compilation by two CMDS staff members provides in one source the wording of and a brief historical note about 31 professional codes, oaths, and prayers used by various groups at various times over the centuries from antiquity to modern times.


From the preface: "...the very identity of medicine is under threat - it is, in fact, already in flux. A framework of values once universally accepted within the western medical tradition has begun to slide into disuse. The twilight of the Hippocratic tradition is seen as a small matter, as if the medical enterprise could very well survive with any set of values it chose... ...it is a fundamental misreading of the history and nature of medicine to regard it as capable of surviving the revolutionary value-changes which are now in progress. Only if medicine were narrowly conceived in terms of technique - a set of skills, a matter of expertise - could this be so. If, by contrast, medicine is actually constituted by its commitment to a set of values, then the dropping of those values marks the beginning of the end of medicine itself."


The author asserts that the dictates of the Hippocratic Oath often result in markedly different consequences for those who instruct future physicians and those who are their patients. He points out (as historian Ludwig Edelstein has) that the Oath "characterizes those duties which a physician undertakes toward patients as an ethical code and those assumed toward the professional guild (one’s teachers) as a covenant....Physicians undertake duties to their patients, but they owe something to their teachers. They have received goods and services for which they owe their filial services. Toward their patients, they function as benefactors, but toward their teachers, they relate as beneficiaries. [It is]...responsiveness to gift [that] characterizes a covenant." Contrary to this view, the author argues that all of a physician’s engagements within the context of medicine should be characterized by a covenental relationship.
Physician's do owe their patients, and they also stand as a primary benefactor of God's grace and mercy. It is the proper perception of this latter relationship—the covenant between God and all of humanity—which is integral to a philosophy of medicine consistent with Christian ministry.


Instead of focusing primarily on the content of the Hippocratic Oath, the author turns his attention to the fact that the Oath originated as a minority position intended to reform a medicine which prescribed poison to patients and approved of abortions. It is consideration of this fact which the author believes would be salutary to the contemporary practice of medicine. He incites Christian physicians to develop and defend a medical ethics which is based on their Christian convictions, instead of legal or philosophical tenets. He states, “...Christian medical ethics cannot proceed with integrity if it always restricts itself to articulating and defending standards of the practice or certain applications of impartial principles of philosophy or law to medical dilemmas. It is lamentable that so little of the work in medical ethics by Christian theologians candidly and explicitly attends to the Christian story and its bearing on medicine.”


This group of medical leaders has proposed a new oath based on a covenant of trust.
Christian Response to Adverse Outcomes Arising from Medical Error

CMDA recognizes that adverse outcomes arising from medical errors occur. Our response to adverse outcomes requires compassion, a prompt sympathetic response that expresses regret, our wish that it had not happened, and provision of appropriate medical care. With any adverse outcome, the patient should be assured of an expeditious and thorough evaluation and an honest explanation upon its completion. As Christian healthcare professionals we desire to respond to our mistakes in a manner that is just and that honors God. We may recognize error when a patient is injured by our care, although many injuries are not due to error and, thankfully, many errors do not lead to injury.¹

Upon discovering an error, we must distinguish our level of responsibility and culpability before God.² This necessitates time to prayerfully reflect while relying on the Spirit and the Word of God to both make us aware and convict us, if a sinful action³ or attitude⁴ led to the error, whether by omission or commission.

Errors typically fall within three categories.

1. Errors for which we are not directly responsible
   An example would be medical system errors. In that setting, we should work to prevent future occurrence.

2. Errors for which we are responsible but not morally culpable⁵
   If we conclude there was no moral failure, we need not be self-accusatory but respond in compassion. Errors with adverse outcomes for which we are responsible but not morally culpable engender an obligation to disclose the error to the injured party. We must recognize the complexity of disclosure.⁶ In addition, we must take necessary steps to prevent recurrence of the error.

3. Errors for which we are both responsible and morally culpable⁷
   If the error resulted from moral failure Scripture speaks of the following steps that should be prayerfully considered:

   a. Repentance:  We must recognize and acknowledge our sin, and with genuine contrition determine not to repeat the sin while taking specific steps to guard against it.⁸

   b. Confession:  Scripture requires that we confess our sins to God.⁹ It is wise for Christian physicians to have a small group of fellow believers to whom they are accountable.¹⁰

   c. Restitution:  There is biblical precedent for restitution.¹¹ Malpractice insurance may be one source of restitution. There may be times when compensation is appropriate, but our malpractice carrier does not agree, and we may need to personally offer some form of redress.

   d. Forgiveness:  God’s forgiveness is freely given to us through Christ when we repent and confess our sins to Him. Confession and/or restitution, when appropriate, provides an opportunity to seek forgiveness from the injured party. One goal we have
as Christians is to live peacefully with all, which may not be accomplished until there has been mutual forgiveness. Some patients may have difficulty ever forgiving; for others the timing may not be right. We must respect these feelings.

e. Thanksgiving: Dealing with sin and experiencing reconciliation based on forgiveness from God and others should lead to thanksgiving for the renewed relationship and should facilitate our worship.

Conclusion
We live in a world that is fundamentally flawed by sin. As Christian healthcare professionals we are called to do good. In spite of our best preparations, intentions, and efforts, medical errors and adverse outcomes occur. Whether or not we are morally culpable, we need God’s help to respond rightly to our errors.

2 Psalm 19:12 “Who can discern his errors? Declare me innocent from hidden faults.”
Psalm 139:23-24 “Search me, O God, and know my heart! Try me and know my thoughts! And see if there be any grievous way in me, and lead me in the way everlasting.”
3 Sinful actions may include such things as causing physical or emotional harm by malicious anger, gossip, lying, taking sexual liberty with a patient, or causing harm while under the influence of alcohol or another abused substance.
4 Mistakes that rise from sinful attitudes frequently require increased sensitivity to the convicting prompts of God’s Spirit. It may be that the mistake was made because we were too busy. Is that wrong? Perhaps so. As Christians, we must pray that God would show us the cause of our failure. Were we too busy because of pride or greed? Could selfishness, lust, sinful anger or innumerable other sinful attitudes have contributed to the mistake?
5 Medicine by its very nature will involve adverse outcomes. In spite of doing our best mistakes will be made, a lung cancer will be diagnosed as pneumonia, a common bile duct will be nicked during a cholecystectomy. These errors are unfortunate but would rarely be the result of sin in the life of the physician and therefore involve no moral culpability.
6 If we confess to the injured party we may ease our own conscience yet put others (including our malpractice carrier) in jeopardy who may not share our personal sense of guilt. Our legal system is helpful in determining social culpability and it may not be appropriate to confess to the injured party till this has been determined.
7 Moral culpability implies a sinful attitude or action leading up to the error.
8 Acts 3:19-20a “Repent then, and turn to God so that your sins may be wiped out that times of refreshing may come from the Lord.” Acts 26:20b “…that they should repent and turn to God performing deeds in keeping with repentance.”
9 1 John 1:9 “If we confess our sins, he is faithful and just to forgive us our sins and to cleanse us from all unrighteousness.”
10 James 5:16 “Therefore, confess your sins to one another and pray for one another.”
11 Exodus 21:18-19 If men quarrel and one hits the other with a stone or with his fist and he does not die but is confined to bed, [19] the one who struck the blow will not be held responsible if the other gets up and walks around outside with his staff; however, he must pay the injured man for the loss of his time and see that he is completely healed.
12 Romans 12:18 “If possible, so far as it depends on you, live peaceably with all.”
13 Matthew 5:23-24 “So if you are offering your gift at the altar and there remember that your brother has something against you, leave your gift there before the altar and go. First be reconciled to your brother, and then come and offer your gift.”

Approved by the House of Representatives
Passed unanimously
April 28, 2011. Mount Hermon, California

66
Conflicts of Interest
As Christian physicians and dentists, we seek to glorify God in our profession by serving our patients. The practice of medicine and dentistry necessarily poses situations in which clinicians' personal interests, financial and otherwise, may conflict with those of their patients. The existence of these conflicts of interest is not inherently wrong.

We believe that when interests conflict, clinicians should resolve the conflicts by voluntarily subordinating their personal interests to the best interests of their patients. On occasion, a clinician may need to arrange alternative means of providing patient care in order to respond to family or personal needs.

We recognize that some clinicians, Christians and non-Christians alike, may at times fail to make the virtuous choice of placing their patient's' interests before their own. We therefore support professional efforts to prohibit health care practitioners from engaging in activities which place their personal interests above those of their patient's, when such activities can be clearly defined.

Approved by House of Delegates
Passed with more than a two-thirds majority

Explanation

A conflict of interest exists in medicine or dentistry when the clinical judgment of the physician or dentist concerning a primary interest may be unduly influenced by a secondary interest. Legitimate primary interests include the health and best interests of our patients, the education of students, and the integrity of research. We most often think of money as the secondary interest which may cloud our thinking, but other secondary interests include fame, fun, free time, even family priorities.

Financial conflicts of interest are inherent in clinical practice; they cannot be eliminated. In fee for service practice, the incentive is to increase utilization. In prepaid practice, the incentive is most often to decrease utilization. There are potential conflicts of interest with hospitals, laboratories, industry, publishers. Numerous empiric studies have confirmed that financial incentives (both positive and negative) do influence clinical decisions.

Financial conflicts of interest must first be recognized, and they must be managed. Ideally, they should be managed by the individual practitioner using personal integrity. He or she should commit to making clinical decisions based on what is best for the patient, not influenced by his or her own income. We must recall Jesus teaching to His disciples that No one can serve two masters...You cannot serve both God and Money. (Matt. 6:24 NIV) In addition to personal integrity, checks can be built into the system by professional guidelines or governmental regulations. Some financial conflicts of interest can be handled adequately by full disclosure (e.g. minor lab testing in the office), others should probably be prohibited (e.g. fee splitting; ownership of imaging centers to which the clinician refers patients).

There are inherent conflicts of interest in some types of medical and dental practice, e.g. industrial medicine, prison medicine, military medicine, sports medicine, legal medicine, and others. It is necessary for practitioners in these and all fields of practice to clearly focus on who they are working for (i.e. the patient), and what is their primary goal (i.e. the patient's best interests).

Conflicts of interest in medical and dental research are another matter. The individual doing research must wear two hats: that of the clinician who is committed to doing what is best for the patient, and that of the investigator who is seeking an answer to a scientific question by using a human subject. The
clinician/patient relationship and the investigator/subject relationship have different goals which must be clearly identified. Institutional Review Boards have been mandated by the federal government to oversee all research involving human subjects in order to assure informed consent and protection from undue risk.

It is possible to carry to extremes the concept of focusing on patient needs such that the clinician ignores personal needs and family obligations. This statement is not meant to encourage workaholism. The clinician must control his or her practice and arrange for protected time for rest, exercise, worship, and family activities.

Abstracts

Greene RF. Kingdom quality stuff. CMDS Journal Summer 1990; XXI (2):12-14 with a response by Mellerstig KE.

Starting with a portion of Bunyan's Pilgrim's Progress, the surgeon/author examines his own priorities and challenges us not to look one way and row another by which he means the natural tendency of Christians to be concerned about advancing God s Kingdom while at the same time spending our time, money, and effort at securing our own lives and estates.

In response, another surgeon contrasts praise for the gift of a second-hand sofa to guilt over the cost of a Christian conference at a Kingdom Quality resort.

Schiedermayer DL. The free lunch syndrome: Physicians and the pharmaceutical industry. CMDS Journal Summer 1993; XXIV(2):30-33

The physician/ethicist author defines this syndrome as mild to moderate greed, mild and early compromise of ethical standards, all found in the clinical setting of pharmaceutical promotional activities and he observes that it seems to afflict many otherwise ethical physicians. After relating the gift-giving practices of pharmaceutical representatives, he examines pertinent biblical and ethical principles. A side-bar offers specific guidelines and examples of those promotional activities which are clearly acceptable, probably acceptable, probably not acceptable, and clearly unacceptable.

Rodwin MA. Medicine, Money and Morals. New York: Oxford University Press, 1993; 411 pp

This book, by an attorney who specializes in health policy, offers an in-depth look at the problems of financial conflicts of interest in the practice of medicine and the profession s response over the last 100 years. He explains why the profession has failed to cope successfully with them, and shows how the problems have become worse over time. He shows what can be learned from the way society has coped with conflicts of interest involving other professions (lawyers, government officials, and financial professionals), all of whom are held to higher standards of accountability than medical professionals. He looks carefully at the current problems of financial incentives and offers some suggested remedies.

Bloche MG. Clinical loyalties and the social purposes of medicine. JAMA 1999;281(3):268-74

Physicians increasingly face conflicts between the ethic of undivided loyalty to patients and pressure to use clinical methods and judgment for social purposes and on behalf of third parties. The principle legal and ethical paradigms by which these conflicts are managed are inadequate, because they either deny or unsuccessfully finesse the reality of contradiction between fidelity to patients and society's other expectations of medicine. This reality needs to be more squarely acknowledged. The challenge for ethics and law is not to resolve this tension -- an impossible task -- but to mediate it in myriad clinical circumstances in a way that preserves the primacy of keeping faith with patients while conceding the legitimacy of society's other expectations of medicine.

Bibliography


This now-classic article by the then-editor of the NEJM was the first to identify the danger of the overuse of technology encouraged by the rise of the for-profit medical industry.

In this editorial, Relman warns of the dangers of joint ventures and other forms of entrepreneurialism. He criticizes the AMA's limited response as inadequate because it does not address the matter of damage to public trust by even the appearance of conflicts of interest.


This opinion piece examines disclosure policies in medical informed consent, consumer protection laws, disclosure by lawyers to clients, and disclosure by government officials, and compares the new emphasis on disclosure as the prominent way to deal with financial conflicts of interest in the practice of medicine. The attorney/author concludes that disclosure is helpful, but insufficient to adequately protect patients.

Three articles on the issue of conflicts of interest resulting from physician self-referral, i.e. physician ownership of ancillary facilities to which he or she might refer patients for income producing procedures: JAMA 1989; 262(3):390-397

- Morreim EH. Conflicts of interest: profits and problems in physician referrals. 390-394
- Todd JS, Horan JK. Physician referral - the AMA view. 395-396
- Rep FH Stark. Physicians' conflicts in patient referrals. 397

Three articles which look at specific conflicts of interest:

- Rennie D, Flanagin A, Glass RM. Conflicts of interest in the publication of science. JAMA 1991; 266(2):266-267

Five articles which document with empiric data that physicians clinical judgment may be influenced by financial incentives:


The author maintains that conflicts of interest in medicine are more complex than is often appreciated. He then offers the clearest description of conflicts of interest available in recent medical literature. He goes on to posit that a better understanding of the nature of conflicts of interest and a clearer formulation of standards could increase confidence in the medical profession.

**Council on Ethical and Judicial Affairs, AMA. Sale of non-health-related goods from physicians' offices. JAMA 1998;280(6):563**
This is new addition to the AMA's position statements on potential conflicts of interest and concludes "With one very narrowly delineated exception, the sale of non-health-related goods from physicians’ offices is an activity that should be avoided."

**Lyckholm LJ. Should physician accept gifts from patients? JAMA 1998;280(22):1944-6**

The author encourages physicians to be sensitive to the patient's motivation in offering a gift. In addition he or she must not let the acceptance of a gift interfere with patient care. She offers some guidelines on this issue.
Death

Background

The Bible speaks of both physical and spiritual death. Physical death is the irreversible cessation of bodily functions. Spiritual death is a lack of responsiveness to God as a result of mankind’s natural alienation from and hostility to God due to sin. Both physical death and spiritual death are the consequences of and penalty for sin. They are the universal lot of all mankind because all have sinned.

Because of Christ Jesus’ atoning sacrificial death on the cross and subsequent resurrection, and through the indwelling of the Holy Spirit, believers have been given new spiritual life. All believers still experience physical death.  

Definition

God created human beings as ensouled bodies (or embodied souls). Together the physical and spiritual aspects of human beings bear the single image of God and constitute the single essential nature of human life. Human physical death can be defined as fundamentally a biological phenomenon whereby the human organism as a whole ceases to function.

The Bible clearly demarcates physical life and death; death is not a process, nor is there a transitional physical state between life and death. Death can therefore be defined as the point in time when the critical functions of the organism as a whole permanently and irreversibly cease. These critical functions include all of the following: 1) The vital functions of spontaneous breathing and autonomic control of the circulation; 2) the integrating functions that assure homeostasis of the organism; 3) the neurological function of consciousness. Death should not be defined in terms of a "loss of personhood" or by appeal to the loss of "higher functions" of the organism, such as loss of self-awareness, rationality, self-control, or social interaction.

Criterion

Based on the above definition of death, the necessary and sufficient criterion of death is the irreversible cessation of all clinical functions of the entire brain (whole-brain concept). Although both a higher brain (cortical) and brain stem criteria are necessary for death, neither alone is sufficient for death.

Patients in permanent vegetative state or irreversible coma, and anencephalic infants do not meet the necessary criterion for this definition of death and are therefore to be considered and treated as living human beings.

Testing

Tests of the above criterion will be dependent on the current state of medical knowledge and technology. These tests should be valid and reliable, accurately determining death by neurologic criteria, and should have an extremely low incidence of false-positive results (high specificity). Tests should be readily applicable at the bedside, focusing on neurological examination: apnea, profound coma and unresponsiveness, and the absence of brain stem function in the absence of reversible causes or pathology. In some situations, additional tests may be indicated.
The traditional bedside tests of death, which include examination for the presence or absence of breathing, responsiveness and pupillary reaction to light, are all measurements of brain function. Heartbeat is an indirect measurement since heartbeat stops shortly after the cessation of breathing. The whole-brain definition and criterion of death is consistent with both the traditional concept of death and the Biblical definition of physical death.

**Respect**

The bodies of the dead return to the "dust of the ground" and yet are destined to be resurrected. Because the bodies of all men and women have once displayed the image of God, however marred by sin, they deserve to be treated with loving care, dignity, decorum and respect. Post-mortem procedures such as dissection (except in the case of legally sanctioned autopsies), organ retrieval, and medical procedures should not be done without respecting the wishes and views of the patient (as in an advance directive), family or guardians.

*Approved by the House of Representatives
Passed with 2 abstentions

**References**

1. The term "organism as a whole" is a biological concept that refers not to the whole organism (i.e., the sum of its parts), but to that set of vital functions of integration, control, and behavior that are greater than the sum of the parts of the organism. Implicit in this concept is the primacy of the functional unity of the organism.

2. The Bible also speaks of other types of death. One is the "second death," which is the permanent separation from God that is the destiny of the unredeemed. The other is "death to sin," which is the suspension of all relations with sin that results from being alive to God through dying and rising with Christ.

3. Scripture refers to body and soul or body, soul, and spirit. CMDA is aware of this viewpoint but feels that the issue in clinical medicine should be approached viewing a human being as a functional unity. The body soul distinction could provide a rationale to those who would disrespect human life if the "higher" (implying soul) brain functions are not present.

*See statement on Vegetative State.*
**Disabled Persons**

We hold all human life to be sacred as created in God's image. This includes persons who might be regarded as disabled or handicapped. The importance of a person does not reside in the functioning of the body or mind or in the person's ability to contribute to society, but rather in his or her intrinsic value as God's creation.

We believe the Bible teaches our mutual interdependence. All people, including disabled persons, are responsible to realize their potential insofar as possible. The family holds the primary responsibility for the additional support needed by the disabled person. The family's resources should be supplemented by those of the church and community.

The role of the physician and dentist is to provide appropriate medical care as needed. In all cases, our response should be characterized by an attitude of compassion, free of condescension and marked by action. In the case of extreme disabilities, legitimate questions may be raised regarding the appropriateness of various levels of treatment.

Having accepted our own spiritual disability and God's forgiveness, we desire to honor, assist, and bring healing to the physically, mentally, and spiritually disabled in our community.

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**Approved by the House of Delegates**

Passed with 52 approvals, 7 opposed, 1 abstention


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**Explanation**

One of the tragic results of the secularization of medical ethics is the prominence given to individual human interests in current discussions of ethical issues. Gone from much of the debate is the supremacy and sovereignty of God and the concept of the inherent worth of the individual. This human-centered, secular view is clearly portrayed in Romans 1:18-32 where Paul reports that God's wrath has been kindled against mankind because they "exchanged the truth of God for a lie, and worshiped and served created things rather than the Creator" (v 25). This perspective easily leads to the assessment that there are some handicapped individuals on whom we should not expend medical resources.

Christians retain the theocentric view that human individuals are created by God, in His image, and thus have a special value which is greater than that of other created beings and "a little lower than the angels". God reminded Moses that He is the creator of all, even those who are deaf or blind (Exodus 4:11). The God-centered, sanctity of life perspective means that human dignity and worth are ascribed by God, and need not be earned by human ability. Thus individuals are not to be judged by their productivity.

CMDS developed their statement on Disabled Persons to affirm the inherent worth of each individual, and to counter the idea of expendable persons. They also tried to emphasize the responsibility which each Christian has, whether as a healthcare professional, a church member, or a family member, to assist persons with diminished physical or cognitive abilities to reach their maximum potential. It is not sufficient to accept persons with disabilities as valuable humans, and then to merely place them in custodial facilities to be fed and kept warm.

**The Quality of Life**

Some who subscribe to this sanctity of life ethic, however, interpret this precept to mean that all human life must be preserved as long as is physiologically possible. They contrast sanctity of life (Christian) and quality of life (secular) perspectives and believe them to be mutually exclusive. This theological vitalism seems to ignore the fact that human life in this fallen world is finite; all will die. In addition, each individual has a quality to his or her life. That quality assessment is very subjective. Many persons tolerate
seemingly intolerable situations without complaint; others complain loudly because of much less severe, or even temporary, disabilities.

Quality of life cannot be ignored, it is a fact of life. This comes into play when professionals are caring for individuals with severe irreversible disabilities. When life-threatening crises intervene, decisions about the appropriate goals and level of treatment are often difficult. There may be legitimate differences of opinion, even among those who solidly believe that human life is sacred, about the proper treatment plan. Hopefully, these differences can be resolved by looking to Scripture, spiritual leaders, and the Holy Spirit for guidance.

Abstracts

Hadorn DC. The problem of discrimination in health care priority setting. JAMA 1992; 268(11):1454-1459

Increasingly stringent fiscal restrictions on the scope of medical services available to patients have resulted in calls for explicit health care priority setting. Several commentators have called for the application of decision-analytic principles to such efforts, which would assign services priority based on the extent to which they produce preferred health outcomes. The Oregon Medicaid exercise is an example of such a process. An important challenge to these utilitarian efforts is the need to avoid discrimination against people with medical disabilities. Both of the key elements entailed by decision-analytic approaches to priority setting—estimation of outcomes and assignment of values to those outcomes—are vulnerable to charges of discrimination, primarily because both the medical outcomes expected in disabled individuals and the values they place on those outcomes may differ from the general public. Priority-setting efforts must proceed carefully to avoid the appearance (and reality) of discrimination.


An Australian disabilities rights group responds to the National Health and Medical Research Council's: Discussion Paper on the Ethics of Limiting Life-Sustaining Treatment. In their conclusion they state "Contrary to the NH&MRC paper, severe disability does not necessarily mean a tragic existence. Rather, it is inadequate and inappropriate support services which handicap people with disabilities and serve to create a low quality of life. With appropriate support, people with disabilities can go on to lead happy and productive lives pursuing their choice of life-style. This is in marked contrast to a stereotype of an institutionalized person with a disability who lacks dignity and exists on welfare." They go on to call for the withdrawal of the position paper and conclude with the statement "We affirm the inherent worthiness of the lives of all people regardless of their ability and/or disability."

Miller PS. The impact of assisted suicide on persons with disabilities---is it a right without freedom? Issues in Law & Medicine 1993;9(1):47-62

The discussion over the right to die has been co-opted by individuals and groups who do not understand, nor even care to identify, the perspective of persons with disabilities, their unique concerns, history, or context. With over forty-three million persons with disabilities in the United States, they are the largest minority group encountering prejudice and discrimination. Yet, third parties counsel persons with disabilities on their right to die without any sensitivity to their unique characteristics as a minority group. Without being offered a choice of independent living alternatives and counseling, with special emphasis on psychological issues facing persons with disabilities, the right to assisted suicide is no right at all; it is the inevitable manifestation of society's prejudice.

Hauerwas S. Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church. Notre Dame, IN: University of Notre Dame Press, 1986

The author, a professor of Christian ethics, says he is not even sure if [he] believe[s] in medical ethics as a specifiable discipline or area. He does, however, believe that medicine and religion are unavoidably interrelated, and that the Christian community should be present to the ill even as they suffer. In this book, he uses the Christian teaching about the care of the weak to formulate theological reflections on living, dying, and experimentation in Part Two. In Part Three, he addresses caring for the mentally handicapped. While challenging the dominant paradigms of contemporary ethics, he articulates a well-
formed theological perspective which illustrates for believers how philosophical and theological ethics can be linked.

Bibliography


The authors, a psychiatrist and a journalist, describe the range of feelings, attitudes, and options open to the families of mentally retarded persons. Often there are troubling and tragic choices to be made. But even more often there is hope—the very real expectation that mentally retarded persons can lead happy and even valuable lives. Issues in Law and Medicine

This quarterly peer-reviewed journal began in 1985 as a cooperative effort of the National Legal Center for the Medically Dependent & Disabled, Inc, the Horatio R. Storer Foundation, and the American Academy of Medical Ethics, Inc. It takes a strong conservative editorial stance as an advocate for persons with disabilities, but it does publish contrasting views as well. It publishes observations and opinions on such issues as limitation of treatment, assisted suicide, euthanasia. This journal publishes annually a review of judicial decisions and legal trends entitled "Medical Treatment Rights of Older Persons and Persons with Disabilities". Its publication office can be reached at P.O. Box 1586, Terre Haute, IN 47808-1586.

Lynn J. Ethical issues in caring for elderly residents of nursing homes. Primary Care June 1986; 13(2):295-307

Residents of nursing homes commonly need the active assistance of their physicians to enhance the quality of their lives and, when possible, to retain authority over the choices affecting them. Physicians need to encourage advance directives, enhance competence, defend the rights and interests of incompetent patients, treat symptoms vigorously, and manage well the residents' inevitable dying. Cost-containment concerns require physicians to re-examine their role as patient advocate.

Maxson, G. 'Who's life is it, anyway?' Ours, that s whose! in On Moral Medicine: Theological Perspectives in Medical Ethics. Grand Rapids, MI: Eerdmans, 1987:470-472

Objecting to the film Whose Life Is It, Anyway?, which regards the lives of persons with disabilities as not worth living, this disabled author attests to the fullness of life which she and her disabled friends experience. Rejecting the film's premise that disabled persons should choose to commit suicide or resort to euthanasia, she acknowledges her reliance on Christ as "that Presence who stands near but outside my harsh circumstances, and molds them into coherence and beauty."


Writing specifically to Christians, the author warns of the dangers of using humanistic principles to support their care of the retarded. He contends that such humanism may lead Christians to justify seeking the good of society at the expense of the few and may foster the belief that the only achievable good lies within this life. Thus, he urges Christians to boldly appeal to their Christian faith in caring for the retarded, remembering that "[s]erving the weak in the name of man is not enough; God calls us to love and care for the weak just as He has loved and cared for us."


Prefacing his essay with a consideration of Jesus' unqualified love for all children, the author contends that the decision in the 1982 Bloomington, Indiana "Infant Doe" case to forgo treatment of an infant with Down syndrome and esophageal atresia was morally wrong. He contends that the "impartial reasoning" on which this decision was based is inadequate to address such an issue and invokes the Christian narrative of Jesus and the children in defending his position. He asserts that the "eschatological vision of Christianity---and the entire Christian story, including the story of Jesus and the children---"provides a
resource to support the fragile Hippocratic tradition of medicine, for it enlists us on the side of life and health in a world where death and evil still apparently reign.”

Zweibel NR, Cassel CK, eds. Clinical and policy issues in the care of the nursing home patient. Clinics in Geriatric Medicine August 1988; 4(3)

This special issue of a quarterly journal on geriatric medicine focuses on clinical and ethical issues in the care of patients in long-term care facilities. The 14 articles address multiple issues, including treatment of infection, nutrition and hydration, bowel and bladder problems, dementia, psychiatric disorders, falls, management of medication, dying patients, quality assessment, decision-making for incompetent patients, and the withdrawal of life-sustaining treatments.


The author, a psychiatrist and anthropologist, shares what he has learned during twenty years spent studying and treating chronic illness. His most telling point is that we must listen to what patients, as well as those closest to them, tell us about their illness or disability and what it means to them.


This anthology of previously published pieces is arranged under ten topics: What it means to be disabled; Societal Attitudes about disability; Social encounters; Family Experiences; Sexuality and disability; Educational opportunities and barriers; Employment and disabled workers; Legal issues; Medical concerns; and What it means to be different.

Eareckson-Tada J. Disabled doesn't mean you're sick. Physician July-August 1991:2-4

The author writes a first-person account of encounters with laypersons and healthcare professionals who consider that she is ill because she is a quadriplegic in a wheelchair. She encourages all who deal with people who have disabilities to change their approach from the "medical model" to the "independent-living model".

May WF. The Patients' Ordeal Bloomington, IN: Indiana University Press, 1991

Instead of taking the traditional perspective of the clinician or the ethicist, this ethics book looks at dilemmas from the perspective of the patient and the family. Rather than asking "what should we do?", May asks "how are we going to manage to rise to the occasion?" It includes chapters on the burned, the retarded, the aged, the battered, and others.

Biebel A. Suddenly disabled. Focus on the Family January 1992:2-4

The mother of a child who developed a neurological disability at age 6 describes her pain and healing and that of her family. She offers constructive ways others may offer comfort, and specific guidance for parents about how to "go to bat" for their disabled child.

Scofield GR. Ethical considerations in rehabilitation medicine. Archives of Physical Medicine and Rehabilitation 1993;74:341-346

As the number of patients with chronic illness or disability grows, rehabilitation professionals will face increasingly difficult questions. Traditional concepts of medical ethics can help find solutions to some, but not all of those questions. Rehabilitation medicine needs an expanded vision of informed consent, one that embraces the needs of patients and promotes rehabilitations s educational model in contrast to the critical care model.


This textbook for clinicians who treat patients with neurological problems includes chapters on "Dementia" (chapter 10) and "Mental Retardation" (chapter 11). Each presents an overview of the topic, encourages the physician to be an advocate for the patient with diminished capacity, and offers practical advice on specific questions which arise in the clinical and social arenas. This scholarly text includes dozens of references at the end of each chapter.
Supplement to the American Journal of Physical Medicine & Rehabilitation. 1995; 74(1)

This special issue offers 12 articles on ethical issues encountered in the care of chronically ill and disabled persons. Issues discussed include goal setting, allocation of resources, resuscitation decisions, quality-adjusted life years, severe neuromuscular diseases, AIDS, professional relationships, and others.


Asserting that the failure of the current health care system to meet adequately the needs of disabled persons may lead to their requests for physician-assisted suicide, the author calls for reform in both Christian and secular health care settings. He presents a brief analysis of disability in the United States, draws a parallel between conditions experienced by the disabled and those and those which are used to advocate or justify euthanasia, considers social sanctions for euthanizing those with disabilities, and urges Christians to employ a model of care designed to value the disabled.

Special issue on ethics and rehabilitation psychology. Rehabilitation Psychology 1996;41(1)

A special issue of this journal (of the Division of Rehabilitation Psychology of the American Psychological Association) has five articles on "Rehabilitation ethic and ethics", "Rehabilitation psychology practice, ethics, and a changing health care environment", "Ethical issues in pediatric rehabilitation: exploring an uneven terrain", "Ethical issues in psychological evaluation of patients for organ transplant surgery", and "Life-sustaining treatment decisions by rehabilitation patients: the uncontested high ground."


The parent of a disabled child offers insights into characteristics of health care professionals which are most appreciated by family members providing home care.
Doctor & Pharmaceutical/Medical Device Industry Relationships

Introduction
Doctors appreciate the contribution that the pharmaceutical and medical device industries make to the practice of medicine. Without the discoveries made by industry, many of the medical advances and products of recent decades would never have been possible. However, there must be appropriate boundaries between practicing doctors and industry. Industry viability understandably requires fiscal integrity and a margin of profit. Doctors’ primary motive should be to promote the welfare of their patients.\textsuperscript{1,2} The resultant conflict of interest requires that a doctor deliberately evaluate the ethics of receiving gifts from industry. There are many published standards for appropriate relationships between industry and doctors.\textsuperscript{3} Many academic medical institutions\textsuperscript{4} and the US Government\textsuperscript{5} have adopted policies on these issues. CMDA, in an effort to give guidance to its members, addresses the question, “What is the appropriate responsibility of a doctor when offered incentives from industry?”

The Current Situation
The choice of what pharmaceutical or medical device to use is largely made by the doctor though this choice is often influenced by institutional or insurance company constraints and incentives. Therapeutic choices must be individualized with due consideration of the best scientific evidence available and costs involved. Industries seek to promote the use of their product to the doctor by providing, among other things, free educational opportunities, gifts, and services. Studies demonstrate that incentives from industry influence recipients more than doctors realize.\textsuperscript{6}

Biblical Foundation
A Christian’s response must consider several Biblical principles:

- The two great commandments are to love God and neighbor.\textsuperscript{7}
  - Jesus warns of the danger of being motivated by a love of money or other things of this world.\textsuperscript{8}
  - Jesus directs that our motives be pure and undivided.\textsuperscript{9}
  - Christians must “guard their hearts”\textsuperscript{10} against undue influence.
- The behavior of a Christian must be “above reproach.”\textsuperscript{11}
  - Christians should avoid any form of inappropriate behavior.\textsuperscript{12}
  - A reputation for doing what is right is of value.\textsuperscript{13}
- Solomon warned that receiving gifts could place people under the influence of others.\textsuperscript{14}

Even with our best intentions, we may be inappropriately biased toward those who give us gifts.\textsuperscript{15}

Ethical Principle
Doctors should consider carefully the basis of their therapeutic decisions to assure that they are made in accordance with best possible evidence applied to the welfare of the patient. Personal gain must never be the compelling reason for our decisions. Incentives from industry, intended to influence therapeutic choices, can compromise doctor integrity and behavior.

Recommendations:
Categories of receiving gifts from industry:

1. Unethical practices:
   a. Contracts that obligate the doctor to prescribe a particular pharmaceutical for reasons of personal gain.
b. Failure to disclose the degree to which the industry or institution controls the content of presentations, recommendations, or product placements.
c. Failure to disclose to the patient any financial relationships with the industry or institution.
d. Selling materials that were gifts, including samples.
e. Receiving greater compensation from a company than would be fair and reasonable for services rendered.

2. Practices requiring extreme caution:
   a. Receiving incentives from industry or institutions to build rapport or promote exposure to their products, e.g., free meals (including staff), entertainment, etc.
   b. Personal use of product samples.

3. Practices requiring caution:
   a. Accepting product samples: Product samples are distributed to doctors as a large part of the industry’s advertising budget. These are intended to bring attention to the products and allow the doctor some experience in using them. They should be received by the doctor with “no strings attached.”
      i. Appropriate uses include distribution to indigent patients\textsuperscript{16,17} and as a means to introduce a patient to a new product to assess efficacy and side effects before requiring their purchase. Product samples may also be used for dose titration.
      ii. Inappropriate uses: Product samples must never be given in a way that doctors promote themselves as benefactors.
   b. Accepting information from Industry. A discerning doctor is wise to look for independent sources of information.\textsuperscript{18} One must exercise caution in allowing the following sources to become the basis for therapeutic decisions:
      i. Sales promotional literature. This material is biased to promote the product. In the United States these materials are regulated by the FDA but are not always in compliance.\textsuperscript{19}
      ii. Industry sponsored studies. When using studies that are financed and published by the manufacturer, the doctor must keep in mind that though the work may be done with integrity, the conclusions may be subject to bias. Negative studies may not be readily available and only favorable outcomes emphasized.

4. Generally ethical practices:
   a. Attending or sponsoring educational activities that have received support from industry where it is clearly stated that industry has no control over the content and any conflict of interest on the part of the faculty is clearly revealed.
   b. Receiving reprints from peer reviewed journals.
   c. Requesting industry contribution to charitable efforts.

5. Situations in which it is difficult to refuse gifts from industry.
   a. Training on certain medical devices provided only by the manufacturer. This is often provided in a setting that involves travel, lodging, meals, etc. as a part of the educational experience. In this context, there may be limited options and the recipient must discern the appropriate response.
   b. Industry employees may leave incentives for a doctor without giving an opportunity to decline. In this situation, it is imperative that the doctor not allow these incentives to affect their practice.

Conclusion
Christian doctors must be wary of any inappropriate influence industry has over their prescribing behaviors and assure that their practices are guided by what is best for their patients and in accord with biblical principles.

Approved by the House of Representatives
Passed Unanimously
April 29, 2010. Ridgecrest, North Carolina

1 The Hippocratic Oath states, “I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone....I will preserve the purity of my life and my arts. In every house where I come I will enter only for the good of my patients.”

2 Susan L. Cohen PhD writing for the Ethics and Human Rights Committee, American College of Doctors—American Society of Internal Medicine. “Doctors and industry have a shared interest in advancing medical knowledge. Nonetheless, the primary ethic of the doctor is to promote the patient’s best interests, while the primary ethic of industry is to promote profitability.”


4 An excellent example is that published by the Yale University School of Medicine, Coleman et al, Academic Medicine Vol 81, No 2, Feb 2006 pg 154 as found at http://www.uthscsa.edu/research/Guidelines%20for%20Clinical%20Faculty%20Pharmaceutical%20Interactions.pdf Feb 27, 2007.

5 http://oig.hhs.gov/authorities/docs/050503FRCPGPharmac.pdf

6 The internet site “No Free Lunch” (http://nofreelunch.org/requiredinfluence.htm February 17, 2007) has done an excellent job in documenting this phenomenon. They reference the following articles:

7 Mark 12:30-31 (ESV) And you shall love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength.’ [31] The second is this: ‘You shall love your neighbor as yourself.’ There is no other commandment greater than these.”

8 Matthew 6: 24b (NIV) You cannot serve both God and money.
1 John 2:15 (ESV) Do not love the world or the things in the world. If anyone loves the world, the love of the Father is not in him.
1 Tim. 6:10 (ESV) For the love of money is a root of all kinds of evils. It is through this craving that some have wandered away from the faith and pierced themselves with many pangs.
Hebrews 13:5 (ESV) Keep your life free from love of money, and be content with what you have, for he has said, "I will never leave you nor forsake you."

9 Matthew 5:8 (ESV)"Blessed are the pure in heart, for they shall see God.
Luke 16:13 (ESV)  No servant can serve two masters, for either he will hate the one and love the other, or he will be devoted to the one and despise the other. You cannot serve God and money."
Proverbs 4:23 (ESV) Keep your heart with all vigilance, for from it flow the springs of life.
Proverbs 4:23 (NIV) Above all else, guard your heart, for it is the wellspring of life.
1 Tim. 5:7 (ESV) Command these things as well, so that they may be without reproach.
1 Thes. 5:22 (ESV) “Abstain from every form of evil,” and note that he goes on in vs 23 to say, “Now may the God of peace himself sanctify you completely, and may your whole spirit and soul and body be kept blameless at the coming of our Lord Jesus Christ.”
Ephes. 1:4 (ESV) even as he chose us in him before the foundation of the world, that we should be holy and blameless before him. In love
Hebrews 12:14 (ESV) Strive for peace with everyone, and for the holiness without which no one will see the Lord.
2 Cor. 7:1 (ESV) Since we have these promises, beloved, let us cleanse ourselves from every defilement of body and spirit, bringing holiness to completion in the fear of God.
Proverbs 22:1 (ESV)  A good name is to be chosen rather than great riches, and favor is better than silver or gold.
Proverbs 18:16 (ESV) A man’s gift makes room for him
Proverbs 19:6 (NASB)  Many will entreat the favor of a generous man, And every man is a friend to him who gives gifts.
Medication samples tend to be new products that do not come as generics and are therefore high priced. The danger of using samples to help the indigent is that it allows them to be comfortable with the higher priced medications and then when samples are no longer available they end up purchasing the more expensive brands.
Most pharmaceutical houses have assistance programs. These, not samples, are their primary effort to provide no/low cost medications for the indigent.

The web site No Free Lunch gives the following references to sources of pharmaceutical information not controlled by the pharmaceutical industry. Therapeutics Letter (Canada) http://www.ti.ubc.ca/ Established in 1994 by the Department of Pharmacology and Therapeutics at the University of British Columbia “to provide doctors and pharmacists with up to date, evidence-based, practical information on rational drug therapy.” Member of the International Society of Drug Bulletins, and free. Drug and Therapeutics Bulletin (UK) http://www.dtb.org.uk A monthly publication giving independent evaluations of, and practical advice on, individual treatments and the management of disease. Medical Letter http://www.medletter.com Since 1958 has published critical appraisals of new drugs, prescribing recommendations based on expert consensus. It reviews virtually all new drugs. By subscription. Prescriber’s Letter http://www.prescribersletter.com

Double Effect

All medical treatments have the potential for adverse secondary effects, some anticipated and others not. The medical acceptability of such adverse secondary effects is judged on a risk-benefit basis. This involves assessing the likelihood of their occurrence, their severity, and the ability to treat them.

Some secondary effects have moral implications. An assessment of the moral acceptability of adverse secondary effects requires consideration of principles, motives, consequences, and implications.* The Rule of Double Effect, introduced into the discipline of moral reasoning by St. Thomas Aquinas, is particularly useful in evaluating the moral acceptability of adverse secondary effects.

The Rule of Double Effect furnishes guidance in a variety of situations such as relieving persistent or intractable pain with addicting narcotics, administering drugs or performing procedures that have harmful side effects, treating terminally ill patients with drugs that have the potential to shorten life, withdrawing burdensome and/or futile interventions even though these are life-sustaining, or using "terminal (palliative) sedation." The Rule of Double Effect distinguishes between morally permissible actions that allow a patient to die and morally impermissible actions that cause a patient’s death. This distinction applies in a variety of situations, but is crucial in the public policy debates regarding appropriate end of life care, euthanasia, and physician-assisted suicide.**

Actions leading to undesirable secondary effects, even if anticipated, can be permissible when all of the following criteria are met:

1. The primary act must be inherently good, or at least morally neutral.
2. The good effect must not be obtained by means of the bad effect.
3. The bad effect must not be intended, only permitted.
4. There must be no other means to obtain the good effect.
5. There must be a proportionately grave reason for permitting the bad effect.

CMDA endorses these guidelines, fully realizing that not all situations in patient care can be anticipated or provided for; nor can the intent of medical caregivers always be discerned with certainty.

* See CMDA statement Moral Complicity with Evil
**See CMDA statements Euthanasia and Physician-Assisted Suicide

Approved by the House of Representatives
Passed by unanimous vote
Eugenics and Enhancement

Eugenics has historically been the effort to improve the inheritable qualities of a race or species. Traditionally eugenics has been practiced through the use of selective breeding, but it is now moving toward direct manipulation of the genome. Advances in molecular genetics that make this possible are also leading to a resurgence of the eugenics movement. This is emerging as the science of directly treating or eliminating undesirable in-heritable characteristics and as the quest for individual human enhancement.

History

The word, eugenics, was coined in 1883 by Charles Darwin’s cousin, Francis Galton, a biologist who used statistical correlations to study the inheritance of intelligence. The term was built out of the Greek Eu (good) and Genics (in birth).

Eugenics has a sordid history. During the late 19th and early 20th centuries in America, and especially in Nazi Germany, eugenics promoted the practice of eliminating human life and races judged to be “inferior.” While eugenics may initially appear attractive, it has by its very nature always led to morally repugnant consequences involving broad facets of society.* Therefore, we are concerned that the modern practices of eugenics will repeat history. The increased power of modern technology demands increased vigilance.

Goals

CMDA affirms the primary goals of medicine – the treatment and prevention of disease and the reduction of suffering, whenever possible, by legitimate and moral means.

• CMDA supports the effort to understand our genetic code for purposes of increasing knowledge, treating disease, and bettering the human condition.
• CMDA opposes the use of any genetic manipulation that has an unacceptable risk of harm to any human being.

Screening

Mapping the human genome has been a significant aid in the identification and possible treatment of genetically determined diseases. Like all powerful information it can be used for good or for ill. **

• CMDA endorses ethical efforts to increase the scope and accuracy of science used to identify, understand, and treat human genetic diseases.
• It should not be mandatory that persons be genetically screened, be made to know their own genetic information, or be required to act upon that knowledge.
• In this context, no person’s genetic information should be used against him or her.

Determinism

We oppose the concept of genetic determinism, that we are our genome or that genes are destiny. Humanity’s prospects for the future will be enormously impoverished if its outlook is limited to its own perceived genetics.

Morals

The application of genetic knowledge for eugenic agendas is unequivocally problematic.

• The goals of modern genetics must be sought within the limits of moral boundaries and qualifications. Medicine, and therefore genetics, must be practiced according to principles of ethical behavior delineated by conscience under the authority of Scripture.
• When an undesired trait or gender is identified by pre-implantation or prenatal screening the discovery is often followed by destruction of the human life exhibiting the undesired trait. CMDA opposes destruction of human life for eugenic purposes. This includes the destruction of embryos, abortion, infanticide and genocide.
Genetic Intolerance
Society, while advocating tolerance, has become increasingly intolerant of any “defective” human life. Our society exerts increasing pressure on parents to neither accept nor bring to birth a child perceived as defective. This intolerance violates the sanctity of human life.

- We must not deem inferior anyone with a “defective” genetic heritage. We recognize that all persons, no matter how normal in appearance, carry defective genetic information within their genome, and that all human physical life is defective to some degree and with certainty becomes more so with aging.
- There are no superior or inferior racial groups. Any efforts to create or eliminate perceived superior or inferior individuals are to be condemned. Similarly, there is no superior or inferior gender. There are no “lives unworthy of life.”***
- Continued improvements in genetic diagnosis sharpen the dichotomy between those who “have” a good genetic endowment and those who “have not.” With the possible advent of genetic enhancement this dichotomy will increase.
- Far more serious and damaging than our genetic deficiencies are our moral deficiencies. Intolerance of those deemed genetically inferior is an example of this moral deficiency.

Safety
Although the use of somatic and germ cell genetic therapy**** has the potential to correct genetically determined disease, there are significant concerns regarding the safety of genetic therapy, particularly germ line therapy.

- Somatic cell therapy: If critical concerns regarding the safety of somatic cell therapy can be resolved, the use of somatic cell therapy may be acceptable for correcting genetically determined diseases.
- Germ cell therapy: CMDA believes that germ cell genetic therapy is unacceptable - at least until safety issues are resolved. The use of germ cell therapy is more problematic due to the transmission of any changes to future generations. Safety issues are magnified in this instance since changes not only affect the patient but future descendants. Even if safety issues are resolved, germ cell therapy still raises significant moral issues, e.g., the impossibility of obtaining consent from those yet to be born.

Genetic Enhancement
The practice of genetic alteration evokes deeper concerns on a more fundamental level. The prospect of using genetic technology to enhance human characteristics is now a theoretical possibility. CMDA recognizes that the distinctions between treatment and enhancement are difficult to discern and are arbitrary in many cases. As Christians, we hold that all humans are made in the image of God. This essential characteristic distinguishes us as human. The goal to recreate man in man’s image raises profound questions about human nature and man’s relationship with his Creator. The ultimate end of man is to glorify God; the re-creation of man to glorify himself is idolatry.

Conclusion
CMDA considers genetic research and therapy to potentially be of great benefit to humanity. We endorse the effort to make progress in this field. We diminish our own prospects both individually and communally if we refuse to work for scientific advancement. However, we must build moral safeguards around our technology. We must accept, learn from, and care for those who are vulnerable and suffering.

* See Addendum: A History of Eugenics
** See Statement: Use of Genetic Information and Technology
Leben unwürdiges Lebens [“Life unworthy of life”] was a Nazi slogan used to justify using or killing innocent human life.

The distinction between somatic and germ cells is that somatic cells do not pass changes on to progeny and germ (sex) cells do.

Passed by the CMDA House of Representatives.
June 16, 2006. Irvine, California.

HISTORICAL PERSPECTIVE*

The word, eugenics, was coined in 1883 by Charles Darwin’s cousin, Francis Galton, a biologist and Social Darwinist who used statistical correlations to study the inheritance of intelligence. The term was built out of the Greek Eu (good) and Genics (in birth). Galton’s aim was to improve human stock by gaining knowledge and instituting public policies that would help “the more suitable races” prevail over “the less suitable races” in order to maximize intelligence and to prevent feeblemindedness. He advocated scientific marital arrangements to breed intelligent children.

The practice of eugenics, quite apart from the existence of the word, has existed from ancient times and it has always been associated with death – with defining and eliminating the unfit. In the ancient world it involved exposing infants. In Greece (both Plato and Aristotle supported the practice), in Sparta, and in Rome under the Laws of the Twelve Tables infants were exposed in order to eliminate visibly impaired newborns and to weed out the weak. In the Middle Ages law, medicine, and religion, largely under the influence of Judeo-Christian teaching, condemned euthanasia, and it was seldom practiced. The exception was monsters or “changelings” believed to be imps left behind by demons who had stolen the “real” baby. These were not considered to be human beings; thus exposing and killing them did not violate the ban on infanticide (a view endorsed by Martin Luther himself). Beginning about 1870 a few physicians and others began to publicly advocate not nurturing or actually killing defective persons or defective newborns.

On November 12, 1915, a now largely forgotten but then famous case catapulted eugenics into the public eye. In Chicago’s German-American Hospital a severely deformed baby boy was born to the Bollinger family. The surgeon who headed the hospital staff, Dr. Harry J. Haiselden, convinced the mother not to treat the child, but to let it die. Haiselden revealed that he had let a number of “defectives” die during the preceding decade, and that he would continue to do so. All this was widely reported by the newspapers. His decision was backed by public figures such as Clarence Darrow and Helen Keller. The courts did not indict him; neither did the media. Subsequently he wrote and starred in a movie concerning this incident. In the movie, entitled “The Black Stork,” Haiselden advocated the protection of society from “defectives.” It was a kind of morality play based on the dangers of allowing mentally or physically defective children live because of the likely possibility that they might become criminals. The movie was shown in theaters from 1916 to 1920. After 1918 it appeared under the title Are You Fit to Marry? It was revised and re-released in 1927. It continued to be shown in small theaters and traveling road shows until perhaps as late as 1942.

During the early 20th Century partly due to the famous case portrayed in “The Black Stork” and partly due to other “eugenic movies” of the time, the eugenics movement made enormous gains in public approval and support in the United States. It was endorsed by the national media, practiced by medical science, given carte blanche by the courts, and defended by the leading intellectuals of the day.

Initially the eugenics movement believed the defective person was unfit to reproduce but should not be killed. Segregation or sterilization of the unfit became the answer. The hope was that
medicine or surgery (even or tonsillectomy or adenoidectomy!) could effect cure. Then “allowing to die” or “twilight sleep” (deep and continuous sedation) was advanced as a humanitarian way to eliminate defectives. Finally killing (in the form of abortion) was advocated to save the parents from suffering. As Helen Keller put it, “Our puny sentimentalism has caused us to forget that a human life is sacred only when it may be of some use to itself and to the world.” Doctor Haiselden insisted that he let defectives die “because he loved them.” He emphasized the need to protect society from what he termed “lives of no value.” He maintained that “by the weeding out of our undesirables, we decrease their burden and ours.” Clarence Darrow said we should: “Chloroform unfit children. Show them the same mercy that is shown beasts that are no longer fit to live.” Haiselden warned that: “Cold hard logic…cannot be overturned by false and sickly sentiment.”

Medicine at this time began to develop an enormous power (the expert) over all of life. The New York Times strongly urged that non-treatment decisions should be “kept strictly within professional circles, without the horrified exclamations of unenlightened senti mentality.” Helen Keller called for “physicians’ juries for defective babies.” A Chicago realtor called for “legislation creating a commission authorized to put to death painlessly hopelessly imbecile children,” though he thought it “desirable to obtain the consent of parents.”

The leading intellectuals believed that scientific methods provided an objectively true basis for both emotions and ethics, far superior to those false sentiments whose only basis was irrational social conventions. Allowing baby Bollinger to die was not a victory of cold logic over love, Haiselden insisted, but a victory of objective love over sentimental love. “Kindness took the highest form,” triumphing over “false sentiment, false man- hood, false humanity,” he proclaimed. The Philadelphia Ledger called his decision “the highest benefaction.”

The practice of eugenics took two directions: 1) Negative Eugenics. Eugenics became closely associated in Europe and the United States with segregation, forced sterilization of the “unfit,” and decisions by doctors and / or parents to allow deformed or defective children to die. “Unfit” was a term aimed against the Black race, immigrants, the poor, the immoral, criminals and the mentally defective. The United States was an early leader in the sterilization movement. By the year 1920 twenty states (beginning with Indiana) had forced sterilization laws, and between 1931 and 1939 over 20,000 institutionalized patients were sterilized. These laws had the support of medicine, the media, and the courts. Buck v. Bell was a famous case in 1927 in which the Supreme Court upheld the constitutionality of Virginia’s involuntary sterilization program. In the words of Justice Oliver Wendell Holmes, Jr., who wrote the majority decision: “Three generations of imbeciles is enough.” Another famous case was the 1936 suit of Ann Cooper Hewitt against her mother and two doctors for sterilizing her without her knowledge or consent during an emergency appendectomy.

2) Positive Eugenics. Beginning in the 1920’s world leaders became concerned that the middle and upper classes were not having children at the same rate as the lower classes. Much effort was made to induce the “fit” (meaning the white middle class) to have children. Advocates of the worldwide Birth Control League, later to be called Planned Parent-hood Federation of America, advocated “more children for the fit, less from the unfit – this is the chief issue of birth control.” Eugenics research in the U.S. was done at Cold Spring Harbor, New York, led by Charles B. Davenport and funded by the Carnegie Institution in Washington and by Mary Harriman.

In Germany eugenics was at first called racial hygiene (Rassenhygiene) – a term coined by the German Social Darwinist, Alfred Ploetz, in writing the movement’s founding document. The Nazi project was a vision of absolute control over the evolutionary process, over the biological human future – a kind of “biocracy.” Rudolf Hess asserted that “National Socialism is nothing but applied biology.”
In the late 1930’s the Nazi government directly joined eugenics to euthanasia. The latter activity began with the killing of the non-rehabilitatable sick or defective and ended with the destruction of anyone (specifically Jews, Gypsies, and Slavs) defined as inferior (life unworthy of life = leben unwürtiges lebens). The crucial work justifying this decision – “The permission to Destroy Life Unworthy of Life” – was published in 1920 and written jointly by two distinguished German professors: the jurist Karl Binding and the physician Alfred Hoche, professor of psychiatry at the University of Freiburg. The latter coined the term, “life unworthy of life.” Their plan was to have a three-man panel (a physician, a psychiatrist, and a lawyer) to decide upon request regarding the permissibility or advisability of euthanasia. The request that someone be killed could be withdrawn at any time.

In early October 1939 – a month after World War II had begun – Hitler issued orders that certain doctors be commissioned to grant “a mercy death (Gnadentod) to patients judged incurably sick by medical examination.” The camouflage organization created for the medical killing was the Reich Work Group of Sanatoriums and Nursing Homes operating from the Berlin Chancellery at its Tiergarten 4 address – hence, the overall code name “T4” for the project. The transportation service created for this function was ironically called the Common Welfare Ambulance Service Ltd. There is evidence that although a specific order for the Final Solution (Endlösung) was issued by Göring to Heydrich on 31 July 1941, it was actually requested by Heydrich and drafted by Eichmann.

The German medical profession aided and abetted this effort. As many as 50% of German physicians joined the Nazi party and many participated in the genetic and other medical research projects in the concentration camps. The medical experimentation on prisoners in the German concentration camp system, so egregiously exemplified by the twin-studies of Dr. Mengele at Auschwitz, was justified on utilitarian grounds as making use of human material that was going to be destroyed anyway. These acts were later judged to be criminal in the Nuremberg trials. From those trials came the modern guidelines for informed consent.

Beginning in the 1940’s and extending into the 1950’s, largely because of the events in Nazi Germany, the term, eugenics, was avoided, forced sterilization was abandoned, and the practice of categorizing people as unfit was viewed as class bias. But beginning in the mid-1950’s efforts to improve the race reappeared. Positive Eugenics was promoted in the form of encouragement to breed from “superior” stock (e.g. from a sperm bank storing sperm produced by scientists). Negative Eugenics began to be endorsed by centers for genetic counseling.

Today eugenics is newly associated with the voluntary and the autonomous, but it is also, as before, allied with the destruction of innocent human life. Its destructive practices once again have the support of medical science, the media and the courts. In addition eugenics is now supported by a growing and increasingly profitable technological industry.

Positive eugenics now involves prenatal genetic testing, in vitro screening of gametes and zygotes, and prenatal testing with the prospect of using technology to eliminate the carriers of undesirable genes or (theoretically) to add desirable genes. There exists the future prospect of producing “superior” babies.

Negative eugenics exists in the practice of destroying unwanted or defective human life identified by in vitro pre-implantation genetic screening or in utero prenatal genetic testing. The issues involved are hidden by such euphemisms as “freedom of choice” or “the right to privacy” or “eliminating or preventing suffering.” These terms really mean the destruction of the prospectively defective child. Much pressure is brought by our society against any decision to give birth to a defective child, and the worth of such a child is impugned (as before) on purely utilitarian grounds. More recently liability for “wrongful birth” of a defective baby or for an
adverse outcome in delivery (often subjectively defined as an “imperfect” baby) has become a substantial threat to medical caregivers.

These societal attitudes are in conflict with our traditional Judeo-Christian religious beliefs that all human life bears the image of God and therefore is sacred and inviolable. They ignore the teachings of our national founding documents which assert and make provision for the idea that all men are created equal and are endowed by their creator with certain inalienable rights, including life. And they violate even the secular philosophical principle that no human life may be used as a means to an end. Our society is degraded when it legitimates the destruction of innocent human life and unconsented to control or use of others.

The eugenics agenda of our society today is in many respects not different in principle from the eugenics agenda of the Western Civilizations of the late 19th and early 20th centuries. Its practices are accompanied by death, justified by science, motivated by the desire to produce superior humans, and made palatable by obscuring euphemisms. The horror of doing evil in the name of good will continue unless we exercise clarity of moral thought and develop ethical boundaries and guidelines for eugenics. Those who would foresee the future of medicine without moral guidelines will do well to look at the history of Eugenics.

*This perspective on the history of eugenics has largely followed the thought of Arthur J. Dyck, Ph.D., in “Eugenics in Historical and Ethical Perspective”, GENETIC ETHICS, Do The Ends Justify The Genes?, edited by John F. Kilner, Rebecca D. Pentz, and Frank E. Young (Eerdmans Publishing Company, Grand Rapids, Michigan, 1997)

The narrative is supplemented by information from:
**Euthanasia**

We, as Christian physicians and dentists, believe that human life is a gift from God and is sacred because it bears His image.

The role of the physician is to affirm human life, relieve suffering, and give compassionate, competent care as long as the patient lives. The physician as well as the patient will be held accountable by God, the giver and taker of life.

We oppose active intervention with the intent to produce death for the relief of suffering, economic considerations or convenience of patient, family, or society.

We do not oppose withdrawal or failure to institute artificial means of life support in patients who are clearly and irreversibly deteriorating, in whom death appears imminent beyond reasonable hope of recovery.

The physician's decisions regarding the life and death of a human being should be made with careful consideration of the wishes and beliefs of the patient or his/her advocates (including the family, the church, and the community). The Christian physician, above all, should be obedient to biblical teaching and sensitive to the counsel of the Christian community. We recognize the right and responsibility of all physicians to refuse to participate in modes of care that violate their moral beliefs or conscience.

While rejecting euthanasia, we encourage the development and use of alternatives to relieve suffering, provide human companionship, and give opportunity for spiritual support and counseling.

*Approved by the House of Delegates
Passed unanimously

**Explanation**

Physician-assisted suicide occurs when a physician helps a person take his or her own life by giving advice, writing a prescription for lethal medication, or assisting the individual with some device which allows the person to take his or her own life. The physician lends expertise, the person does the act.

Voluntary euthanasia occurs when another person, out of compassion, does an action with the intention of ending the life of a suffering patient at his or her request. Non-voluntary euthanasia is a similar compassionate act, but in circumstances where the patient is unable to make a voluntary request (e.g. an unconscious, retarded or demented adult; an infant or child). Involuntary euthanasia is a compassionate act to end the life of a patient who is perceived to be suffering and could make a voluntary request, but has not done so.

Distinction between active euthanasia and passive euthanasia is not helpful, and often confusing. It is clearer to limit the term euthanasia to situations in which one person acts to cause the death of another (which is what many people mean by active euthanasia). According to this understanding, acts of discontinuing treatment with the realization that patients will die of their disease do not constitute euthanasia. Thus using the term passive euthanasia to describe such acts is a misnomer. When discontinuation is done with the intention of ending the life of someone who is not already unavoidably in a dying process, it is morally objectionable for many of the same reasons that euthanasia is
objectionable. But since discontinuation in other situations is morally acceptable, it is helpful not to refer to discontinuation under any circumstances as a form of euthanasia.

Secular Perspective

Societal changes of the 1960's - 1980's have led to a focus and emphasis on an individual's right to self-determination. While this includes some increased acceptance of suicide as a rational option for an individual who feels that life has become too burdensome, the act of suicide is still often viewed by others as a tragic and lonely experience. This is especially true when the means of self-destruction involves violence (e.g. guns and other self-inflicted wounds, hanging, jumping from heights, etc.). Thus there has been a move to depersonalize suicide by involving others (assisted suicide) and to sanitize it by making it a medical procedure (physician-assisted suicide and euthanasia).

Proponents of legalization of euthanasia offer several reasons why society should allow physicians to be involved in these acts: some people have no loved one who can help them; some people are unwilling or unable to help their loved ones commit suicide; physicians know the prognosis so are better able to assess the appropriateness of a request; physicians have access to and know how to use lethal drugs; medical expertise can prevent "botched up" suicide attempts; physicians know how to obey standards; and, physicians can be more objective because they are not emotionally involved.

Legal Perspective

Euthanasia has been openly practiced by physicians in The Netherlands since 1984, and such acts were decriminalized in 1993, although legal and judicial oversight continues. The best estimates are that about 3% of all deaths in that country are induced by physicians. There is public debate about extending the availability of euthanasia to children and incompetent adults, and there is a professional inclination to change the system to physician-assisted suicide rather than direct physician involvement.

The Northern Territory of Australia legalized physician-assisted suicide and physician-administered euthanasia in 1995.

Attempts in several states in the U.S. to pass legislation allowing physician-assisted suicide and/or euthanasia failed by narrow margins in the late 1980's and early 1990's. In 1994, the state of Oregon passed a voter initiative to allow physician-assisted suicide with restrictions, but it has not gone into effect at the time of this writing because of legal challenges.

Case law (as opposed to statutory law) in the U.S. addressed the issue of physician-assisted suicide in early 1996. The 9th Circuit Court of Appeals in San Francisco and the 2nd Circuit Court of Appeals in New York declared unconstitutional state laws in Washington and New York (respectively) which prohibited physician-assisted suicide. Different legal arguments were used in the two cases. It is anticipated that these judicial rulings will be appealed to the U.S. Supreme Court.

Professional Perspective

Physician-assisted suicide and euthanasia were explicitly proscribed in the Hippocratic Oath. Although this was a minority opinion when introduced 2500 years ago, the Hippocratic ethic gradually became the dominant influence for practitioners of modern medicine and dentistry. Practitioners have adopted the role of healer with the goals of healing when possible, and relief of suffering. While there have doubtless been individual physicians and dentists over the centuries who have occasionally helped their patients to die, this activity has clearly remained outside the boundaries of acceptable medical treatment.

There is professional concern that acceptance of physician involvement in either direct or indirect induced death would seriously undermine the trust that is a necessary component of the physician-patient relationship. If euthanasia becomes accepted, a physician might be tempted to end a patient's life without a request, either out of compassion, or out of self-interest (e.g. when the care of a patient becomes too difficult or burdensome). In addition, there is concern that there might be less impetus to continue work on the significant gains made in good palliative care in the past 20 years.

Christian Perspective
What is fundamentally wrong with euthanasia from a biblical perspective is that it involves the killing of human beings who are necessarily made in the image of God (Genesis 9:6). Physician-assisted suicide is wrong for similar reasons, in that people kill human beings (themselves) with the assistance of others who thereby become accessories to killing. As discussed further in the "Explanation of the Statement on Patient Refusal of Therapy", patient autonomy (or better: freedom) must be understood within the limits of God's sovereignty and does not include the right to dispose of that which is not one's own ("you are not your own" ---I Cor. 6:19).

Christians are indeed called upon to be compassionate and to relieve suffering, but not at any expense. If happiness were what life is all about, then suffering would be the ultimate evil to be avoided at all costs. The cross would represent the epitome of what is to be avoided. Its crushing load on Jesus back and the nails driven through his hands and feet graphically display the burden of the fallenness of the world that Jesus had to bear, in fact, chose to bear. Yet, those who follow Jesus are not called to avoid such suffering but to suffer this fallenness with him, to take up crosses of their own.

The basic question, then, is whether God or suffering is going to set the agenda of one's life---and death. Christian physicians and their patients will not find God's way by trying to avoid all suffering at any cost. They will find it by remaining true to God's biblically-revealed character and will, especially in the midst of suffering. The ultimate test of what is setting the agenda of our lives may well be how we deal with suffering in the face of death.

Such was the case for Jesus in the garden of Gethsemane. He was "overwhelmed with sorrow to the point of death" (Mark 14:34) and zealously prayed to be spared from the suffering that he knew would only get worse. Yet he affirmed that his primary commitment was to the larger purposes of God, whatever suffering they might entail. The absence of suffering is, generally speaking, something we will only get worse.

Yielding to the call of "compassion" to kill or assist in the killing of a patient is misguided for another reason as well. It is all too easy to underestimate the fallenness (self-centeredness) of human nature, particularly when the people in view seem to have the needs of others at heart. The statements of so-called "mercy killers" in the past have often been telling in this regard. "I killed her because I could not bear to see her suffer" generally means what it says---that first and foremost the action reflected the killer's need to be free from his or her own discomfort. Barriers to killing patients or assisting them to kill themselves not only protect society in general and patients in particular but also protect physicians and surrogate decision-makers from their own weaknesses---from subtly self-centered decisions that may well haunt them for the rest of their lives. The CMDS statements on Physician-Assisted Suicide and Euthanasia are designed to uphold such protections while affirming more constructive expressions of compassion.

Abstracts

Gaylin W, Kass LR, Pellegrino ED, Siegler M. Doctors must not kill. JAMA 1988; 259(14):2139-2140

In January of 1988, JAMA published an anonymous piece by an OBGYN resident who tells of giving a lethal overdose of morphine to a dying young woman, perhaps at her request. These four authors, noted in the field of medical ethics, question the authenticity of the reported event. If it is true, they conclude that he or she committed a felony and acted both unethically and unprofessionally. They find his or her conduct inexcusable. They go on to criticize JAMA for publishing a supposed account of medical malfeasance.


The author begins by examining the transgressions of the Hippocratic Oath in Nazi Germany. He borrows from the work of Robert Lifton to discuss the psychological concept of "doubling" which allowed physicians to cope with the healing-killing paradox. He then describes some physicians who resisted doubling. He goes on to discuss the specific issues of euthanasia and abortion. He concludes by encouraging Christian physicians to be sensitive to their dying patients, to avoid prolonging their suffering, but to resist the temptations of doubling. He encourages Christian physicians to (1) pray about these issues, (2) talk to each other about our concerns in these areas, and (3) refuse to participate in procedures and practices which violate our consciences.
The author is one of 9 included in this special supplement to the HCR entitled "Mercy, Murder, & Morality: Perspectives on Euthanasia." Writing from a Roman Catholic perspective, he begins by declaring the intrinsic wrongness of directly killing the innocent because of the Judeo-Christian conviction that human life is sacred because it is created in the image and likeness of God, and called to fulfillment in love of God and neighbor. In discussing "slippery slopes and loose cannons", he contends that socially accepting killing of innocent persons will interact with other social factors to threaten the lives of others whom we all agree should be protected. The social factors he enumerates are: the psychological vulnerability of elderly and dying patients, the crisis in health care costs, legal doctrines on substituted judgment, expanded definitions of terminal illness, prejudice against citizens with disabilities, the character of the medical profession, and the human will to power. He concludes that the combined force of these arguments provides a serious case against assisted death for any class of persons.


The author, a physician/ethicist, went to Holland to study euthanasia practices and says that he found a scarcity of information about regulatory mechanisms. He believes that regulatory criteria are unenforceable. He describes euthanasia deaths in 26 patients, and he evaluates each. It is his opinion that significant abuses would likely go undetected by public authority.


The author begins with by telling the story of her family's decision against using a feeding tube to forestall her father's inevitable death. She then relates some of the dilemmas presented by new technology and suggests that in order to gain wisdom for these decisions, we must (1) become well acquainted with the Scriptures, (2) understand how the Scriptures apply to the situation, and (3) put the two together in a process of personal decision making. She reminds the reader of the following Scriptural principles: life is precious, suffering people should have every access to the means of God's grace, love for God and love for others is paramount, and God demands that we must examine our motives. She states that if we are motivated by faith and love, conscience cannot be violated. After a discussion of "pulling the plug", she goes on to address the issue of mercy-killing. She concludes that "any means to produce death in order to alleviate suffering is never justified."

Emanuel, EJ. Euthanasia: historical, ethical, and empiric perspectives. Archives of Internal Medicine. 1994;154(9):1890-1901

Debates about the ethics of euthanasia date from ancient Greece and Rome. In 1970, S.D. Williams, a nonphysician, proposed that anesthetics be used to intentionally and the lives of patients. Between 1870 and 1936, a debate about the ethics of euthanasia raged in the United States and Britain. These debates predate and invoke different arguments than do debates about euthanasia in Germany. Recognizing the increased interest in euthanasia, this article reviews the definitions related to euthanasia, the situation in the Netherlands, and the empirical data regarding euthanasia in the United States.

Arkes, Hadley, et al. "Always to Care, Never to Kill: A Declaration on Euthanasia". First Things 2/92; 20: 45-47

In asserting the necessity for Christians to expose euthanasia for the immoral act that it is, the author contends that in caring for the sick and the dying, we are called "always to care, never to kill". He maintains that it is imperative that the distinction between allowing to die and killing be upheld, with the former being sometimes permitted and the latter always proscribed. He warns that, with the loss of such a distinction and the subsequent legalization of euthanasia, euthanasia will not remain limited as an option only for those who are terminally ill. Once euthanasia becomes legal on the basis that persons have the right to self-determination and to the relief of suffering, there will be no justification for restricting such an option to the terminally ill. If one has a "right" to die, why must she wait until she is dying to claim that right? If one has a "right" to the relief of suffering, might he not be relieved of such via euthanasia even without his consent? In considering these issues, the author invokes a discussion of religious, moral, political, and institutional wisdom as modes of counteracting the expressed "right" to euthanasia.

In this analysis of euthanasia, the author contends that to properly address issues of death and dying, one must simultaneously invoke a consideration of the nature of health, healing, and human life. According to him, “[i]t is the isolation of the question of death and dying from other human questions that helps lead us into the blind alley of a programme of euthanasia.” He asserts that the physician’s role as healer must be seen as an eschatological one which foreshadows the Christian hope of the final Resurrection of the body. Therefore, physician assistance in bringing about patients’ deaths must be absolutely prohibited. It is maintained that Christians must engage in the euthanasia debate with the perspective that human dignity is a fundamental attribute of human life bestowed on us by God; our dignity is not, therefore, defined by or limited to a state of good health. Consequently, Christians must proscribe the act of euthanasia as one which is an affront to, and not an acknowledgment of, the inherent dignity of human beings.


Research by Van der Maas reveals that in 1990, there were 1,000 instances in which physicians terminated the lives of their patients without being requested to do so. (This constitutes what the Dutch would term “non-voluntary euthanasia”.) In addition, Van der Maas’ data shows that in 7,100 other cases, physicians administered treatment for pain relief with the partial or explicit intent (and not merely the foreseen but unintended side effect) of hastening death. Further, in 7,875 cases, physicians either failed to initiate or withdrew treatment with the partial or explicit purpose of ending life. In the 1,000 cases in which physicians terminated the lives of their patients in the absence of a patient request to do so, the physicians involved saw a distinction between killing patients without their request and increasing the administration of pain-relieving treatment with the expressed intent of shortening his life. Although there is a firm belief among many people that the nature of the medical profession proscribes the intentional ending of life, the actual practice of euthanasia is difficult to discern and monitor because it consists of the "actual intentional shortening of life" and not just the intention. That is, it is not always clear whether physicians actions constitute euthanasia. In considering this difficulty, the author invokes a discussion of cases and rulings on euthanasia and also provides a summary of the common arguments both in favor of and in opposition to euthanasia.


This physician and scholar asserts that a false dichotomy between the terms "death with dignity" and the "sanctity of life" is often set up in the debate over issues at the end of life. By exploring the meaning and roots of these concepts, he concludes that the two concepts are in fact wedded so as to preclude, at one extreme, the continuation of all medical treatment regardless of prognosis and, at the other extreme, the act of euthanasia.

Bibliography


Predating the current debate by 30 years, this long treatise by a respected law professor argues persuasively that it is not necessary to invoke theological reasons to oppose euthanasia. He finds "substantial utilitarian obstacles" to such a proposed policy change including the possibility of error, abuse, and the discovery of new treatments.

Sacred Congregation for the Doctrine of the Faith (of the Vatican). Declaration on euthanasia. 1980

The Roman Catholic position against intentional ending of life is re-evaluated in light of recent scientific advances. Euthanasia is clearly defined and is discussed in the context of the value of human life and the meaning of suffering for Christians. While clearly condemning intentional killing, it replaces the older distinction of "ordinary vs extraordinary" treatments with the concept of "proportionate vs disproportionate" remedies and concludes that it is permissible to withhold or withdraw some treatments in some circumstances.

Kass rejects the concept of medicine as a contract wherein the physician is paid money as a dispenser of services to meet the requests of autonomous patients. He also rejects the concept of medicine as a dispenser of services based purely on human compassion. He maintains that medicine is not morally neutral, but has its own intrinsic ethic which includes a taboo against killing patients—a taboo "which a physician true to his calling will not violate, either for love or for money."


The authors argue that legalization of voluntary euthanasia is likely to expand to involuntary. They also discuss the dominance given to cost-containment and express concerns that the idea of a "life devoid of value" will further drive the issue. They make a plea for good terminal care as the morally preferable alternative, and they conclude with a strong affirmation of life.


The authors critique the two arguments offered by proponents (relief of suffering and individual rights) and make a strong case against euthanasia because it is perilous public policy and it violates the norms of medicine.


This is a report of the Remmelink Commission appointed by the Dutch government to document the actual practice of euthanasia in the Netherlands. Of the nearly 129,000 deaths in 1990, 1.8% were caused by euthanasia, 0.3% by physician-assisted suicide, 0.8% by "life-terminating acts without explicit and persistent request" and an astonishing 17.5% by medication to alleviate pain and suffering.


This 16 page supplement contains four essays: "What is at Stake?" by Alexander Capron & Vicki Michel, "Consider the Dutch" by Carlos Gomez, "Why Doctors must not Kill" by Leon Kass, and "Aid-in-Dying: the Social Dimension" by Daniel Callahan. All give well-articulated arguments against passage of state legislation allowing euthanasia.

Emanuel EJ. The history of euthanasia debates in the United States and Britain. Annals of Internal Medicine 1994; 121:793-802

This historical review shows that the arguments propounded for and against euthanasia in the 19th century are identical to contemporary arguments.

Professional Association position statements in opposition to euthanasia:


British Medical Association. Euthanasia: report of the working party on euthanasia. 1988
Fetal Tissue for Experimentation and Transplantation

We affirm that human life warrants protection from the time of conception because it bears the image of God. Medical interventions that involve the unborn child should be permitted only with the intent of providing diagnostic information or fetal therapy, and only when the potential benefits clearly outweigh the potential risks to both child and mother.

The use of fetal tissue for experimentation and transplantation introduces the opportunity for the gross abuse of human life, such as conception and abortion for the sole purpose of obtaining fetal tissue.

Also, the use of fetal tissue from elective abortions could be interpreted as further justification for abortion.

CMDA does not oppose the use of the tissues of spontaneously aborted, non-viable fetuses, with parental consent, for research or transplantation.

Approved by the House of Delegates
Passed by a majority vote, 1 opposed

Explanation

Background

Fetal tissue has been found to have tremendous chemical and physiologic potential, and it is less prone to rejection than adult tissue if inserted in another individual. For these reasons, it has been studied and used as a possible treatment through tissue transplantation for several incurable debilitating diseases. Many of the degenerative diseases hoped to be improved or corrected in this manner are diseases of the central nervous system. Research has focused on the CNS because nerve tissue has a very limited capacity for repair or regeneration. If this transplanted tissue can replace degenerating tissue, or if it can produce a chemical which the patient is missing, its use in therapy may slow, stop, or even reverse some of the horrible effects of serious disease. Animal research has shown promise in several different conditions. Human fetal tissue has been used, or proposed for use, in such diseases as diabetes, Parkinson’s Disease, Alzheimer Dementia, Huntington’s Disease, and others. Early results have been mixed --- some failures, some successes, and some early successes which proved to be transient. Such is the way of science: an idea --- animal experiments --- human trials --- refinement --- progress, etc.

However, this scientific endeavor has been fraught with major ethical dilemmas since its beginning because of the source of the tissue used in these innovative treatments. This is not inert matter being used. It is not even live tissue obtained with consent from a dead human donor. It is tissue from a human fetus --- most often tissue obtained after an abortion requested because a normal pregnancy was unwanted.

Secular Perspective

The use of fetal tissue to assist patients with debilitating disease is very attractive. If the goal of medicine is to do good for the patient, this therapeutic approach seems to qualify. Some would simply say that the end justifies the means. This purely utilitarian approach would entirely ignore the source of the therapeutic tissue.
However, many others who comment on this topic do recognize and address the concern of those who oppose abortion on moral grounds. They would contend that even if abortion is a moral issue, the use of fetal tissue to help patients in need is justified because the two acts (abortion and therapy) can be separated temporally and morally. In fact, they go on to argue that the health improvement achieved by the use of the fetal tissue could serve as a means of redeeming some good out of a tragic choice, perhaps even some degree of redemption from an immoral act.

Much of the secular discussion then, focuses on such issues as the need (or not) for consent of the mother of the fetus, the introduction of experimental therapy, the sequence and timing of the decisions for abortion and for tissue retrieval, the adequacy of information given to the recipient, etc.

**Christian Perspective**

For the Christian, or for anyone who highly values prenatal life and considers abortion to be an immoral act, the possibility of fetal tissue transplantation takes on serious implications. [A biblical perspective on abortion can be found elsewhere in this resource material.] But even beginning with a presumption that abortion is wrong, are there questions in this issue of fetal tissue transplantation for which a Christian perspective may be unique and different from those who rely only on human reasoning?

Probably the biggest concern is the issue of moral complicity. If a healthcare professional, or even a patient for that matter, is involved in the use of tissue retrieved from an aborted fetus, is that person involved in the immoral act itself?

Some would argue that the act of implantation of fetal tissue into another individual, of and by itself, is morally neutral, or perhaps even morally good. They might draw the analogy that the use of solid organs retrieved from a murder victim is a good thing and does not implicate the professionals or the patient in the act of murder.

There are added concerns, however, with the use of fetal tissue --- tissue which was recently a unique human individual but is now reduced to the status of "tissue" because the pregnancy was unwanted. Knowing that some good might come out of an abortion might sway the decision made by some women for ending pregnancy. The presumed good outcome might also lend more social legitimacy to the abortion industry. In theory, it could lead to a new industry of fetal tissue retrieval, or it could even cause some women to get pregnant with the specific intent of donating tissue to a loved one in need of this type of therapy. While these latter do seem unlikely, the issue of moral complicity is not as simple as merely separating the two individual acts in a specific clinical situation.

Scripture does give examples of moral complicity. In the Old Testament God told the Children of Israel to destroy captured idols, "Do not bring a detestable thing into your house or you, like it, will be set apart for destruction" (Deut 7:26), suggesting that if they did not, they would incur the same guilt as the idol worshipers. Other Old Testament passages also suggest that God felt it possible to be "guilty by association." However, in I Corinthians 8, Paul implies that eating meat which had been offered as a sacrifice to an idol was not inherently wrong, but the believer was admonished to not let his freedom in this regard become a stumbling block to his weaker brother. (see Warf reference for a more detailed discussion of this issue)

The CMDS position statement on **The Use of Fetal Tissue for Experimentation and Transplantation** attempts to follow this scriptural guidance. It affirms the value of fetal life, restricts interventions on the intact fetus to those for its own benefit, and recommends against the use of fetal tissue obtained from elective abortions, while allowing the therapeutic use of such tissue if otherwise obtained.

**Abstracts**


Abortion remains one of the most controversial debates in America today and has produced an emotional, moral and political impasse. These authors are concerned that this deadlock has inadvertently thrown issues related to abortion into the political arena where they are subject to the same rough treatment as abortion. “Even though the abortion debate in the United States is not likely to be resolved by ethical argument, it should not be permitted to hold every related issue of medical ethics hostage, as it does now.  

96
Crucial issues such as human-embryo research, prenatal genetic screening, and the manipulation of embryos before their implantation must be disengaged from the abortion issue to receive the public debate they require. The authors make a plea for decoupling these other issues from the politicized abortion debate, asserting that “In politics, the majority vote wins. In ethics, however, ethical reasoning should prevail…Unless we are content to let the politics of abortion bring discussions of publicly funded medical research to gridlock, we must do much better at articulating an ethical basis for abortion-related research.”


“Recent scientific advances in human stem cell research have brought into fresh focus the dignity and status of the human embryo. These advances have prompted a decision by the Department of Health and Human Services (HHS) and the National Institutes of Health (NIH) to fund stem cell research which is dependent upon the destruction of human embryos. Moreover, the National Bioethics Advisory Commission (NBAC) is calling for a modification of the current ban against federal funded embryo research, to permit direct federal funding for destructive harvesting of stem cells from human embryos. These developments require that the legal, ethical, and scientific issues associated with this research be critically addressed and articulated. Our careful consideration of these issues leads to the conclusion that human stem cell research requiring the destruction of human embryos is objectionable on legal, ethical, and scientific grounds. Moreover, destruction of human embryonic life is unnecessary for medical progress, as alternative methods of obtaining human stem cells and of repairing and regenerating human tissue exist and continue to be developed.”

Warf BC. Fetal tissue research and transplantation. Chapter 4 in New Issues in Medical Ethics. Bristol, TN. Christian Medical Dental Society, 1995

Warf summarizes the scientific basis for the interest in fetal tissue, explains the arguments surrounding the issues, and thoughtfully builds a biblically based argument against fetal tissue research. He states that use of fetal tissue makes one guilty of complicity in the immoral act of abortion.


In 1989, in the wake of the first operations to transplant fetal tissue to the brains of sufferers of Parkinson's Disease, the UK Code of Practice governing the use of the fetus for research was overhauled by an eminent committee under the chairmanship of the Reverend Dr. John Polkingham. The author concludes that, although the commission’s recommendation meet the major objections to the Code of Practice, the report is nevertheless vulnerable to criticism in its treatment of at least three issues: the moral status of the fetus; parental consent to fetal use; and the ethical interrelation of fetal use and abortion. The author argues that the since the committee has deemed the fetus to have a moral status "broadly comparable to that of a living person" it stands to reason that under the Declaration of Helsinki the fetus is afforded the rights of a living human, in which the “interest of science and society should never take precedence over considerations related to the well-being of the subject,” and as such the recommendations of the committee are invalid.


Martin critically examines the report of the NIH panel created to study the issue of fetal tissue transplantation and finds fault with the assumptions made and conclusions drawn. By refusing to ethically justify fetal tissue research, and relying solely on legal justification, Martin contends that the panel did not address the most significant issue regarding this subject.

The panel further states that separating the abortion from the process of obtaining maternal consent ethically justifies fetal tissue research as the mother's decision to have the abortion is not influenced by the possible use of the tissue in research. Martin disagrees stating the decision to have an abortion is rarely finalized until abortion takes place. As researchers often need the consent to use fetal tissue before the abortion takes place (to ensure that minimal degradation takes place), the consent to have an abortion and to have the resulting tissue used in research cannot be separated. Thus a woman's decision to use fetal tissue can and will be influenced by the possible role that the tissue will have in research. Martin further states that it is contrary to the principle of full disclosure for the consent to use the tissue be withheld until after the abortion has taken place thus limiting a patient's access to information. Martin concludes that the ethical justification of fetal tissue research based solely on the separation of the abortion and the consent to use the tissue for research is impractical and immoral, and argues against fetal tissue research.
Simmons calls Christians to carefully consider the issue of fetal tissue research and transplantation, taking into consideration the possible benefits to those suffering from disease. He also realizes the potential for excess in this arena, and reminds readers that God, not man, is "sovereign over human suffering," and that suffering like, other emotions and sensations, plays a role in our growth as humans seeking God. He calls the church to carefully consider the issue and develop a response.

"By enlisting him [the fetus] in a cause he has not made his own, and subjecting him to experiments of no relevance to his future we inflict upon him a very great wrong indeed-- and reveal something about ourselves and our vision of what is truly human and humane." Meilaender argues that by participating in fetal tissue research we do race ever faster to new cures for disease, but at a price we as a society cannot afford. He asks if we can justify the use of those too weak to defend their interests and maintain our humanity --- and concludes that we cannot. He warns of a future dystopia in which the marvels of research and technology abound, in which we have lost our humanity and our understanding of what it means to be, and have in the process become barbarians.

Bibliography

This pastor, in contrast to many Christian writers on this topic, argues for the respectful and compassionate use of fetal tissue until there is a better alternative developed.

Campbell argues against the recommendations of the Human Fetal Tissue Transplantation Research panel because it fails to take into account the "traditions of value and wisdom" of society, which he fears will bring us only "moral blunders embedded in technical wonders."

The author effectively argues against the use of fetal tissue in therapy by revealing the shortcomings of the current belief that fetal tissue is medically effective, challenging the feasibility of separating the consent for the abortion and tissue research, and argues that our support for fetal tissue research will make us more willing to support research on unwilling human subjects.

Dickens BM. The ethics of fetal tissue research: Consensus and contradiction. Canadian Medical Association Journal. 1994;151(3):279-282
The author argues against recommendations of the Royal Commission on New Reproductive technologies on the basis that they are reactionary and fail to separate the immoral abortion from fetal tissue transplantation. For example, he argues that it is impossible to separate consent for abortion from that for tissue transplantation, the bedrock of both the US and Canadian transplant guidelines, as researchers need to know about tissue availability before the abortion takes place.

The author argues that ectopic pregnancies, spontaneously aborted fetuses, and stillbirths would at best be rare and unpredictable sources of normal, viable fetal tissue. Since that availability of any tissue from these sources is unpredictable, it makes it difficult for researchers and transplant surgeons' optimal use of it when it becomes available.

This lengthy article discusses in detail the Human Fetal Transplant Research Panel report be examining in detail the arguments from different perspectives surrounding this issue. It explores the arguments made by the dissenters on the panel.

This article succinctly reviews the arguments surrounding the fetal tissue research debate.

The architecture of the fetal tissue transplant controversy is similar to that of many bioethical debates, with a novel twist because the contested status of the fetus and abortion. Respect for the needs of sick patients appears to conflict with the respect for prenatal life and larger societal concerns.

Walters argues for a uniform standard for fetal tissue research, in which the respect for life shown to the fetus to be carried to term will also be shown to the aborted fetus—that is only experiments permissible on fetuses carried to term should be performed on aborted fetuses.
Genetic Information and Manipulation Technologies

As genetic knowledge increases and technologies to manipulate genes become more powerful, our need for wisdom in application intensifies. In regard to human genetics in particular, the conditions that allow for hubris call for an even greater measure of humility.

As Christian healthcare professionals, we affirm that:

- All human beings have been individually created through the providential interest and design of Almighty God. Being created in the image of God, every human being has inestimable worth, regardless of genotype or phenotype (see CMDA statement on the Human Life: Its Moral Worth).
- The diversity of individuals is part of the wonder and strength of God's sovereign design.
- Each human life is a composite of genetic, environmental, historical, social, volitional, and spiritual factors.
- God has endowed humans with minds capable of exploring, but only partially understanding, the magnificence and intricacies of His Creation. Human knowledge and wisdom are limited and may be used for evil or for good.
- God has mandated responsible stewardship of Creation, both of ourselves and of the surrounding world.

Therefore, in regard to genetic technologies in medicine, CMDA believes:

- The presence of a disability, either inherited or acquired, does not detract from a person's intrinsic worth.
- Fallen humanity lacks the wisdom and moral restraint necessary to take control of human genetic destiny.

CMDA supports:

- The use of genetic information in guiding the care of patients.
- Strict confidentiality of an individual's genetic information, as for all personal health information.
- Healthcare professionals informing the patient with a genetic diagnosis of potential familial risk and encouraging the patient to share information about heritability risk with family members.
- Somatic cell manipulation (excluding somatic cell nuclear transfer, i.e., human cloning) to replace absent or defective genes, as this is consistent with the goals of medicine and may be good stewardship of knowledge. Such manipulation should be performed only after extensive study demonstrates the specificity, benefits, and risks of these interventions, or as part of an approved clinical trial.
- The scientific exploration of life, including its genetic foundation, as this is proper and consistent with God's mandate and humanity's created nature, but it must be conducted within the constraints of biblical principles in order to conform with God's design for human flourishing.
- Genetic testing of minors (embryos, fetuses, children), provided the result could potentially benefit them prior to majority. Because a minor is unable to give informed consent, presymptomatic testing of a minor should not be performed for disorders that will not either affect his or her health until after majority or lead to therapeutic intervention before majority.

CMDA opposes:
• The search for and use of genetic information to justify destroying an existing human life, born or unborn, for example, as has occurred with Down syndrome.
• The use of genetic information for positive or negative discriminatory purposes, including sex selection of human embryos, or infringement upon the right to procreate (see CMDA statement on Eugenics and Enhancement).
• The use of a patient's genetic information for societal benefit if such use could potentially harm that individual.
• The reductionist belief that humans and their behavior are simply the product of their genetic destiny.

CMDA is especially concerned about heritable germline or embryo manipulations, as these technologies carry a higher risk of harm and abuse than somatic cell manipulations. First, there is the potential that any errors will be transmitted to future generations. Second, germline manipulations will affect the individual for the remainder of his or her life, whereas some somatic manipulations will be self-limited in duration. Third, the proposed and desired uses of germline technologies are fraught with the strong probability of selfish, narcissistic, and eugenic goals, commodifying offspring, supporting the false concept of genetic reductionism, increasing discrimination and intolerance of the disabled, and increasing the number of early human lives being conceived, then destroyed.

While, in concept, specific single disease-producing mutations could be corrected early in life, which could be consistent with the proper goals of medicine, this process would necessarily alter the germline. Development of germline manipulation technology would irreversibly open the door to proportionately greater harms. This concern is not merely hypothetical. The proven record of maleficence by some scientists, physicians, governments, bioethicists, and social engineers in the historical record and in contemporary experience demonstrates contempt for appropriate ethical boundaries and guidelines.

In conclusion, CMDA opposes:
• All forms of human germline manipulation; these should remain prohibited.
• The use of genetic manipulation to augment human attributes (see CMDA statement on Human Enhancement).
• The deliberate use of genetic manipulation to disable or kill.

In deciding how to apply genetic knowledge in medicine, we should prayerfully seek God’s wisdom and guidance, for He is the Author of the genetic code and the Creator and Redeemer of humankind.

Unanimously approved by the House of Representatives
April 26, 2018
Ridgecrest, North Carolina
Healthcare Delivery

As Christian physicians and dentists, we believe God commands Christians to attend to health care needs of people. Jesus taught, and His life demonstrated, that caring for people includes providing for their spiritual, emotional, and physical needs. Values inherent in God’s Word and Jesus’ teaching include kindness, compassion, responsibility, impartiality, stewardship, and the sanctity of life. Therefore, Christians should work toward a system of health care delivery consistent with these values.

We affirm the following guidelines for health care delivery:

- Society as a whole should seek a basic level of health care for all.
- Purchase of additional health care not covered by the basic plan should not be prohibited.
- Public and/or pooled funds should not be used to finance the taking of human life.
- Institutions, clinicians, patients, and their families should share responsibility for good stewardship of medical and fiscal resources.
- The Christian community should share responsibility for health care, especially of the poor.
- All clinicians should strive to deliver health care to the poor.
- The clinician’s priority should be the best interests of the patient. Clinicians should not make allocation decisions at the bedside that violate this priority, nor should clinicians allow health care delivery systems to coerce them to do so. Patient care decisions should never be influenced by clinician income considerations.
- Individuals should be responsible for their own and their dependents’ health, including lifestyle choices.
- Individuals should provide for their own and their dependents’ health care to the best of their ability.

If competent physicians and dentists practice the love and compassion of Christ toward all patients, recognizing that in the eyes of God each individual has intrinsic worth, good health care delivery will be enhanced.

Approved by the House of Delegates
Passed with 79 approvals; 1 abstention.

Explanation

Background

Prior to World War II, most medical care in the U.S. was delivered by individual physicians and paid for by individual patients. Costs were not often prohibitive, physicians and patients were not very cost conscious, and most physicians were generous with the provision of reduced fee or even free care to those in need. Technological advances led to the availability of more treatments for more conditions, at increasing cost. This increasing cost, combined with the efforts of organized labor, led to the implementation of indemnity health insurance policies which continued to pay professionals on a fee-for-service basis. Most health insurance was paid for by employers. At about the same time, many physicians began to share night and weekend coverage and/or practice in groups. Medical care was more readily
available, and paid for by someone else. Both patients and physicians were perfectly happy to receive and give more medical care.

In 1966, the federal government stepped in to pay for health care for those over 65 and for the poor, still paying on a fee-for-service basis, though sometimes on a reduced scale. This led many physicians to curtail the practice of giving free care to those in need. It encouraged some patients and some physicians to overuse primary and referral services, further adding to the escalating costs.

Skyrocketing costs subsequently led to the re-structuring of healthcare finance. Prospective payment plans were instituted which often paid on a capitation basis. In effect, physicians were now rewarded for doing less. Physicians were forced to be more cost conscious, and patients often felt they were being denied care which they had been used to receiving without question.

Similar changes are taking place in the practice of dentistry.

These changes in cost and in payment mechanism have changed the patient-physician relationship. The changes have generated some new potential conflicts of interest.

**Secular Perspective**

There has been an enormous amount of public discussion of health care delivery and finance in recent years. Much of the debate has focused on economics and whether health care is a right; and if it is a right, who should be responsible for its payment. Health care has become a commodity, professionals have become "providers", and patients have become "consumers".

Secular discussion of this issue has relied primarily on the basic principles of medical ethics: non-maleficence (do no harm), beneficence (do what is good), autonomy (self-determination), and justice (treating likes alike).

**Christian Perspective**

Much of the traditional ethos of medicine can be traced back to the competence and beneficence taught by Hippocrates and the compassion demonstrated and taught by Jesus and the early Christian church. Clearly this includes more than economics and rights. Clearly it includes compassion and responsibility, as was taught by Jesus (Matthew 25:42, 45). Clearly it includes a concern about conflicts of interest; Jesus also warned that we cannot serve both God and mammon (Luke 16:13). But Christians are not unanimous on what the system should look like.

In 1997, a national conference of Christian scholars was held in Deerfield, IL to discuss issues of health care delivery from a clearly Christian perspective. That conference was jointly sponsored by The Center for Bioethics and Human Dignity, the Christian Medical and Dental Society, the Christian Nurses Fellowship, and the Christian Legal Society. The proceedings of that conference are available in a book entitled *The Changing Face of Health Care* published in 1998 by Eerdmans (U.S.) and Paternoster (U.K.). Several of the accompanying resources are taken from this book.

**Abstracts**


The author argues that the current profit driven health care system is fundamentally inconsistent with the Christian perspective of health care delivery. As Christians we are called to emulate the life of Christ and the actions of the Good Samaritan. The author believes that a system which delivers health care with scorn, disdain, and little room for the poor, the marginalized, and the undereducated is incompatible with fundamental Christian principles which value and place preference on the needs of these people. The author unequivocally states that medical knowledge is not a commodity, but a gift to be shared with Christ-like compassion and love.

Pellegrino argues that by placing a priority on profit over charity, and investors over patients, we so fundamentally skew the relationship between healer and healed, that we risk destroying the foundations
that our faith plays in our practice of medicine. He vigorously urges Christian health care professionals to refuse to participate in health care schemes (including cost containment) that overthrow the supremacy of the patient's needs. "There may well be times in this era of commercialized medicine when all physician, nurses, and especially those who are committed Christian will have the responsibility of collective refusal to serve the plan." His arguments against managed care are not based on opposition to the efficiency drive which is presumably central to managed care schemes. In fact, he argues that efficiency is central to being able to provide the most service to as many people as possible.

Dougherty CJ. Ethical values at stake in health care reform. JAMA. 1992;268(17):2409-12

The author argues that a universal health plan would satisfy six key ethical shortcomings not being addressed by the current health care system. He states that both our Judeo/Christian heritage and post-enlightenment concepts of the dignity and intrinsic value of each individual compels us to provide a basic level of health care to all. He believes that providing a basic level of care to all will allow us to address the problem of the uninsured, and it will revive the now strained patient-physician relationship. The author further states that such a system will improve the common good and streamline administration, thus containing costs and simplifying organization.

Moore GT. Let's provide primary care to all uninsured Americans - Now! JAMA. 1991;265(16):2018-9

Moore implores Americans to give up attempting to provide all costly and specialized health coverage in a universal health plan, and simply provide much needed primary care coverage to all. The author states that it is not feasible to provide universal access to the most expensive and advanced health care system in the world. He says that by providing everyone with access to primary care physicians, measures can be taken to prevent disease and necessary expensive procedures can be provided to the poor through charity.

Council on Ethical and Judicial Affairs, AMA. Caring for the poor. JAMA. 1993;269(19):2533-8

This report outlines the traditional responsibility that physicians have had for taking care of the poor, the historical shift of this responsibility from private charity to the national government, and the shortcomings of the current system. Recognizing the extraordinary privilege the practice of medicine is, and the immense social cost involved in the training of physicians, the Council call physicians to return to the practices of yesteryear --- providing 50 hours of free charity care to the poor (versus debt forgiveness). Furthermore, it asks leaders in the field to provide better systems by which physicians can serve the needs of the poor.


The author examines the biblical commands on justice, and concludes "there is the basic equality and dignity of every human being, founded in their common origin, and their shared states as the bearers of God's image and the subjects of God's care". In addition, as stewards of God's material realm, we have a responsibility to ensure that, regarding the basic needs of life, there is not an extreme disparity between those with the most and those with the least. She laments that we are the only major industrialized democracy does not provide universal coverage to all of its citizens, which she believes is the best way to provide coverage to the poor. The author then urges us to be careful stewards of scarce medical resources, not by judging the merits of individual lives (microanalysis), which she believes Christians cannot do by the virtue of their faith, but by carefully controlling large scale expenditures of these resources (macroanalysis).


Rutecki details the differences in care for different socioeconomic groups and health care programs (HMO, PPO, etc.). He argues that the relationship between physician and patient is above that of the contract, and is covenantal. In this light, he believes that the physician's primary responsibility is to the patient, not to society. He advocates the "unswerving commitment" of the physician to the patient, increased activism on the part of physicians, and increased access to physicians for the poor.
Buckley reviews the current state of affairs in the managed care arena, and finds provisions of managed care to be "a direct threat to Christian and Hippocratic traditions of healing." He worries about the precedence that economics takes over ethics, and the development of two classes of patients, those of HMOs, and those with fee-for-service plans. He reiterates earlier calls for the primacy of the patient, and calls Christian physicians to "work for the reformation of managed care as it exists now in its formative stages."


The author argues that health insurance in the United States is driven by competitive risk rating and is promoted in ways to give policyholders optimal value for their money and to be fair to those of lower risks. He finds that in practice however, competitive risk rating costs more than noncompetitive universal health insurance, and it erodes the basic goal of spreading large losses over a wide base. This article describes not only how risk rating covers least those with the greatest medical bills, but also how it has spawned a labyrinth of complex manipulations by insurance companies to charge more or pay less than actuarily fair risk would justify. The final section shows that even if risk rating were done fairly, it contradicts moral fairness. Many of the leading proposals do not discuss these practical and ethical issues. The medical profession and policymakers need to discuss them and take a stand on them.


The author believes that our humanistic culture greatly over-values medical care. He discusses the question whether medical care is a basic right. He states that individuals and families should bear the cost of health care primarily, although he recognizes that this financial burden has increased so that it is beyond the means of almost all families. The church, rather than the government, should be the primary backup for this short-fall. However, he does not call for the immediate cessation of government welfare; the burdens would be too great. He does believe that our biblical goal should be to transfer welfare programs from the state to those upon whom God has placed the obligation.

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Lundberg GD. Fifty hours for the poor. JAMA; 258(21): 3157

The editors of JAMA and the ABA Journal urge physicians and lawyers to return the gifts and the respect society has bestowed upon them by providing 50 hours of free service to the poor.


The author advocates for a managed-competition, single-payer health care system.


The American College of Physicians proposes and discusses in detail a national universal health program.

Eddy DM. What do we do about costs? JAMA. 1990;264(9):1161-70

The author calls us to recognize the costs of our health care, and openly and honestly discuss methods and practices to lower these costs.


The authors argue for the elimination of trade secrets and gag rules from managed care because of the ethical problems inherent in them.

The Council advocates a universal health care, citing ethical precedence for such, with provisions for the purchase of additional coverage beyond the basic plan.


Universal Coverage and Individual responsibility are advocated in a plan which embraces the free market via the 'managed competition' plan.


This study finds that the poor are more susceptible to substandard medical care.


The author explores the ethical issues that confront physicians faced with treating patients who have insufficient financial resources, including a comparison of the way law and ethics interpret the physician-patient relationship.

Ashley BM, O'Rourke KD. Personal responsibility for health. Chapter 3 in Healthcare Ethics: A Theological Analysis. St. Louis, MO: Catholic Hospital Association, 1989

After explaining in earlier chapters that the community is responsible for the full personal development of each individual, including his health, the authors state that the primary responsibility for a person's health belongs to the individual. They explain the implications of this responsibility for daily life as well as the meaning of stewardship.
Healthcare Education and the Christian Faith

Education in the healthcare professions presents particular challenges in combining education, the profession, and the care of the patient. Christians in healthcare education should look to their faith for support and guidance in addressing these issues.

Healthcare Trainees:
Medical and dental students and residents are partially trained healthcare professionals. Christian healthcare trainees are subject to the same standards and guidance as are fully trained Christian healthcare professionals (see Ethics Statement*).

All authority is established by God. Healthcare trainees should respect the authority of attending clinicians and others responsible for patient care. In situations where there is a difference of opinion between a trainee and those professionals in authority, excluding matters of conscience, the trainee should respectfully state his or her opinion and reasons, and should then honor the final decision of the person in authority. If the trainee believes a patient may be harmed by the decision, he or she should tactfully seek counsel from one or more experienced professionals.

Professional trainees should not place a patient at physical risk for the sake of learning, but should seek supervision from others with more experience or knowledge, when appropriate. They should not put themselves at moral risk, but rather graciously decline to participate in any aspect of training or patient care which would violate their conscience.

Healthcare in a teaching setting requires cooperation and communication among many members of the professional team. This presents unique challenges for the trainee in regard to patient privacy and confidentiality. Special efforts must be made in such settings to retain and demonstrate the highest respect for patients.

Trainees should be honest with patients about their level of training; e.g. medical and dental students must not introduce themselves to patients as "Doctor". They should likewise be honest with their professional colleagues and in matters of documentation, never compromising their integrity for the sake of being a "team player". They need to be honest with themselves and with those to whom they report when they make mistakes.

Healthcare Educators:
Clinicians involved in the training of medical and dental students and residents should exert proper supervision and authority without physical, emotional, or sexual abuse. Trainees should be treated with courtesy and respect at all times and should not be asked or expected to expend themselves to the point of endangering patients or of damaging their personal or family lives. Conversely, the teacher should model balance in their personal and professional lives and assist the trainee in establishing the same. Christian healthcare educators should model the demeanor of Jesus in His teaching and ministry.

Residents and students should be trained in all aspects of the well-being of their patients, including physical, mental, emotional, social, and spiritual aspects of health.

The teacher should ensure that the patient's care is not compromised by the inexperience of the trainee.
If a trainee in the healthcare professions expresses an unwillingness to participate in an aspect of training or patient care as a matter of conscience, that stance should be explored in a non-judgmental manner to ensure that both parties fully understand the issue. The trainee's position on matters of conscience should be honored without academic or personal penalty.

Healthcare trainees and educators should work together with compassion, competence and integrity to enhance patient care and to strengthen professional standards. Following the model of our Lord Himself in equipping and sending disciples, health care education should ensure the excellence of future practitioners and educators.


Approved by the House of Delegates
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Healthcare Education and Christian Faith

Background

Education in medicine and dentistry has traditionally consisted of several years of rigorous study and supervised practical experience. The primary goal has been to prepare students to be competent and caring professionals. The importance of this goal has led educators to insist on high standards of performance and to expect personal sacrifice from trainees.

Increasingly complex technology, an expanded knowledge base and a broader scope of healthcare have resulted in a vast amount of material that must be available to healthcare trainees and practitioners. Tensions are not uncommon in healthcare education because of the increased demands on trainees and the lofty expectations of the educators, along with an increased assertiveness of contemporary healthcare trainees as compared to their predecessors of earlier generations. These tensions have regretfully led to occasional instances of strained relationships, even to instances of alleged, perceived or real student abuse or harassment. In an effort to motivate students to excel, educators have on occasion publically degraded or humiliated those who they judge are inadequately prepared or behaving inappropriately.

At the same time, there is a new awareness that other tensions may arise in healthcare education from ethical issues which arise specifically because healthcare trainees are only partially trained, e.g. conflicts of interest between doing what is best for the patient and what is best for one's own education, truth-telling about one's level of competence and experience, cooperation with other professionals when one's own values are challenged, etc.

Secular perspective

Health professional educators have responded to these changes with curriculum revisions and an increased focus on teaching students efficient means of information acquisition, management, storage, and retrieval. Even with these changes, they have continued to insist on high standards of performance from trainees. The development and nurture of professional values requires mutual respect between student and teacher. Such trust is difficult or impossible if the educational environment is one of tension, disrespect, or abuse. While teachers do have the responsibility to motivate and correct students, when correction of an individual is needed, this should be done in private and in a way which does not show disrespect for him or her as a future colleague.
An important part of the teaching of mutual respect among professionals is the perception of students as they observe faculty in their interactions with each other. Therefore faculty should be models of professionalism in all of their interactions and should avoid inappropriate behavior or mistreatment of other professionals and staff. This includes the avoidance of derogatory remarks about or attitudes toward individual colleagues, services, or departments.

Students also learn professional behavior and demeanor by observing their teachers as they interact with patients. Such professional interactions should always be courteous and respectful. Respect for individuals includes, but is not limited to, such things as punctuality, thoughtfulness, mindfulness of personal space, as well as manner and mode of address, appropriately modest draping, tone and content of verbal interchanges, and body language. In addition, discussion of patients out of their hearing should continue to show the same degree of respect and should not include contemptuous, derogatory, judgmental or demeaning remarks.

In response to the above-mentioned tensions in professional education, in 1999, the Liaison Committee on Medical Education (formed in 1942 by the AMA Council on Medical Education and the Association of American Medical Colleges to establish standards for and accredit U.S. and Canadian medical schools) mandated that every medical school establish policy and procedure related to standards of conduct in the teacher-learner relationship, including issues of student mistreatment. In addition, some state legislatures have enacted laws limiting the number of hours that professional trainees are allowed to be on duty.

**Christian Perspective**

Christian trainees and educators have not been able to avoid these changes and tensions. However, in addition to the professional values and traditions, they have biblical principles and teachings to give guidance and to assist in the resolution of these tensions.

Christian educators are committed to many fundamental values such as: compassion, integrity, excellence, freedom, justice, purity/self-control, and humility. These values may occasionally be formally taught by faculty, but more often are learned informally by students through observation of models of professional behavior toward students, colleagues, and patients.

Christian students in the healthcare professions should likewise model attitudes, words and deeds consistent with those taught by Jesus Christ.

**Abstracted Articles:**


"The thesis that medical students become more cynical than students of other professions seems justified in light of psychological studies and reports from medical students. This article explores whether this might be due, in part, to disappointment about how important ideals are followed. Psychological tests themselves offer an opportunity to examine this, because the medical profession espouses the goals of gaining proper consent from all subjects, including students, and of giving appropriate attention to excellence of research design and method. When studies used to evaluate medical students' attitudes are viewed from this perspective, however, weaknesses on both scores seem apparent. Students seem well aware of some of these flaws. Although such testing is a small part of medical education, it confirms students' views that there is cause for disillusionment about how certain goals are realized. It also suggests a way to cure some students' cynicism. Students should be taught consistently, both by example as well as by precept of their profession's sincere commitment to professed goals. In practical terms this means, for example, that studies using students as subjects should have a proper review by the institutional review board, with adequate attention given to excellence of design, confidentiality, and methods of gaining informed and unpressured consent. Such studies could then serve as paradigms to students. Other goals of the profession should also be applied to students, and applied for students."


"In a survey of the incidence, severity, and significance of medical student abuse as perceived by the student population of one major medical school, 46.6% of all respondents stated that they had been abused at some time while enrolled in medical school, with 80.6% of seniors reporting being abused by
the senior year. More than two thirds (69.1%) of those abused reported that at least one of the episodes they experienced was of 'major importance and very upsetting.' Half (49.6%) of the students indicated that the most serious episode of abuse affected them adversely for a month or more; 16.2% said that it would 'always affect them.' Students identified various types of abuse and proposed a number of measures for the prevention and management of abuse in medical school. We conclude that medical student abuse was perceived by these students to be a significant cause of stress and should be a major concern of those involved with medical student education.


"Senior students at 10 medical schools in the United States responded to a questionnaire that asked how often, if ever, they perceived themselves being mistreated or harassed during the course of their medical education. Results show that perceived mistreatment most often took the form of public humiliation (86.7%), although someone else taking credit for one's work (53.5%), being threatened with unfair grades (34.9%), and threatened with physical harm (26.4%) were also reported. Students also reported high rates of sexual harassment (55%) and pervasive negative comments about entering a career in medicine (91%). Residents and attending physicians were cited most frequently as sources of this mistreatment. With the exception of more reports of sexual harassment from women students, perceived mistreatment did not differ significantly across variables such as age, sex, religion, marital status, or having a physician parent. Scores from the 10 schools also did not vary significantly, although the presence of a larger percentage of women in the class appeared to increase overall reports of mistreatment from both sexes."


It seems that we have medical education pretty well figured out. Two years of basic sciences, two years of clinical experience, a minimum of three years of residency training and then one is a full-fledged doctor with all the requisite knowledge and responsibilities. But there are those who don't quite fit into the system mold, those who need extra help or more attention along the way. The author recalls two students that the system failed, instances that he calls "medical malpractice." The problem, the author argues, is that although teaching is billed at high priority, in reality it is on the back burner. "Part of the arrogance of medicine is the idea that receiving an MD degree means acquiring an instant ability to teach. Teaching requires instruction in education techniques. Teaching takes personnel, time and money. But when the faculty's primary obsession is whether that NIH grant is coming through to pay their salaries or whether their latest article has been accepted so that they can get tenure, teaching will never get the time it deserves." The author concludes, "I am not sure how best to do the teaching, nor so I know who is best qualified to teach. But I am sure of one thing: the present clinical clerkship and residency system of laissez-faire/sink-or-swim is outmoded and amounts to education malpractice."


"Any vice practiced often enough and by enough people soon becomes the moral norm." With this statement, the author begins a discourse on cheating and its consequences, the practice of which has almost become ingrained in medical school. Citing some of his experiences with medical students, the author deplores this trend stating that, "such widespread tolerance of dishonesty in future physicians is disquieting indeed." After analyzing the moral deficiency of the most common arguments for cheating, the author suggests several solutions. He concludes, "acceptance or indifference is not tolerable in preparation for a profession in which fidelity to trust is a major obligation."


"A survey was used from 1983 through 1990 in a required first-year course, Ethics and Medical Care, at The Johns Hopkins University School of Medicine, to explore where students drew the line about moral issues. Starting in 1988, a similar questionnaire was administered to each class of fourth-year medical students. This report summarizes the students' attitudes- reported anonymously in both surveys- regarding circumstances under which they would perform or refer for an abortion. Attitudes towards abortion changed little in four years. Comfort levels with patient referral were greatest when the life of the mother was threatened and in the case of rape. Students' attitudes correlated most strongly with personal beliefs about when a fetus was considered a human life and less so with students' genders. The first-year survey results were shared with the students in the course's annual sessions on abortion in order to aid
them in understanding the assumptions underlying ethical dilemmas surrounding abortion and to make visible the class's moral pluralism on the subject. The survey also helped them determine their tolerance, if any, for patients' views or actions that conflicted with their personal moral stances."


"During medical training students and residents reconstruct their view of the world. Patients become bodies; both the faults and virtues of the medical profession become exaggerated. This reconstruction has moral relevance: it is in part a moral blindness. The pain of medical training, together with its narrowness, contributes substantially to these faulty reconstructions. Possible improvements include teaching more social science, selecting chief residents and faculty for their attitudes, helping students acquire communication skills, and helping them deal with their own pain. More importantly, clearer moral vision requires time and scope for reflection."


"Many existing ethics curricula fail to address the subtle yet critical ethical issues that medical students confront daily. The authors report on the kinds of dilemmas students face as clinical clerks, using cases that students submitted in 1991-92 during an innovative and well-received ethics class given at a tertiary care hospital as part of the internal medicine clerkship. Analysis of these cases reveals that many dilemmas are intimately tied to the student's unique role on the medical health care team. Recurring themes included the student's pursuit of experience, differing degrees of knowledge and ignorance among team members, and dealing with disagreement within the hierarchical authority structure of the medical team. The authors conclude that some components of ethical education must be participant-driven and developmentally stage-specific, focusing more attention on the kinds of ethical decisions made by medical students as opposed to those made by residents or practicing physicians."


"Medicine endorses a code of ethics and encourages a high moral character among doctors. This study examines the influence of medical education on the moral reasoning and development of medical students. Kohlberg's Moral Judgment Interview was given to a sample of 20 medical students (41.7% of students in that class). The students were tested at the beginning and at the end of their medical course to determine whether their moral reasoning scores had increased to the same extent as other people who extend their formal education. It was found that normally expected increases in moral reasoning scores did not occur over the 4 years of medical education for these students, suggesting that their education experience somehow inhibited their moral reasoning ability rather than facilitating it. With a range of moral reasoning scores between 315 and 482, the finding of a mean increase from first year to fourth year of 18.5 points was not statistically significant at the P < 0.05 level. Statistical analysis revealed no significant correlations at the P < 0.05 level between the moral reasoning scores and age, gender, Medical College Admission Test scores, or grade point average scores. Along with a brief description of Kohlberg's cognitive moral development theory, some interpretations and explanations are given for the findings of the study."


Although sexual harassment has been increasingly recognized in the medical field, "there is little information on the prevalence of this problem and whether it is adequately addressed by training institutions." The authors undertook to examine this problem by surveying internal medicine residents in a university training program. 73% of the female respondents and 22% of the male respondents reported "at least one during their training. The women were more likely than the men to have been physically harassed, and the women's harassers were of higher professional status." The authors conclude, "Many medical trainees encounter what they believe to be sexual harassment during medical school or residency, and this often creates a hostile learning and work environment. Training institutions need to address the adverse effects this may have on medical education and patient care."

In this study, the authors sought to "investigate the association between attitudes toward caring for the medically indigent and years of medical training." They compared the attitudes between first year medical students (MS-Is) and fourth year medical students (MS-IVs) through questionnaires at Southwest Medical School. They conclude, "The MS-IVs are less favorably inclined toward caring for the medically indigent than MS-Is, though these differences are apparent only for males. Further research is needed to explore why females appear to be more resistant to attitude changes, and what educational interventions are necessary to better train physicians to respond to national health care issues."


One oft quoted maxim of medicine is "First do no harm". The author proposes another- the Socratic maxim: "Primum non tacere. First do not be silent" particularly to students. As an clinical clerk, a student may feel intimidated into not asking questions or pointing out things relevant to patient care. The author argues that this is not acceptable to either the student or the patient. The benefit to the patient of a student speaking up is obvious and the benefit of speaking up to the student is no less important. "It is the work of medical students to acquire the knowledge, skills, and habits that good physicians need. To acquire these skills and habits, and even this knowledge, it is not enough for students passively to observe medical practice and to note what they will do when they are full-fledged physicians....Habits of reflection, character, and intervention need to be developed and exercised if they are to be ready-at-hand in the future." The author cautions that medical students are not the only ones that need to speak up. "Speaking up is a problem for everyone in medicine, and those with more power and authority have a greater obligation to confront the problem." He concludes, "I guess I am really suggesting that the practice of medicine needs to become more Socratic. Perhaps medicine could not function if everyone acted like Socrates- perhaps there would be too much discussion and too little patient care. Yet I believe that medicine could function quite well if everyone were a little more Socratic, a little more willing to raise questions about what is right and good."


There are special ethical dilemmas that students confront when they enter the hospital as clinical clerks. The authors had a good look at what these dilemmas are and how they affect the personal ethics of students as they functioned as fourth-year preceptors of an ethics mini-course that all students took during their first clinical rotation in internal medicine. Pressed from above by superiors and an hierarchal social structure, and from inside from a desire to learn and from outside by the needs of patients, a student must balance his own place on the medical team with feelings of inadequacy and fear added to the personal beliefs and ideals brought to the hospital setting. This, the authors found out, is what shapes medical student ethics to be uniquely its own. With in-depth discussions of clinical vignettes, this article is a well written first-hand look into the world of the medical student. In conclusion the authors point out the lack of adequate ethics training and "the need to move beyond static conceptions of 'core values'...Essentially we are arguing that medical ethics education must consider the meandering and arduous journey that students make on their way to becoming ethical physicians- that the nature of this odyssey will shape the kind of doctors they will become. Too much discussion currently focuses on issues relevant to the destination; more is needed on the challenges posed by the trip itself. By attending to the experiences, high and low, that makes up the daily rounds of clinical clerks, and by caring as much about their ethical as their intellectual development, perhaps medical education could help students to complete the journey with their humanity and compassion intact."


During clinical clerkships, students may be exposed to situations in which either they feel an obligation to participate in a believed unethical act or they observe an unethical act performed by superiors. The authors undertook to study how "clinical students perceive their ethical environment, their feelings about their dilemmas, and whether these dilemmas erode students' ethical principles" by mailing surveys to third
and fourth year students in Pennsylvania. Over half of the students who responded (58%) reported having done something they believed was unethical with 62% believing "that at least some of their ethical principles had been eroded or lost." Also, "students who witnessed an episode of unethical behavior were more likely to have acted improperly themselves for fear of poor evaluation." These students were twice as likely to report ethical erosion. The authors conclude, "The ethical dilemmas that medical students perceive as affecting them while serving as clinical clerks are apparently common and often detrimental, and warrant the attention of physicians, educators, and ethicists."


The quality of medical education is largely dependent upon the relationships between medical students, residents and their supervisors. Thus, open and honest communication is necessary in fostering an environment conducive to learning. "Many of the sources of conflict between supervisors and medical students, resident physicians, and other staff can be avoided through open, ongoing communication....Addressing the concerns that cause disputes between trainees and supervisors, through adequate communication and the promotion of clear standards of ethical conduct, will avoid situations in which minor concerns develop into serious problems." This article, put out by the Council on Ethical and Judicial Affairs from the American Medical Association, discusses two issues- "handling disputes between medical supervisors and trainees through grievance and disciplinary committee proceedings," and "disputes that cannot wait for resolution through traditional committee procedures." It ends with guidelines for dealing with disputes.


The author, a student at the time of this writing, attending Mount Sinai School of Medicine, submitted this essay in response to the John Conley Foundation essay contest entitled "How can medical students best develop ethical thinking and behavior?" In this paper he calls for medical schools to take a rigorous approach towards teaching medical ethics and integrating it into the pre-clinical and clinical years. Specifically, he proposes two initiatives: (1) putting ethics on the Boards; (2) establish an ethics department at every medical school. "The first step would make medical schools want to teach ethics. The second would give them the necessary means to do so."


There are many diverse bodies of opinion regarding medical ethics. Some think of medical ethics as a "morally-neutral activity", in which medicine is regarded like science and where the ethics of individual practitioners count. However, the author argues that medicine is inherently ethical and "in this understanding of medicine medical ethics is regarded as a medically based ethic." Today's legal environment has created "two strands of medicine, a conscience governed medicine, and a law governed medicine, whereby the truly ethical self-governed medicine has disintegrated." In view of this, the author has proposed teaching medical ethics in the Hippocratic tradition. She focuses in particular on the third paragraph which, in her words, "reveals to us in a nutshell, the core of medicine, and so, the core of the Hippocratic ethics." After analyzing its core points, she concludes, "The Oath, by upholding and invoking justice, recognizes and upholds an unconditional respect for the sick and for the physicians' professional and moral integrity....Here, in my view, we could find the seed of that non-discriminatory and universal concern for the sick and injured that medicine upholds."


Various medical organizations have put out ethical guidelines, including the American College of Physicians (ACP) in its ACP Ethics Manuel, and the authors of this study attempted to determine whether its members were aware of the guidelines and if they followed them. Surveys were mailed to a random sample of 1000 associates of the ACP (mostly internal medicine residents) and 40% completed the questionnaire. Only 17% were aware of the guidelines on ethics and "on average, associates responded yes to 16% of questions where a yes response indicated they have acted outside guidelines on ethics one or more times." The authors conclude, "Few responding ACP associates indicated awareness of the ACP guidelines on ethics. Physicians in training nevertheless reported acting according to the presented
guidelines most of the time...Physicians in training need to know more about ethical standards that apply to their own practice and should be aware when their actions deviated from ethical norms. Before acting outside guidelines on ethics, trainees should discuss their conflicts with others, such as attending physicians, clinical ethicists, or hospital ethics committees."


"The upsurge in formal medical ethics training stems from the desire for more compassionate, less 'dehumanized' physicians who can competently face the ethical dilemmas posed by technologic advances and resource constraints. How best to encourage ethical thinking and behavior among medical students remains an open question. However, the authors argue that medical ethics education suffers from an overreliance on strategies that target ethical thinking, with relative inattention to students as ethical actors in specific clinical contexts. In order to produce ethically competent physicians, medical educators must not only teach students to understand and learn from the dilemmas that shape their moral world but also train them to respond to those dilemmas appropriately. The authors discuss current practices in ethics education and how traditional approaches may not equip students with the types of moral 'navigating skills' they need to become ethical physicians. They illustrate how medical students can and do learn norms of ethical behavior on the wards and argue why medical education ought to focus more explicitly this aspect of clinical training. They conclude by recommending ways medical educators can encourage ethical thinking and behavior throughout the entire course of medical training."


The medical school experience often leads a student to develop an attitude more cynical than when one started. Termed "traumatic deidealization" this cynicism has been documented. However, "no previous studies reporting cynicism in medical students have employed an empirically validated instrument that measures cynicism specifically in the medical domain." The authors developed the Cynicism in Medicine Questionnaire and gave it to medical students, residents and faculty to fill out. Using the results, they compared two different previously proposed models on how cynicism develops in students. They found that medical students were the most cynical, with a decline through residency to the lowest levels found among faculty physicians. They conclude, "The data support our proposed 'professional identity' model, which attributes cynicism among medical students to their struggle to develop coping skills while trying to survive the complex challenges of the medical education environment. Medical students begin their training with altruistic motives and idealized concepts of health care. As inexperienced and powerless members of the health care team, however, students may develop cynicism as a means to manage their environment....As physicians-in-training develop greater confidence and skills and achieve greater status in the health care team, they become more adept at tolerating ambiguity, synthesizing information, and analyzing ethical situations. In achieving this balance, they become less cynical and more optimistic in their professional identities." 


"Persons concerned with medical education sometimes argued that medical students need no formal education in ethics. They contended that if admissions were restricted to persons of good character and those students were exposed to good role models, the ethics of medicine would take care of itself. However, no one seems to give much philosophic attention to the ideas of model or role model. In this essay, I undertake such an analysis and add an analysis of role. I show the weakness in relying on role models exclusively and draw implications from these for appeals to virtue theory. Furthermore, I indicate some of the problems about how virtue theory is invoked as the ethical theory that would most closely be associated to the role model rhetoric and consider some of the problems with virtue theory. Although Socrates was interested in the character of the (young) persons with whom he spoke, Socratic education is much more than what role modeling and virtue theory endorse. It -that is, philosophy- is invaluable for ethics education."

How much does lack of sleep really affect one's cognitive skills? In this study, the authors set out to compare the effects of lack of sleep against the effects of alcohol, a known and measurable quantity. They found that after 17 hours of sustained wakefulness "cognitive psychomotor performance decreased to a level equivalent to the performance impairment observed at a blood alcohol concentration of 0.05%" and after 24 hours of sustained wakefulness "cognitive psychomotor performance decreased to a level equivalent to the performance deficit observed at a blood alcohol concentration of roughly 0.10%." The authors conclude, "Our results underscore the fact that relatively moderate levels of fatigue impair performance to an extent equivalent to or greater than is currently acceptable for alcohol intoxication."


Although the origins of the Hippocratic Oath is disputed, few would contradict the fact that it has been a major force in shaping the ethical nature of medicine. With the rise of ethics as a discipline, debate now centers on "whether the Hippocratic Oath or newer alternatives oaths are preferable statements of the ethical basis of modern medicine." Research by these authors show that while the tradition of administering an oath to graduating medical students "has steadily increased during this century", the content of the various oaths administered differ both from one to another and from then to now. In order to study how the contents of oaths administered differ, the authors mailed surveys to all the schools in the U.S. and Canada in 1993. Out of the 150 schools that responded, only one still used the classical version of the Hippocratic Oath, while 68 other schools (46%) used some other form of it. Excepting for three schools (2%) that didn't administer oaths, the rest of the schools used an alternative oath. In analyzing the content of the different oaths, the authors found that "When compared to the contents of the classical Hippocratic Oath, currently used oaths are less likely to agree to be accountable, invoke a deity, or foreshow euthanasia, abortion, or sexual contact with patients." They concluded, "We document with some concern this dilution of the core values of Hippocratic medicine."


"The author begins his essay by discussing George Elliot's novel Middlemarch, in which a doctor, early in his career, wanders from his idealistic commitment to serving the poor. Although he establishes a prominent practice, he considers himself a failure because 'he had not done what he once meant to do.' The essay explores how many of us (physicians included) forsake certain ideals of principles- not in one grand gesture, but in moment-to-moment decisions, in day-to-day rationalizations and self-deceptions, until we find ourselves caught in lives whose implications we have long ago stopped examining, never mind judging. Medical education barricages students with information, fosters sometimes ruthless competition, and perpetuates rote memorization and an obsession with test scores- all of which stifle moral reflection. Apart from radically rethinking medical education (doing away with the MCAT, for example, as Lewis Thomas proposed), how can we teach students to consider what it means to be a good doctor? Calling upon the work of Eliot, Walker Percy, and others, the author discusses how the study of literature can broaden and deepen the inner lives of medical students and encourage moral reflectiveness."


Many studies have been done regarding the first year of residency or internship in terms of income and long hours, but these have "shed little light on how residents view their training experience." The authors undertook to randomly survey 10% of all second-year residents listed in the American Medical Association's medical research and information database on six criteria in order to learn more about the internship experience. They conclude, "Residents report significant problems during their internship experience. Satisfaction with internship is enhanced by positive learning experiences and lack of mistreatment."


As medical students approach their clinical years, there is often a temptation to misrepresent oneself as
"Doctor". A serious ethical dilemma for students, this article analyzes the assumptions that could lead a student to rationalize deception, identifies the underlying problem and then proposes appropriate solutions. The authors conclude, "The goals of adequately informing the patient and receiving adequate medical training are not mutually exclusive; quite the contrary, adequately informing and communicating honestly with the patient provide the integral foundation on which clinical training, patient interaction, and ethical awareness are built."

Bibliography


The Libby Zion case unleashed a storm of fury and fault-finding, two of the targets being residents' work hours and adequate supervision of house officers. In its Sounding Board section, the NEJM published four articles from five doctors analyzing and proposing solutions to the problems that conceivably led to this tragedy.


In this article the author points out the shortage of physicians in rural and inner city areas and blames medical education and residency training for discouraging "physicians from becoming seriously involved with health care for the poor." He concludes by outlining remedies for overcoming the common obstacles posed to students, residents and doctors who want to practice in an underserved area.


Using Loma Linda University's mentoring program as an example, David Beibel describes the need for Christian physician mentors. He goes on to outline the underlying principles of an explicitly Christian mentoring program, stressing one not need be part of an established program to make a difference in a medical student's life.
Healthcare Right of Conscience

Respect for conscientiously held beliefs of individuals and for individual differences is an essential part of our free society. The right of choice is foundational in our healthcare process, and it applies to both healthcare professionals and patients alike. Issues of conscience arise when some aspect of medical care is in conflict with the personal beliefs and values of the patient or the healthcare professional. CMDA believes that in such circumstances the Rights of Conscience have priority.

Patient’s Right of Conscience:
- The right of competent patients on the basis of conscience to refuse treatment, even when such refusal would likely bring harm to themselves, should be respected.
- The right of competent patients on the basis of conscience to refuse treatment, when such refusal would likely threaten the health and/or life of others, should be resisted and should become a matter of public interest and responsibility.
- The right of a healthcare surrogate on the basis of conscience to refuse treatment, thereby threatening the health and/or life of another, should be resisted and should become a matter of public interest and responsibility.

The Healthcare Professional’s Right of Conscience:
- All healthcare professionals have the right to refuse to participate in situations or procedures that they believe to be morally wrong and/or harmful to the patient or others. In such circumstances, healthcare professionals have an obligation to ensure that the patient’s records are transferred to the healthcare professional of the patient’s choice.

The Healthcare Institution’s Right of Conscience:
- Healthcare institutions have the right to refuse to provide services that are contrary to their foundational beliefs.
- Healthcare institutions have the obligation to disclose the services they would refuse to give.
- Healthcare institutions should not lose public funding as a result of exercising their right of conscience.

Healthcare Education Right of Conscience:
- Institutions, educators and trainees should be allowed to refuse to participate in policies and procedures that they deem morally objectionable without threat of reprisal.
- Healthcare professionals at all levels should seek to learn about and understand policies and procedures that they deem morally objectionable.
- No organization or governing body should mandate participation in policies or procedures that violate conscience.
CMDA believes Christian healthcare professionals in our society should give dual service* to a Holy God and the humanity He created and sustains. We believe the Christian healthcare professional’s conscience should be informed by available evidence and Scripture. We believe obedience to conscience is obligatory for all Christians.

*See statement on Moral Complicity with Evil.

Approved by the House of Representatives
Passed with 53 approvals; 2 abstentions.
Homosexuality

CMDA affirms the long-accepted and widely held Christian teaching that the appropriate context for sexual relations is solely within marriage, defined as a consensual, exclusive and lifelong commitment between one man and one woman. This is the view reflected throughout the Bible and in Christian texts of all denominations—Protestant, Catholic, and Orthodox—throughout their history and, until recently, a view that was universal and uncontested among Christians. Commitment to this historic Christian view of sexuality benefits individuals, families, and all society.

CMDA recognizes that many individuals experience or struggle with same-sex attraction. In these matters CMDA distinguishes homosexual thoughts and desires from willful homosexual behaviors.

CMDA also recognizes that, in recent years, there has been a sea change in cultural acceptance and legal recognition of homosexuality, including voices that celebrate it and seek to make it conventional. These factors have placed Christian healthcare professionals in the position of being at variance with evolving views of sexual choices and behaviors that may be socially approved but which are contrary to a Christian worldview. Whereas the shift in cultural mores has been rationalized by a strong emphasis on the freedom of personal choice, CMDA believes that personal autonomy is not an absolute principle but one that must be weighed alongside other relevant moral principles. In matters of sexuality the broader impact of individual choices should be considered.

Because we are guided by Christ, who assisted all who sought his help regardless of sexual or social status, CMDA affirms the obligation of Christian healthcare professionals to care for all patients in need, regardless of sexual orientation, gender identification, or family makeup, with sensitivity and compassion, even when we cannot validate their choices.

Recognizing that sexuality has not only bodily but also moral and spiritual significance, CMDA views homosexuality within the following framework:

A. Biblical
1. All people are loved by God (John 3:16-17).
2. All struggle with moral failure and fall short of God’s standards (Romans 3:10-12) and, therefore, need the forgiveness that God provides through Christ alone (John 3:36; Romans 3:22-24; Colossians 1:15-23; 1 Timothy 2:5-6).
3. The moral authority of the Bible in matters of sexuality rests in God, who inspired and reliably guided its human authors (Joshua 1:8; Matthew 5:18, 24:35; Luke 16:17; 1 Thessalonians 2:13; 2 Timothy 3:16; Hebrews 4:12; 2 Peter 1:21). The moral teachings of the Scriptures are trustworthy (Psalm 119:86a; John 17:17b), beneficial (Deuteronomy 30:19; Psalm 119:105,133; Luke 11:28), and true for all times (Psalm 119:89; Isaiah 40:8; Hebrews 13:8).
4. We live in a fallen world (Genesis 3), and we are all fallen creatures with a sinful nature (Romans 3:9-12). The fall is expressed in nature and in humanity in many ways, including sexuality. Same-sex attraction is but one example of the fall, as are also extramarital sexual attractions among heterosexuals, all of which, if indulged, lead to adverse consequences (Romans 1:24-32; Ephesians 5:3).
5. Having homosexual thoughts or desires is not itself sinful, but by acting on them one assumes moral responsibility. A lifestyle that is directed by pursuing sexual desires or governed by personal sexual fulfillment misses the divinely ordained purpose of sex, which is for procreation and for facilitating unity in the lifelong commitment of marriage between one man and one woman, which fosters a secure and nurturing environment for children and which reflects the unity of Christ and the church (Exodus 20:1-18; Leviticus 20:10-21; Romans 1; Ephesians 5:23-33).
6. The Scriptures prescribe and promise God’s blessing on life-long heterosexual union in marriage, and chastity in all other circumstances (Genesis 39:7-9; Exodus 20:14; Job 31:1; Proverbs 2:16-22, 5; Song of Songs 8:6; 1 Corinthians 7).
7. The Scriptures are uniform throughout in forbidding as sinful the practice of homosexuality (Leviticus 18:22, 20:13; 1 Kings 14:24; Mark 10:6; Romans 1:26-27; 1 Corinthians 6:9; Jude 1:7). Same-sex attraction cannot be consummated within God’s design for human sexuality and procreation (Genesis 2:24; Ephesians 5). The Scriptures affirm, however, the value of non-erotic same-sex friendships (1 Samuel 20:17).
8. It is possible by God’s grace for those with same-sex attraction to live a chaste life (Psalm 51:10, 119:9-16; Romans 6:11-14, 12:1-2; 1 Corinthians 6:18, 10:13; 2 Corinthians 7:1; 1 Thessalonians 4:3-5, 5:23-24; Galatians 2:20, 5:16,22-25; Colossians 3:5).

B. Social

1. In our current culture, which is saturated with sexual references, there is a prevailing view that personal fulfillment is to be found through abolishing traditional sexual boundaries and following desires and passions that transgress those boundaries. One outcome of this trend is the view that same-sex relationships should be regarded as equivalent to opposite-sex relationships. In our current culture some hold to the erroneous belief that to embrace diversity means to enforce acceptance and affirmation of same-sex relationships while suppressing other viewpoints.
2. CMDA believes that, in contrast to the current culture, living out one’s sexuality within God’s design will result in a healthier and more fulfilled life. CMDA recognizes that this traditional view has become counter-cultural; however, CMDA affirms that God’s design transcends culture.
3. CMDA recognizes that the causes of same-sex attraction are multifactorial and may include biological, developmental, psychosocial, environmental, and cultural factors that are not of the individual’s choosing. Deciding on a same-sex lifestyle and pursuing same-sex fantasies and encounters, however, are voluntary and involve moral responsibility.
4. CMDA recognizes that, for individuals who struggle with same-sex attraction, choosing not to act on same-sex erotic desires may be difficult. Similarly, many individuals who are sexually oriented to the opposite sex also struggle with erotic desires that are contrary to the teachings of Scripture.
5. Approval of same-sex marriage is harmful to the stability of society, the rearing of children, and the institution of marriage. If the only criterion for marriage were mutual consent or commitment, then there would be no logical grounds to prohibit polygamy, polyandry, or incestuous unions.
6. Adoption into homosexual environments puts children at risk. Children need both male and female influences in their social development. Children should not be exposed to the promiscuity that the gay culture promotes, just as they should not be exposed to heterosexual promiscuity. Homosexual relationships are typically brief and successive. Children reared by same-sex couples are at increased risk of later engaging in homosexual activity.

C. Medical

1. Among individuals who engage in homosexual acts, there is an increased incidence of drug or alcohol dependence, compulsive sexual behavior, anxiety, depression, and suicide. These consequences are harmful to the health of same-sex patients and are associated with increased medical costs to society.
2. Some homosexual acts are physically harmful because they disregard normal human anatomy and function. These acts are associated with increased risks of tissue injury and transmission of infectious diseases.
3. Homosexual behavior can be changed, even when desire persists. There is valid evidence that many individuals who chose to abstain from homosexual acts have been able to do so.

CMDA Recommendations for the Christian Community

1. A person struggling with same-sex attraction should evoke neither scorn nor enmity, but rather our concern, compassion, help, and understanding. Christians must respond to the complex issues surrounding same-sex attraction with grace, civility, and love.
2. Christians should welcome inclusion of same-sex-attracted individuals, affirming them as equal without condoning their sexual choices and behaviors.
3. The Christian community and especially the family must resist stereotyping and rejecting individuals who do not fit the popular norms of masculinity and femininity. Parents should guide
their children in appropriate gender identity development. For children who are experiencing gender identity confusion, the Christian community should provide appropriate role models and informed guidance.

4. The Christian community must help society understand that traditional marriage is good and a part of the natural order. CMDA is concerned that to redefine marriage in a way that includes same-sex relationships will have detrimental spiritual, emotional, cultural, and medical repercussions.

5. The Christian community must condemn hatred and violence directed against those involved in homosexual behavior. Love for the person does not equate with support of the decision to engage in a gay or lesbian lifestyle.

6. The Christian community must encourage and strongly support those who wish to abandon homosexual behavior.

7. CMDA affirms family life in the paradigm of fathers and mothers rearing their own children as well as adoption of children by a married mother and father. However, CMDA cannot affirm the adoption of children by same-sex couples, because such placement deliberately excludes the parental role model of one sex and is thus detrimental to the best interests of the child.

8. Christian communities must seek for ways to minister to children in families of same-sex couples in ways that offer them the love of Christ.

9. The Christian community is to be a refuge of love for all who are broken – including sexually broken – not to affirm their sin, nor to condemn or castigate, but to shepherd them to Jesus, who alone can forgive, heal, restore, and redirect to a Godly, honorable, and virtuous way of life. God provides the remedy for all moral failure through faith in Jesus Christ and the life-changing power of the Holy Spirit.

CMDA Recommendations for Christian Healthcare Professionals

1. CMDA advocates culturally competent medical care of patients who identify as gay or lesbian. Such care requires our compassion, an open and trusting dialogue, a genuine effort to understand and respond to the patient’s psychological distress, and acceptance of the person without necessarily agreeing with the person’s sexual views.

2. CMDA believes that the appropriate medical response to patients who identify as gay or lesbian should be to support and encourage them in areas we can affirm and to help them understand themselves as people God loves and who are made in his image, even when we cannot validate their lifestyle choices or sexual behaviors.

3. A patient’s wishes regarding hospital visitation rights and surrogate medical decision-making by a committed same-sex partner should be respected.

4. CMDA believes that Christian healthcare professionals should avoid participating in any reproductive technology procedures in which children are brought into a family other than that of a married husband and wife, or in which children at any stage of biological development are marketed as products. This would include surrogacy-for-hire or in vitro procedures for non-married heterosexual couples or same-sex couples.

CMDA Recommendations Regarding Nondiscrimination

1. Christian healthcare professionals, in particular, must care for their same-sex-attracted patients in a non-judgmental and compassionate manner, consistent with the humility Jesus modeled and the love Jesus commanded us to show all people.

2. Christian healthcare professionals who hold to a biblical or traditional view of human sexuality and marriage should be tolerated in a diverse society and permitted to express their views in civil discourse free from exclusion, oppression, or unjust discrimination. Healthcare professionals who hold the position that same-sex relationships are harmful and inconsistent with the will of God must not be stigmatized or accused of being bigoted, phobic, unprofessional, or discriminatory because of this sincerely held and widely shared belief.

3. Healthcare professionals must not be prevented from providing support and counseling to patients who request assistance with abstaining from homosexual behavior.

Unanimously approved by the House of Representatives
Annotated References

**Biblical References**

**God’s Plan for Sexual Relationships**

The LORD God said, “It is not good for the man to be alone. I will make a helper suitable for him.” Now the LORD God had formed out of the ground all the beasts of the field and all the birds of the air. He brought them to the man to see what he would name them; and whatever the man called each living creature, that was its name. So the man gave names to all the livestock, the birds of the air and all the beasts of the field. But for Adam no suitable helper was found. So the LORD God caused the man to fall into a deep sleep; and while he was sleeping, he took one of the man’s ribs and closed up the place with flesh. Then the LORD God made a woman from the rib he had taken out of the man, and he brought her to the man. The man said, “This is now bone of my bones and flesh of my flesh; she shall be called ‘woman,’ for she was taken out of man.” For this reason a man will leave his father and mother and be united to his wife, and they will become one flesh. Genesis 2:18-24 (NIV)

**Condemnation of Homosexual Behavior**

- Do not lie with a man as one lies with a woman; that is detestable. Leviticus 18:22 (NIV)
- If a man lies with a man as one lies with a woman, both of them have done what is detestable. Leviticus 20:13 (NIV)
- Because of this, God gave them over to shameful lusts. Even their women exchanged natural relations for unnatural ones. In the same way the men also abandoned natural relations with women and were inflamed with lust for one another. Men committed indecent acts with other men, and received in themselves the due penalty for their perversion. Romans 1:26-27 (NIV)

**Incidences of Homosexual Acts or Attempted Acts Condemned**

- Genesis 19 – involving men of Sodom
- Judges 19 – involving men of Gibeah
- Ezekiel 16 – involving men of Israel
- Jude v. 7 – reference to the perversions of Sodom and Gomorrah

**Judgment for Homosexual Behavior**

- Do not be deceived: Neither the sexually immoral nor idolaters nor adulterers nor male prostitutes nor homosexual offenders nor thieves nor the greedy nor drunkards nor slanderers nor swindlers will inherit the kingdom of God. 1 Corinthians 6:9-10 (NIV)

*This last passage suggests that it is the practice of these sins that brings God’s condemnation, not the associated temptations.*

**Recovery**

- And that is what some of you were. But you were washed, you were sanctified, you were justified in the name of the Lord Jesus Christ and by the Spirit of Our God. 1 Corinthians 6:11 (NIV)

**Temptation, Sin and Forgiveness**
No temptation has seized you except what is common to man. And God is faithful; he will not let you be tempted beyond what you can bear. But when you are tempted, he will also provide a way out so that you can stand up under it. 1 Corinthians 10:13 (NIV)

For all have sinned and fall short of the glory of God Romans 3:23 (NIV)

If we confess our sins, he is faithful and just and will forgive us our sins and purify us from all unrighteousness. 1 John 1:9 (NIV)

Genetics and Childhood Molestation


- In this identical twin study which utilized the Australian twin registry, the authors did not directly calculate the pairwise concordance rates. However, researchers Jones and Yarhouse did in their (2000) publication, Homosexuality. The use of scientific research in the church's moral debate, Downers Grove, Illinois: IVP, and found a concordance rate of 14% for lesbians and 11% for gays.

Whitehead Neil, Whitehead, Briar. (2007) authors of My Genes Made Me Do It! A Scientific Look at Sexual Orientation, Chapter 10, www.mygenes.co.nz/. analyzed what these concordance rates mean in their following comments on this study and the impact of this and other identical twin studies on our understanding of the causes of same sex attraction (SSA) or homosexuality.

➢ An “11% concordance rate does not mean that 11% of identical twins have SSA. Numerous studies of western populations (Chapter 2) have shown that homosexuality is present in something between 2-3% of people, and this, of course, includes twins…”

➢ “Nor does 11% concordance mean that homosexuality is genetically inevitable for 11% of the homosexual population.”

➢ “Eleven per cent concordance simply shows that when one of any number of twins from a general twin registry is (a male) homosexual, his co-twin is homosexual one time in nine, or 11% of the time.”

- Dr. Whitehead concludes by saying that, “The predominant cause of SSA both in men and women is individual post-natal random reactions to biological and environmental factors.” Ibid. Chapter 10, p.177-180

- Under Summary Dr. Whitehead further adds “One thing seems clear: any genetic contribution to SSA (same sex attraction) is much less than in most traits for which genetic influence has been measured. SSA seems 90% a result of random factors. SSA is in fact a good example of not being “born that way”! Ibid. Chapter 10, p. 183.


- The above is a study of adolescent twins in the USA. The researchers found concordance rates of same-sex romantic attraction to be low among monozygotic twins: 7.7% for males and 5.3% for females. Ibid. p. 1199.

- Bearman and Bruckner concluded, “If same-sex romantic attraction has a genetic component, it is massively overwhelmed by other factors.” They also found “no evidence of intrauterine transfer of hormone effects on social behavior.” But, they did “find substantial indirect evidence in support of a socialization model at the individual level.” They also believed that previous work (research) was “largely incorrect as a result of reliance on nonrepresentative samples.” Ibid. pp.1198-1199.

Dr. Whitehead, comments below on what this large study revealed:  

Whitehead, N.E. Latest Twin Study Confirms Genetic Contribution To SSA Is Minor  

www.narth.com/docs/isminor.html

- This study from Finland is 3 times larger than any previous study. They used a sample of over 9,000. “If one identical twin—male or female—has SSA, the chances are only about 10% that the co-twin also has it. In other words, identical twins usually differ for SSA.”


- The above is a Swedish twin study involving 1513 female and 807 male monozygotic pairs. Below is an assessment of what this study found: Of the identical twins in this study where one of the twins engaged in same sex behavior, the other twin also engaged in same sex behavior slightly less than 10% (of the time) for the males and slightly over 12% (of the time) for the females.

Dr. Neil Whitehead and Briar Whitehead note in their continually updated online book My Genes Made Me Do It! A Scientific Look at Sexual Orientation, that over the decades the better randomized the study the lower the concordance rate. www.mygenes.co.nz/

Dr. Neil Whitehead and Briar Whitehead in Chapter 10 of their book My Genes Made Me Do It! A Scientific Look at Sexual Orientation provide an excellent overview of gene studies and their impact on the origins of same sex attraction as does their summary chapter on the subject. Both are available free online at www.mygenes.co.nz/

People Can Change has an excellent website which includes a survey study of around 200 males who were going through therapy for SSA and were likely to have looked at and considered what possible issues might have contributed to their SSA. They were asked to indicate whether any of about 25 factors played a role in their SSA. They were also asked to indicate which three factors were the most important in causing their SSA. In this regard the factor that was most often picked was their relationship with their father whether or not he was present in the home. www.peoplecanchange.com/


- “While many mental health care providers and professional associations have expressed considerable skepticism that sexual orientation could be changed with psychotherapy and also assumed that therapeutic attempts at reorientation would produce harm, recent empirical evidence demonstrates that homosexual orientation can indeed be therapeutically changed in motivated clients, and that reorientation therapies do not produce emotional harm when attempted (e.g., Byrd & Nicolosi, 2002; Byrd et al., 2008; Shaeffet al., 1999; Spitzer, 2003).”

Journal of Human Sexuality, 1, 2009 What Research Shows: NARTH’s Response to the APA Claims on Homosexuality, p.1-121 This is one of the most if not the most comprehensive review of research in this area currently in existence as it has over 600 references.) www.narth.com/.

- This monograph reviewing research dealing with therapy of same sex attraction, lists article after article indicating that shifts towards heterosexual attraction is possible, and that in a significant number of cases exclusive heterosexual functioning has been achieved. They also reveal that
even in cases where the individual did not experience a change in their sexual orientation, they often found that the therapy was helpful or a positive experience. (p. 1:9- 1:52)

- The authors of the study also note “There is a general consensus in the scientific literature that greater pathology exists among homosexually oriented people than among heterosexuals. In fact, it is difficult to find another group in society with such high risks for experiencing such a wide range of medical, psychological and relational dysfunction.”


- In a review of the literature they noted homosexuals and heterosexuals demonstrated spontaneous as well as assisted sexual reorientation. “About one half of those with exclusive SSA (same sex attraction) had at an earlier time been bisexual or heterosexual, and about the same number changed from being exclusively SSA to bisexual or even heterosexual.”


- They noted that about 2% of the heterosexual population (the heterosexual represents nearly all, or 97% to 98% of the total population) had at one time previously been exclusively homosexual. (Only about 2 to 3% of the population is involved in any same sex sexual activity.)


- As part of the famous Masters and Johnson Institute they wrote an article regarding the institute’s work in treating dissatisfied homosexuals who wanted to alter their sexual orientation. Instead of looking at success rates, they chose to look at their failure rate in trying to help homosexuals establish a heterosexual lifestyle. After the intensive phase of their intervention their failure rate was just 20.9%, and after 5 years it was still just 28.4%.


- 59% of male child sex offenders had been “victim of contact sexual abuse as a child.”
- “The incidence of homosexuality in the adopted brothers of homosexuals (11%) was much higher than recent estimates for the rate of homosexuality in the population (1 to 5%).”
- “Indeed, perhaps the major finding of these heritability studies is that despite having all of their genes in common and having prenatal and postnatal environments as close to identical as possible, approximately half of the identical twins were nonetheless discordant for orientation. This finding underscores just how little is known about the origins of sexual orientation.”


- “It is imperative that clinicians and behavioral scientists begin to appreciate the complexities of sexual orientation and resist the urge to search for simplistic explanations, either psychosocial or biologic.”
- “Critical review shows the evidence favoring a biologic theory to be lacking.”
- “Although identical twins have the same genetic code, non-identical twins and regular siblings share the same proportion of genetic material. Therefore, the genetic theories should show a similar amount of homosexual concordance between non-identical twins and regular siblings.”
- “First, they point out the fact that the study rests on the assumption that the relevant environment is the same for identical twins and non-identical twins. Then, the effects of potential bias in the sample is called into question, as Bailey and Pillard recruited their homosexual research subjects by advertising in various homosexually-oriented publications.”
“Third, there was no way to separate the intermingling of environmental and genetic effects, since all sets of twins in the study had been raised together and presumably subject to most, if not all, of the same environmental effects.”

“The most interesting question, however, is that if there is something in the genetic code that makes a person homosexual, why did not all of the identical twins become homosexual, since they have the exact same genetic code?”

“While all behavior must have an ultimate biologic substrate, the appeal of current biologic explanations for sexual orientation may derive more from a dissatisfaction with the current status of psychosocial explanations than from a substantiating body of experimental data. Critical review shows the evidence favoring a biologic theory to be lacking. In an alternative model, temperamental and personality traits interact with the familial and social milieus and the individual’s sexuality emerges.”


63% of lesbians surveyed stated that they had chosen to be lesbians, 28% felt they had no choice, and 11% did not know why they were lesbians.


Boys who were sexually molested have subsequently “a higher incidence of homosexuality.”


“Some typical childhood factors related to homosexuality are: feeling of being different from other children; parent, sibling, peer relationships; perception of father as being distant, uninvolved, unapproving; perception of parental perfection required; perception of mother as being too close, too involved; premature introduction to sexuality (such as child abuse or incest); gender confusion; defensive detachment, reparative drive, same-sex ambivalence; unmet affection needs; diminished/distorted masculinity, femininity.”

“…homosexual men are more likely to become sexually active at much younger ages than heterosexual men. The average age of homosexual males at their first sexual encounter was 12.7, versus 15.7 for heterosexual males.”

“This evidence may suggest that abuse and early sexual experiences can contribute to homosexuality, perhaps because of familiarity with sexual acts, and in some cases because of an initial sexual experience with someone of the same gender.”


“We conclude that social phobia may be a hidden contributing factor in some instances of homosexual behavior.” (p. 40)


“These data suggest that some history of childhood femininity is almost always a precursor of adolescent homosexual behavior.” (p. 259)

This study of male twins who were Vietnam veterans found that male homosexuals were 5.1 times more likely to experience suicidal thoughts and behaviors than were their heterosexual twins.


“…the absence of masculine behaviors and traits appeared to be a more powerful predictor of later homosexual orientation than the traditionally feminine or cross-sexed traits and behaviors.” (p. 475)


“The myth of the all-powerful gene is based on flawed science that discounts the environmental context in which we and our genes exist.”

“A gene does not determine a phenotype [noticeable trait] by acting alone; a gene cannot act by itself…Each gene simply specifies one of the proteins involved in the process.”


Nearly one in four young men report sexual abuse as a child resulting in significant life difficulties (as compared to non-abused males).


“Even if we knew absolutely everything about genes and absolutely everything about environment, we still could not predict the final phenotype of any individual.” (p. 142)

Nimmons, David. (March 1994). Sex and the Brain, Discover, 64-71.

“It is important to stress what I didn’t find. I did not prove that homosexuality is genetic, or find a genetic cause for being gay. I didn’t show that gay men are born that way, the most common mistake people make in interpreting my work. Nor did I locate a gay center in the brain. INAH 3 is less likely to be the sole gay nucleus of the brain than a part of a chain of nuclei engaged in men and women’s sexual behavior…. Since I looked at adult brains, we don’t know if the differences I found were there at birth, or if they appeared later.”


942 nonclinical adult participants, gay men and lesbian women reported a significantly higher rate of childhood molestation than did heterosexual men and women. Forty-six percent of the homosexual men in contrast to 7% of the heterosexual men reported homosexual molestation.
Twenty-two percent of lesbian women in contrast to 1% of heterosexual women reported homosexual molestation.


- “Neil Whitehead tabulated other twin studies on other topics and those traits’ heritability: lying--43%, anorexia nervosa--44%, fear of the unknown--46%, psychological inpatient care--47%, extroversion--50%, depression--50%, altruism--50%, divorce--52%, racial prejudice, bigotry--70%.
- “(Dean) Hamer’s genetic sequences have been calculated to affect about 5% of the homosexual population, so even if he is correct, there must be some other explanation for what causes the vast majority of homosexuality.”
- “If a hormonal imbalance was responsible for homosexuality, then perhaps a simple dose of hormones to an adult would cure homosexuality. This is not the case, as has been demonstrated several times.”


- Homosexually-assaulted males identified themselves as subsequently becoming practicing homosexuals almost 7 times as often as bisexuals and almost 6 times as often as the non-assaulted control group. 58% of adolescents reporting sexual abuse by a man prior to puberty revealed either homosexual or bisexual orientation (control group 90% heterosexual). Age of molestation was 4-14 years. “Nearly half of men who have reported a childhood experience with an older man were currently involved in homosexual activity.” A disproportionately high number of male homosexuals were incestuously molested by a homosexual parent. Conclusion was that the experience led the boy to perceive himself as homosexual based on his having been found sexually attractive by an older man.

Social Factors


- Daryl Bem’s “Exotic Becomes Erotic” theory states that “what is exotic to children becomes erotic to them as adolescents.” For example, “boys who play with girls mostly instead of other boys, and who tend to like the way girls play, become familiar and comfortable with femininity. Male behavior and males become exotic, and thus erotic later in life.”


- “Fisher analyzed the 58 studies and reported that a large majority supported the notion that homosexual sons perceive their fathers as negative, distant, unfriendly figures.” “There is not a single even moderately well controlled study that we have been able to locate in which male homosexuals refer to father positively or affectionately.” (p. 136)


- “the second most common cause of SSAD [same sex attraction disorder] among males is mistrust of women’s love… Male children in fatherless homes often feel overly responsible for
their mothers. As they enter their adolescence, they may come to view female love as draining and exhausting.” (p. 89)

“Experience has taught me that healing is a difficult process, but through the mutual efforts of the therapist and the patient, serious emotional wounds can be healed over a period of time.” (p. 96)


“Some typical childhood factors related to homosexuality are: feeling of being different from other children; parent, sibling, peer relationships; perception of father as being distant, uninvolved, unapproving; perception of parental perfection required; perception of mother as being too close, too involved; premature introduction to sexuality (such as child abuse or incest); gender confusion; defensive detachment, reparative drive, same-sex ambivalence; unmet affection needs; diminished/distorted masculinity, femininity.”

“...homosexual men are more likely to become sexually active at much younger ages than heterosexual men. The average age of homosexual males at their first sexual encounter was 12.7, versus 15.7 for heterosexual males.”

“This evidence may suggest that abuse and early sexual experiences can contribute to homosexuality, perhaps because of familiarity with sexual acts, and in some cases because of an initial sexual experience with someone of the same gender.”


“Experiences of being ostracized and ridiculed may play a more important role than has been recognized in the total abandonment of the male role at a later time.” (p. 687)

“Feminine boys, unlike men with postpubertal gender identity disorders seem remarkably responsive to treatment.” (p. 684)


Nicolosi surveyed 850 individuals and 200 therapists and counselors – specifically seeking out individuals who claim to have made a degree of change in sexual orientation. Before counseling or therapy, 68% of respondents perceived themselves as exclusively or almost entirely homosexual, with another 22% stating they were more homosexual than heterosexual. After treatment only 13% perceived themselves as exclusively or almost entire homosexuality, while 33% described themselves as either exclusively or almost entirely heterosexual, 99% of respondents said they now believe treatment to change homosexuality can be effective and valuable.


“The 16-item discriminate-function … yielded correct classification of 94.4% of heterosexual men and 91.8% of the homosexual men. These results indicate that heterosexual and homosexual men can be classified with equivalent accuracy on the basis of recalling having had or not having had gender conforming (masculine) experiences in childhood.” (p. 550)

homosexuals reported experiencing their first orgasm at a younger age than the heterosexuals.” 24% of homosexuals’ first orgasms occurred during homosexual contacts versus 2% of heterosexuals. (p.511)


“...we feel that parental tolerance of cross-gender behavior at the time of its emergence is instrumental in allowing the behavior to develop...” (p. 259)
“...In general we concur with those (e.g. Green 1972; Newman 1976; Stoller, 1978) who believe that the earlier treatment begins, the better.” (p. 281) “It has been our experience that a sizable number of children and their families can achieve a great deal of change. In these cases, the gender identity disorder resolves fully, and nothing in the children’s behavior or fantasy suggests that gender identity issues remain problematic... All things considered, however, we take the position that in such cases clinicians should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity.” (p. 282)

Physical Health


GBS problems such as proctitis, proctocolitis, and enteritis as “sexually transmitted gastrointestinal syndromes.”


Men who have sex with men who engage in unsafe sexual practices remain at an increased risk for contracting hepatitis C.


“Outbreaks of hepatitis A among men who have sex with men are a recurring problem in many large cities in the industrialized world.”


Men who have sex with men” and “men who have sex with men and inject drugs” together accounted for 64 percent of the cumulative total of male AIDS cases.


According to the Centers for Disease Control and Prevention (CDC), from 1994 to 1997 the proportion of homosexuals reporting having had anal sex increased from 57.6 percent to 61.2 percent, while the percentage of those reporting “always” using condoms declined from 69.6 percent to 60 percent.

The proportion of men reporting having multiple sex partners and unprotected anal sex increased from 23.6 percent to 33.3 percent.
Male rectal gonorrhea is increasing among homosexuals amidst an overall decline in national gonorrhea rates.

“At least half of all new HIV infections in the United States are among people under twenty-five, and the majority of young people are infected sexually.” By the end of 1999, 29,629 young people aged thirteen to twenty-four were diagnosed with AIDS in the United States. MSM were the single largest risk category: in 1999, for example, 50 percent of all new AIDS cases were reported among young homosexuals.

Men who have sex with men are at increased risk for hepatitis B.


Interviews of 21, 850 males: Increasing percentages of men who have sex with men reported engaging in unprotected anal intercourse. There was an increase in rectal gonorrhea rates.


920 young black males, ages 15-22, who have sex with men, have very high rates (16%) of HIV infection.


- 19,999 cases of syphilis reported in 2014 represented a 15.1% increase since 2013.
- Men who had sex with men accounted for 74.7% of cases of syphilis.


Lesbian and bisexual women have higher reported rates of risk for cancer and cardiovascular disease as well as obesity and high rates of human papilloma virus infection.

Sample of gay men living outside of the large coastal gay communities, found that neither attendance at a safe sex lecture, reading a safe sex brochure, receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site was associated with participation in safe sex.


“Human herpesvirus 8 (HHV-8), the causal agent of Kaposi’s sarcoma, is transmitted sexually among homosexual men.”


Increased prevalence rates were found in lesbian/bisexual women for obesity, alcohol use, and tobacco use.


Anal cancers were strongly associated with a history of male homosexual activity.


Women who have sexual relations with women are at significantly higher risk for certain sexually transmitted diseases: “BV (bacterial vaginosis), hepatitis C, and HIV risk behaviors in WSW as compared with controls.”


Lesbian women consume alcohol more frequently, and in larger amounts, than heterosexual women. Lesbians were at significantly greater risk than heterosexual women for both binge drinking (19.4 percent compared to 11.7 percent), and for heavy drinking (7 percent compared to 2.7 percent).


In a study of 324 women and 93 men with invasive or in situ anal cancer, findings supported the previously recognized association between anal cancer and homosexual contact.


Thirty-six percent of homosexuals engaging in unprotected oral, anal, or vaginal sex failed to disclose that they were HIV positive to casual sex partners.

45 percent of homosexuals reporting having had unprotected anal intercourse during the previous six months did not know the HIV serostatus of all their sex partners. 68 percent did not know the HIV serostatus of their partners.


“Life expectancy at age 20 years for gay and bisexual men is 8 to 20 years less than for all men. If the same pattern of mortality were to continue, we estimate that nearly half of gay and bisexual men currently aged 20 years will not reach their 65th birthday.”


“The overall probability of seroconversion [from HIV- to HIV+] prior to age 55 years is about 50%, with seroconversion still continuing at and after age 55. Given that this cohort consists of volunteers receiving extensive and anti-HIV-1 transmission education, the future seroconversion rates of the general homosexual population may be even higher.


Household survey of unmarried men 18 through 29 years of age found that of 328 homosexual men 20.1% tested positive tested for HIV.


Human herpesvirus 8 (HHV-8) is likely the cause of Kaposi’s Sarcoma. Its prevalence in men who have sex with men is much higher than in the general population.


“Who wants to encourage their kids to engage in a life that exposes them to a 50 percent chance of HIV infection? Who even wants to be neutral about such a possibility? If the rationale behind social tolerance of homosexuality is that it allows gay kids an equal shot at the pursuit of happiness, that rationale is hopelessly undermined by an endless epidemic that negates happiness.” (p. 286)

- “A San Francisco study of Gay and bisexual men revealed that HPV infection was almost universal among HIV-positive men, and that 60 percent of HIV-negative men carried HPV.


- Syphilis and gonorrhea are rising in the homosexual and bisexual population.


- Young MSM who do not disclose their sexual orientation (non-disclosers) are thought to be at particularly high risk for human immunodeficiency virus (HIV) infection because of low self-esteem, depression, or lack of peer support and prevention services that are available to MSM who are more open about their sexuality (disclosers).


- Men who have sex with men were found to have a 100 to 700 times greater prevalence rate of HIV infection than primarily heterosexual men who applied for service in the U.S. military. Men who have sex with men were also found to have a high prevalence of hepatitis B viral markers (10.7%). High HIV rates were correlated with anal sex and having had sex with 20 or more men.


- “Sixteen percent of adult men in the general population have said they were sexually abused as children.”


- “Most instances of anal cancer are caused by a cancer-causing strain of HPV through receptive anal intercourse. HPV infects over 90 percent of HIV-positive gay men and 65 percent of HIV-negative gay men, according to a number of recent studies.”

**Mental Health & Substance Abuse**


- Lesbians were more likely to report cigarette use, alcohol use, and heavy alcohol use.


- “Homosexual people are at a substantially higher risk for some forms of emotional problems, including suicidality, major depression and anxiety disorder. Gay, lesbian, or bisexual people
were at an increased lifetime risk for suicidal ideation and behavior, major depression, generalized anxiety disorder, conduct disorder, and nicotine dependence.”


- “Among adolescents, commonly reported sequelae (of child sexual abuse) include sexual dissatisfaction, promiscuity, homosexuality, and an increased risk for re-victimization.” (p. 537)
- “A review of studies reporting symptomology among sexually abused adolescents revealed evidence for the presence of depression, low self-esteem, and suicidal ideation.” (p. 544)


- More than half of lesbians had felt too nervous to accomplish ordinary activities at some time during the past year and over one-third had been depressed.


- “Girls with GID [Gender Identity Disorder] …have difficulty connecting with their mothers, who are perceived as weak and ineffective. We see this perception as arising from the high levels of psychopathology observed in these mothers, especially severe depression and borderline personality disorder.” (p. 877)
- “In our female adolescents with GID, a history of sexual abuse or fears of sexual aggression has appeared commonly.” (p. 878)


- Homosexually active men were more likely than other men to have evidence of major depression and panic attack syndromes. Homosexually active women were more likely than other women to be classified with alcohol or drug dependency syndromes. Both men and women reporting any same-gender sex partners were more likely than others to have used mental health services.


- Lesbians and bisexual women were more likely than heterosexual women to use tobacco products and to report any alcohol consumption, but only lesbians were significantly more likely than heterosexual women to drink heavily.


- The gay, lesbian, bisexual subjects have significantly higher rates of: suicidal ideation (67.9%/29.0%), suicide attempt (32.1%/7.1%), and psychiatric disorders age 14-21 – major depression (71.4%/38.2%), generalized anxiety disorder (28.5%/12.5%), conduct disorder (32.1%/11.0%), nicotine dependence (64.3%/26.7%), other substance abuse/dependence (60.7%/44.3%), and multiple disorders (78.6%/38.2%) than the heterosexual sample. (p. 879)
Findings support recent evidence suggesting that gay, lesbian, and bisexual young people are at increased risk of mental health problems, with these associations being particularly evident for measures of suicidal behavior and multiple disorder.


“…an alarming number of gay men and women (31.96%) are trapped in an alcohol-centered lifestyle.”


Gay and bisexual teenagers may take more risks, and engage in risky behavior earlier in life, than teenagers who describe themselves as heterosexual. GLB [gay, lesbian, bisexual] teenagers were more likely to consider or attempt suicide, abuse alcohol or drugs, participate in risky sexual activity, or be victimized, and to initiate these behaviors earlier.”


Higher 12-month prevalences of anxiety, mood, and substance use disorders and of suicidal thoughts and plans than did respondents with opposite-sex partners only. Homosexual orientation, defined as having same-sex sexual partners, is associated with a general elevation of risk for anxiety, mood, and substance use disorders and for suicidal thoughts and plans.


This study of male twins who were Vietnam veterans found that male homosexuals were 5.1 times more likely to experience suicidal thoughts and behaviors than were their heterosexual twins.


The bisexual group was highest on measures of anxiety, depression and negative affect, with the homosexual group falling between the other two groups. Both the bisexual and homosexual groups were high on suicidality.


“This paper presents the findings of a large (n=3400) survey of the homosexual population...Substantially higher proportions of the homosexual sample used alcohol, marijuana, or cocaine than was the case in the general population.”


Lesbians were found to smoke, drink alcohol and use caffeine more than other women.

“…men who never drank prior to sex were very unlikely to have engaged in unprotected anal intercourse, whereas 90% of men who had at least one occasion of unprotected anal intercourse also drank at least some of the time prior to sexual intercourse.” “…a virtual absence of individuals who did not drink but did engage unprotected anal intercourse.” (p. 181)


The rate of homosexuality in the BPD [Borderline Personality Disorder] sample was 16.7%, as compared with 1.7% in the non-BPD comparison group. The homosexual BPD group had a rate of overall Childhood Sexual Abuse of 100% as compared to 37.3% for the heterosexual BPD group. “It is interesting that 3 out of 10 homosexual borderline patients also reported father-son incest.” (p. 59)


The 1989 Report of the Secretary’s Task Force on Youth Suicide concluded that “gay youth are 2 to 3 times more likely to attempt suicide than other young people. They may comprise up to 30% of completed youth suicides annually. To date, at least 10 peer-reviewed studies have found unusually high rates of attempted suicide, in the range of 20% to 42% among young bisexual and homosexual research volunteers. All have found a clinically and statistically significant association between suicide attempts and homosexuality, strongest among males.


“Perhaps the most significant study to date was reported by Robert L. Spitzer, MD at the American Psychiatric Association. In his research, Dr. Spitzer studied 200 men and women who had participated in gender affirmative therapy. He concluded that 66% of the men and 44% of the women had arrived at what he called good heterosexual functioning. In addition, 89% of the men and 95% of the women said they were bothered slightly, or not at all, by unwanted homosexual feelings.”


“In general, reports on the group treatment of homosexuals are optimistic; in almost all cases the therapists report a favorable outcome of therapy whether the therapeutic goal was one of achieving a change in sexual orientation or whether it was a reduction in concomitant problems.” (p.22)


30% of the homosexuals in their sample reported excessive drinking or alcohol dependence. (p. 119)

The average male homosexual live-in relationship lasts between two and three years (p. 225)


A Dutch study of 5998 heterosexual and homosexual men and women showed that “psychiatric disorders were more prevalent among homosexually active people compared with heterosexualy active people…On a lifetime basis, homosexual women had a significantly higher
prevalence of general mood disorders and major depression than did heterosexual women...Lifetime prevalence of both alcohol and other drug dependence was also significantly higher in homosexual women than in heterosexual women.”


- New Zealand study of 770 heterosexual men and women and 172 men and women who experienced different degrees of same sex attraction, the authors found: That attempts to inflict self-harm increase with the degree of homosexual attraction. There were elevated rates of substance abuse in both sexes experiencing same sex attraction. This was particularly prominent in lesbians.


- Lesbian and bisexual women more often used alcohol and cigarettes, exhibited other risk factors for reproductive cancers and cardiovascular disease, and scored lower on measures of mental health and social support.


- Neil Whitehead tabulated other twin studies on other topics and those traits’ heritability: lying-43%, anorexia nervosa--44%, fear of the unknown--46%, psychological inpatient care--47%, extroversion--50%, depression--50%, altruism--50%, divorce--52%, racial prejudice, bigotry--70%.
- "(Dean) Hamer’s genetic sequences have been calculated to affect about 5% of the homosexual population, so even if he is correct, there must be some other explanation for what causes the vast majority of homosexuality.”
- “If a hormonal imbalance was responsible for homosexuality, then perhaps a simple dose of hormones to an adult would cure homosexuality. This is not the case, as has been demonstrated several times.”


- “Homosexuality was 10 times more common among the men and six times more common among the women with borderline personality disorder than in the general population or in a depressed control group.” (p. 748)

**Pedophilia**

Male Intergenerational Intimacy. The Journal of Homosexuality. 20 (1-2).

- One writer claims that pedophilia offers “companionship, security and protection” (162) that neither his parents nor peers are able to provide, and urges parents to value their son’s pedophile lover “not as a rival or competitor, not as a thief of their property, but as a partner in the boy’s upbringing, someone to be welcomed into their home...” (164). In the same issue, Gerald Jones, seeking to legitimize his ideology in academic jargon, claims that “same-sex intergenerational intimacy (i.e., pedophilia) may be developmentally functional,” refers to studies indicating “benign or even beneficial results in boys who were...involved with men,” and contends that pedophilia is a morally neutral behavior. (279-280).
- Regarding the prevalence of pedophilia amongst homosexuals, literature discussing the history of homosexuality (see David F. Greenberg, The Construction of Homosexuality [Chicago: The
University of Chicago Press, 1988]), quasi-scholarly journals (PAIDIKA, The Journal of Paedophilia, Amsterdam, Netherlands), as well as current materials published by the North American Man-Boy Love Association (NAMBLA) reveal that erotic relationships with children are a significant element in the homosexual community.


- “Leading mainstream homosexual newspapers and magazines such as the Advocate, Edge, Metroline, The Guide, and The San Francisco Sentinel have not only published pro-NAMBLA articles and columns but also many have editorialized in favor of NAMBLA and sex with children. The editor of The Guide, Ed Hougen, stated in an interview with Lambda Report, “I believe they [NAMBLA] are generally interested in the right of young people to be sexual….I am glad there is a group like NAMBLA that is willing to be courageous.” The San Francisco Sentinel was more blunt: “NAMBLA’s position on sex is not unreasonable, just unpopular. [W]hen a 14-year-old gay boy approaches a man for sex, it’s because he wants sex with a man.”


- “Incredibly the pro-pedophile group, North American Man Boy Love Association (NAMBLA), which calls itself a homosexual group, wrote a letter to the national Scout office urging ‘the Boy Scouts of America to cease its discrimination against openly gay or lesbian persons in the appointment of its scout masters and scouters and in its membership. This will permit scouts to be exposed to a variety of lifestyles and will permit more of those individuals who genuinely wish to serve boys to do so.’”


- “Gay authors and leaders such as Allen Ginsberg, Gayle Rubin, Larry Kramer (founder of ACT-UP), Pat Califia, Jane Rule, Michael Kearns, and Michel Foucault have all written in favor of either NAMBLA or man-boy relationships.”


- “In 1995, the homosexual magazine Guide stated: ‘We can be proud that the gay movement has been home to the few voices who have had the courage to say out loud that children are naturally sexual, that they deserve the right to sexual expression with whoever they choose…[w]e must listen to our prophets. Instead of fearing being labeled pedophiles, we must proudly proclaim that sex is good, including children’s sexuality….We must do it for the children’s sake.”


- “Mainstream’ homosexual conferences commonly feature speeches about intergenerational sex as it is now called. For example, at one of the nation’s largest homosexual gatherings, the annual National Gay Lesbian Task Force convention, featured a workshop at its 2001 confab entitled, ‘Your Eyes Say Yes But the Law Says No’, which included a speech by an S&M activist about laws affecting intergenerational sex. The convention also featured another workshop entitled Drag ‘101: How to Turn Kids in Make-up into Kings and Queens’.”


- “Child molestation, by comparison, was a relatively infrequent crime, occurring from an average of 23.2 times by a pedophile (non-incest) with female targets to an average of 281.7 times by a pedophile (non-incest) whose targets were males.”
“...homosexuals sexually molest young boys with an incidence that is five times greater than the molestation of girls.”


“Among adolescents, commonly reported sequelae (of child sexual abuse) include sexual dissatisfaction, promiscuity, homosexuality, and an increased risk for re-victimization.” (p. 537)

“A review of studies reporting symptomatology among sexually abused adolescents revealed evidence for the presence of depression, low self-esteem, and suicidal ideation.” (p. 544)


45% of white male homosexuals had sex with 500 or more partners, with 28% having 1,000 or more sex partners.

“This study involved interviews with 1,500 gay men and women.”

“25% of white gay men have had sex with boys 16 years old and younger.”


The best epidemiological evidence indicates that only 2 to 4% of men attracted to adults prefer men (ACSF Investigators, 1992; Billy et al., 1993; Fay et al., 1989; Johnson et al., 1992); in contrast, around 25 to 40% of men attracted to children prefer boys (Blanchard et al., 1999; Gebhard et al., 1965; Mohr et al., 1964). Thus, the rate of homosexual attraction is 6 to 20 times higher among pedophiles.

Divided 260 pedophile participants into three groups: “152 heterosexual pedophiles (men with offenses or self-reported attractions involving girls only), 43 bisexual pedophiles (boys and girls), and 65 homosexual pedophiles (boys only).”


“According to the literature, findings of a two-to-one ratio of heterosexual to homosexual pedophiles have been documented.”


GLASS’s founder and former executive director, Teresa DeCrescenzo, edited a book that helps youth discover their homosexuality.


The 72 male victims (vs. 344 girls) were significantly younger (median, 7 years) and sustained more violence and trauma.

42% of a sample of 1,001 homosexual men reported childhood experiences that met the criteria for sexual abuse.

1,001 adult homosexual and bisexual men attending sexually transmitted disease clinics were interviewed regarding potentially abusive sexual contacts during childhood and adolescence. Thirty-seven percent of participants reported they had been encouraged or forced to have sexual contact before age 19 with an older or more powerful partner; Median age of the participant at first contact was 10; median age difference between partners was 11 years. Fifty-one percent involved use of force; 33% involved anal sex. 93% of participants reporting sexual contact with an older or more powerful partner were classified as sexually abused.


“Research confirms that homosexuals molest children at a rate vastly higher than heterosexuals…”

Freund, et al. (1984, Fall) Pedophilia and Heterosexuality vs. Homosexuality. Journal of Sex and Marital Therapy. 10: (3) 197.


“In a 1992 study published in the Journal of Sex and Marital Therapy, sex researchers K. Freud and R.I. Watson found that homosexual males are three times more likely than straight men to engage in pedophilia and that the average pedophile victimizes between 20 and 150 boys before being arrested.”

“The incident in Los Angeles involving group homes operated by the Gay and Lesbian Adolescent Social Services (GLASS) exemplifies this danger (of homosexual contact with minors). GLASS receives taxpayer monies to take in troubled youth referred to them by the social service departments of various southern counties in California.”

“The proportional prevalence of offenders against male children in this group of 457 offenders against children was 36 percent.” See also, Kurt Freund, et al., “Heterosexuality, Homosexuality, and Erotic Age Preference.” “Approximately one-third of these individuals had victimized boys and two-thirds had victimized girls. This finding is consistent with the proportions reported in two earlier studies,” p. 107.


“This unprecedented glimpse into the world of Scout pedophiles revealed that thousands of boys had been molested by Scout leaders and other volunteers between 1971 and 1991 resulting in the expulsion of over 1,800 Scout volunteers for pedophile activity. The documents show that some Scout leaders molested over forty boys before getting caught and that many, once caught, simply moved to a different Scout troop and continued abusing boys.”


“Man/boy and woman/girl relations without doubt are same-sex relations and they do constitute an aspect of gay and lesbian life.” Graupner argues that, as such, consensual sexual relations between adult homosexuals and youths as young as fourteen qualifies as a “gay rights issue”.

141

- A total of 42% of pedophiles and 44% of hebephiles reported being sexually victimized in their own childhoods. Both groups appear to choose their age specific victims in accordance with the age of their own experience of sexual victimization.


- A study of 279 homosexual/bisexual men. “More than half of both case and control patients reported a sexual act with a male by age 16 years, approximately 20 percent by age 10 years.”


- “73% of homosexuals surveyed had at some time had sex with boys sixteen to nineteen years of age or younger.”


- Child molesters responded with moderate sexual arousal (20-40% of full erection) to the nude males of all ages. Non-offenders showed no response to the male stimuli.


- The rate of homosexuality in the BPD [Borderline Personality Disorder] sample was 16.7%, as compared with 1.7% in the non-BPD comparison group. The homosexual BPD group had a rate of overall Childhood Sexual Abuse rate of 100% as compared to 37.3% for the heterosexual BPD group. “It is interesting that 3 out of 10 homosexual borderline patients also reported father-son incest.” (p. 59)


- “Pedophilia may be a cultural label rather than anything inherently medical or psychiatric; anthropological findings support this view.” (p. 68)


- As the gay movement has retreated from its vision of sexual freedom for all in favor of integration into existing social and political structures, it has sought to marginalize cross-generational love as a “non-gay” issue. The two movements continue to overlap, amid signs of mutual support as well as tension.

- “Boy-lovers were involved in the gay movement from the beginning, and their presence was tolerated. Gay youth groups encouraged adults to attend their dances… There was a mood of tolerance, even joy at discovering the myriad of lifestyles within the gay and lesbian subculture.”

Zebulon, A., et al., Sexual Partner Age Preferences of Homosexual and Heterosexual Men and Women. p. 73.
The study compared the sexual age preferences of heterosexual men, heterosexual women, homosexual men, and lesbians. Marked contrast to the other three categories, “all but 9 of the 48 homosexual men preferred the youngest two male age categories,” which included males as young as age fifteen.

**Promiscuity**


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“A review of studies reporting symptomology among sexually abused adolescents revealed evidence for the presence of depression, low self-esteem, and suicidal ideation.” (p. 544)


45% of white male homosexuals had sex with 500 or more partners, with 28% having 1,000 or more sex partners.

“This study involved interview with 1,500 gay men and women.”

“25% of white gay men have had sex with boys sixteen years and younger.”


Women who have sexual relations with women are at significantly higher risk for certain sexually transmitted diseases: “BV (bacterial vaginosis), hepatitis C, and HIV risk behaviors in WSW as compared with controls.”


“These data suggest that some history of childhood femininity is almost always a precursor of adolescent homosexual behavior.” (p. 259)


75% of homosexual men report their first homosexual experience to have been prior to age 16.

Study of 156 males in homosexual relationships lasting from one to thirty-seven years-- only seven couples have a totally exclusive sexual relationship.


“Few homosexual relationships last longer than two years, with many men reporting hundreds of lifetime partners.”


Study of 2,585 homosexually active men in Australia showed that more men over 50 years old reported they had 101-500 lifetime partners than any other category involving numbers of sexual partners. Only 2.7% reported just one lifetime sexual partner.

**Violence**


Intimate partner battering victimization to be 39.2% among men who had sex with men during the last 5 years.


This study analyzes 22 cases of male rape and the impact it had on the rapists and their male victims.


“Slightly more than half of the [lesbians] reported that they had been abused by a female lover/partner.”


90% of the lesbians surveyed had been recipients of one or more acts of verbal aggression from their intimate partners during the year prior to this study, with 31% reporting one or more incidents of physical abuse.

**Parenting**

(February 26, 2002). European Court of Human Rights. Case of Frette v. France.

“Many of the European Union States did not allow single persons to apply for adoption, while others subjected the possibility to restrictive conditions because adoption by homosexuals, living alone or with a partner, gave rise to serious misgivings as to whether that was in the child’s best interests.”

“In the Court’s opinion there is no doubt that the decisions to reject the applicant’s application for authorization pursued a legitimate aim, namely to protect the health and rights of children who could be involved in an adoption procedure, for which the granting of authorization was, in principle, a prerequisite.”


“Describing themselves as ‘personally oppos[ing] discrimination on the basis of sexual orientation’, they challenge the predominant claim that sexual orientation of parents does not
matter at all and agree ‘that ideological pressures constrain intellectual development in this field.’“

“Stacey and Biblarz also noted ‘at least 15 intriguing, statistically significant differences in gender behavior and preference among children…in lesbian and heterosexual single-mother homes.’“


□ Children of homosexuals are more likely to become homosexual than are children of traditionally married couples. Adding together various studies suggests that they are at least 3 times more apt to become homosexual than are children who are raised by traditional married couples.


□ “Describing same-sex parenting research as ‘compromised by methodological flaws and driven by political agendas instead of an objective search for truth.’“
□ “Another study found that ‘children of lesbians became active lesbians themselves [at] a rate which is at least four times the base rate of lesbianism in the adult female population.’“
□ “Fidelity rates among committed homosexual couples also appear to be much less than that of heterosexual couples.”


□ Considers 144 academic papers including 50 on same-sex parenting. “If public policy is based on clear research, there is no case for changing the adoption law to allow same-sex couples or unmarried couples to be able to adopt children.”

□ “Few homosexual relationships last longer than two years, with many men reporting hundreds of lifetimes partners.”


□ Data from studies including children of married heterosexual couples, cohabiting heterosexual couples and homosexual couples, and examines the extent to which these children differ with regard to scholastic achievement and aspects of social development. It shows that in the majority of cases, the most successful are children of married couples, followed by children of cohabiting couples and finally by children of homosexual couples.

Marriage


□ “State legislatures often make distinctions in the law, denying benefits to some while granting them to others. Marriage laws, for instance, not only require a couple to be of the opposite sex, but also impose age requirements, requirements of a mental and even physical capacity, and proscriptions against polygamy or polyandry.”
“In the U.S. 98.2% of those in the five major religions affirm marriage, while 1.7% support same-sex marriage. Worldwide, 99.9% affirm marriage, while .1% support same-sex marriage.”


“Similarly, if the courts allow same-sex marriages, what basis would there to be to prohibit polygamous or incestuous relationships? Or, to take it a step further, what basis would there be to prohibit marriage between man and animal? In truth, there would be none.”

“If one removes the core concept of marriage as the union of man and woman...instead of a unique community, marriage becomes one more relationship. And why should this relationship be so special? If it has no necessary connection to children, or even to sex, what makes it different from an ordinary friendship? Friendships are multiple; why limit marriage to two persons? Sexual relationships can be multiple; why promote exclusivity? Relationships can come and go, and reasonably so; why promote permanence? If marriage is a freely chosen relationship unconnected to sex, children, exclusivity or permanence, why have legal marriage at all?”

Miller, Robyn Cheryl (2001) Marriage Between Persons of Same Sex, 81 A.L.R. 5th 1 (summarizing same-sex marriage cases decided to date).

“In truth, every court that has addressed the issue has rejected the right to same-sex marriage under both the Equal Protection and Due Process Clauses of the Fourteenth Amendment.”

Other


**Human Cloning**

As Christian physicians and dentists, we believe that human life is sacred because each individual is made by God in His own image. God’s design is that each individual is formed by the union of genetic material from a husband and wife. We further believe that the family is the basic social unit designed by God to receive and nurture new human life.

There are moral reasons to refrain from proceeding with human cloning. First and foremost, the development of this technology will require the deliberate sacrifice of human embryos. We believe this to be immoral. The use of human life merely as a means to an end is likewise morally unacceptable. Another moral concern is the question of the timing and significance of ensoulment. Furthermore, cloning may deviate from the wisdom of God's design for human genetic diversity and therefore may be unwise.

There are scientific reasons to oppose human cloning such as the potential for mutation, transmission of mitochondrial diseases, and the negative effects from the aging genetic material. There are also societal reasons to be hesitant about human cloning such as questions about parentage, lineage, family structure and the uniqueness of the individual.

Therefore, we believe that human cloning should not be pursued given our current understanding and knowledge. We affirm the need for continued moral scrutiny as research on animal cloning proceeds and proposals for the application of this technology to humans are advanced.

**Explanation**

**Background**

Cloning, the production of an individual genetically identical to another, has been the stuff of science fiction and theoretical philosophical discussion for the past generation. Although one form of cloning (the stimulation of twinning) has been used in animal husbandry for many years, it was felt by laypersons and scientists alike that technical obstacles would prevent the production of a new baby animal from the cells of an existing adult. This perception changed overnight in February 1997 with the announcement of the successful cloning of a sheep by Professor Wilmut and his associates in Scotland.

**Secular Perspective**

This announcement was greeted with mixed response from scientists, philosophers, public policy experts, and laypersons. It rekindled the old debate about the propriety of trying to clone humans.

Some argued that when this technique becomes available for use in humans, it would be a natural extension of already existing techniques of artificial reproduction. It would provide one more way for an infertile couple to have a child. According to these proponents, it would actually be preferable to those currently used techniques which produce a child who bears no genetic ties to either parent; in fact, it would make a child who is genetically identical to one of the parents.

Most who ventured an opinion, however, were more cautious. Many wanted to ban human cloning, either temporarily or permanently. The concerns raised were mostly of a consequential nature: concerns about...
possible genetic damage to the new individual, difficulties with sorting out relationships, etc. Others were concerned about the motivations to pursue cloning: replacement of a dying child, a source of transplantable organs, duplication of individuals deemed to be superior, asexual reproduction by lesbians, etc.

But many expressed an intuitive feeling that there was something fundamentally wrong with trying to duplicate a human being: questions were raised about individual uniqueness, lineage and family structure, the commodification of life, using people as means rather than as ends, etc. This technological possibility seems like a difference in kind, not merely a difference in degree from current technology.

Christian Perspective

Among the voices raised in commentary on the revitalized issue of human cloning were many theologians. Some condemned the idea as inconsistent with God's plan. Some raised questions about ensoulment. Others felt that cloning is an amoral technology; the ethical issues were it how it was to be used.

The CMDS statement on Human Cloning recognizes the consequential and prudential reasons to avoid cloning, but it's opposition relies more strongly on several basic biblical principles. Each individual human life is sacred. This sanctity of human life is because of the mystery of God's implantation of His image in each unique creation (Gen. 1:26-27). God's design for perpetuation of the human race is for sexual reproduction (Gen. 1:28) within a family structure which was ordained by Him (Gen 2:24) and affirmed by Jesus (Matt. 19:5). [see CMDS statement on Human Sexuality] Although God does give to humankind dominion over nature (Gen. 1:26, 28), CMDS does not believe that this dominion extends to an alteration of God's basic design for procreation. Natural reproduction, even using some forms of assisted reproductive technology, preserves God design because it results in unique individuals whose genetic makeup is determined by God. Cloning, on the other hand, usurps God's authority by substituting human choice and standards.

Abstracts


One of the original participants of the great cloning debates of the 1970s, Kass vigorously argues against cloning. Kass states that cloning would "undermine the justification and support that biological parenthood gives to a monogamous marriage." He argues that this is the ultimate outcome of the sexual revolution, where fathers are not needed. Furthermore, he believes that by destroying our links to our past, we loose our accountability to our ancestors—forget our debt to the past. He calls us to step back and carefully consider the implications of this new technology—and not to simply be taken by the glamour of it.

The author fears that once cloning technology became as widespread as assisted reproduction techniques, a person would be able to visit a gene bank and select a celebrity or athlete's DNA. Arguing that this is a further extension of the pro-abortion line of reasoning that children should be wanted, Kass wonders if wanted children, designed children, would simply become an extension of the parent—and not autonomous individuals.

Arguing that cloning is simply an act of self-preservation, Kass believes that sexual reproduction involves acknowledging the limitations of corporeal existence, the acceptance of the divine. Furthermore, he states that through the sexual experience one gets a fleeting glimpse at the wholeness we will experience with God, and that through the birth and life of a child we experience transcendence. The child is a product of love for another, not love for oneself.

The author argues further that subjecting a future human life to experimentation, wrought with the possibility of deformity and death, is immoral. He questions whether a clone, no longer a surprise to the world, would ever be able to live a unique life; he would be subject to constant comparison to his 'alter ego.' Kass also vigorously argues that the 'single parent child' would never truly experience belonging in the social relations that we currently subscribe to—brother-sister, mother-child, etc.

Kass proposes an international ban on human cloning. By accepting the deep ethical norms of the people, Kass believes that the scientific community would engender the respect of the general public, and would be free to pursue genetic knowledge. Acknowledging that there are some acts so egregious, so
repugnant that we do not even attempt to rationalize them, the author calls us to bring cloning into that realm. Quoting Paul Ramsey, Kass ends by saying "The good things that men do can be made complete only by the things that they refuse to do."


Meileander argues that procreation is a product of love, the child a gift of the act of love. It is not a human project, as the child is begotten by humans through the work of God. When procreation becomes reproduction, a human act occurring in the laboratory, it ceases to be a gift from God, a selfless act of love. The author argues that cloning is the polar opposite of the selfless love from which a child springs forth. It is selfishness, the attempt to produce a child that will live, and clone, in perpetuity, as the original.


The author argues that regardless of the apparently miraculous achievements of science, it is impossible to clone the human brain with its billions of experience-molded synapses. He states that even if the neurons were identically attached, the simple change in firing of a single neuron would alter that person in such a way that they would again become an individual—concluding "everyone has a soul."


The author argues that there are technical and moral reasons to oppose human cloning. While the technical reasons (fetal wastage, perpetuation of genetic disease, unknown effects of aging, mutations, distortion of family relationships, etc.) may be sufficient for many to say "not yet", the moral reasons dictate a stance of not ever. The author believes that it is a violation of God's plan for unique, genetically different individuals and offspring.


Verhey states that cloning would lead to a loss of the individual, with the process of procreation resulting in a child less of a product of love, and more of a product—bound by the consumeristic desire for perfection. He calls us to reexamine our Baconian lust for technology and knowledge, and to adopt C.S. Lewis awe for the creation.


The debate about cloning that took place 25 years ago, although directed toward a different sort of cloning, elucidates fundamental issues currently at stake in reproductive technologies and research. Paul Ramsey and Joseph Fletcher were participants in this early debate. The differences between Ramsey and Fletcher about the meaning and sufficiency of freedom, the understanding and weighing of good and evil, the connection between embodiment and personhood, and the relationship of humans with nature suggest both a broader agenda for the debate about cloning and a cautious move forward in the development of embryo splitting.

**Bibliography**


A Catholic ethicist explains his opposition to human cloning based on the loss of individuality, and the usurpation of God's plan for human nurturing and families.


The author argues against the ban on cloning, stating that "it will reduce cloning to a political football, raise serious constitutional problems, and chill important research."

The author believes that while the National Bioethics Advisory Commission’s report is quite simple and conciliatory, to provide the democratic process time to carefully review the process, and develop a more formal response to cloning.


The author argues against a ban on human cloning, stating that "science fiction should not drive science policy." Sadly, the author fails to address the ethical concerns of such research, calling them "vague and highly speculative."
Human Enhancement

Humans have created and continue to create technologies that modify living substrate, manipulating existing functional performance or behavior. Many of these technologies are welcomed for their therapeutic potential to bring healing and restoration. However, such technologies have also been directed to the re-engineering of human life, which some refer to as "enhancement." They include, but are not limited to, genetic technologies, synthetic biology, nanotechnologies, pharmacology, and neurotechnologies. The purpose of this statement is to examine whether or not human re-engineering through technology is:

- Acceptable within our place as created beings charged with stewardship of our lives before our Creator God,
- Ethical within the historical norms of medical ethics, and
- Prudent and just within the context of limited medical resources in a world in which suffering due to poverty and absence or profound deficiency of even simple life-saving technology is the reality for over one-third of humanity (according to World Health Organization data).

A critical aspect of this question is how the relevant terms are defined. The reader is encouraged to review the appended glossary before proceeding with the remainder of this statement, and in interpreting this statement to respect CMDA's use of these terms.

CMDA Affirms:

- That the purpose of human life is defined by God, not by the sinful desires of human beings (Rom 9:20-21; 1 Cor 6:19-20; Eph 2:10; Gal 2:20; Mark 7:21-23)
- That, according to Scripture, the purpose of human life is fellowship with God and our fellow human beings within the confines of our created nature (Rom 8:22-30; Deu 6:4-5; Matt 22:37-40; John 17:3)
- That the model of human being and flourishing is the person of Jesus Christ (Rom 8:29)
- That no human re-engineering technologies are capable of attaining the model of Jesus Christ or are necessary for human flourishing (2 Cor 3:18)
- That immortality can be achieved only by the saving work of Jesus Christ (1 John 5:12); utopian false promises of re-engineered, matter-based, so-called technological immortality are an idolatrous illusion and a counterfeit salvation
- That human beings should commit to stewardship of their talents and gifts for the glory of God, the development of godly character, and service to one another (Micah 6:8; Matt 25:14-30; Rom 12:1-3; 1 Cor 10:23-24; 1 Peter 3:3-4)

CMDA Concludes:

- That the goals of medicine should remain healing, restoration, and palliation, never commodification of persons or purveying of narcissistic wish fulfillment
- That the pursuit of human re-engineering would, in contrast, sinfully distract from God's intentions for human flourishing and stewardship
- That the pursuit of non-healing or non-restorative endeavors for the purpose of human re-engineering is unjust; a deviation from the historical goals of medicine; and a misappropriation of medical knowledge, training and resources
- That the misuse of biomedical technology to address issues caused by social pathology is poor stewardship that aggravates rather than solves those issues and is ultimately futile, as it fails to legitimately or effectively address the true problems, which lie outside the domain of medicine
- That the human biomedical re-engineering project, which has the potential to radically alter or even eradicate dimensions of God-given human nature is, therefore, unacceptable, unethical, and imprudent
- That the refusal to support or perform human re-engineering technologies is not a violation of respect for patient autonomy, properly understood
That coerced re-engineering of human beings by governments, military forces, insurers, or private enterprises for the condition of employment or service is contrary to human dignity and freedom; health care professionals should maintain the right of conscientious objection against complicity with such coercion (see CMDA Statement on Right of Conscience)

That acceptance of some forms of cosmetic enhancement about which conscientious Christian health care professionals disagree should not imply tacit approval for biomedical enhancements in general or re-engineering specifically

That every scientist, researcher, engineer, and medical professional should interrogate each biomedical technology and its use in specific situations with the following 10 questions¹ to assist in the determination whether the application is God-honoring, acceptable, ethical, prudent, and just:

1. Does the technology treat our common, limited medical resources responsibly within the constraints of just stewardship before God?
2. Has the technology been sufficiently evaluated in regard to its possible risks and benefits, short-term and long-term? What are the consequences, reversible and irreversible, of the technology for future generations?
3. Does the technology diminish or exacerbate unjust social inequalities?
4. Does the technology facilitate healing or restoration from disease or disability, or is it intended for human re-engineering? Is the technology being used to address biomedical pathology or social pathology?
5. Does the technology enrich or impoverish human relationships?
6. Does the technology truly ennable, assisting virtue, or would it subvert authenticity, misrepresent and distort identity, or corrupt attitudes?
7. Does the technology promote a community that values and accepts all individuals regardless of their attributes?
8. Does the technology require or promote the commodification, exploitation, or destruction of human life?
   o Does it demean, debase, or degrade individuals?
   o Does it require or reinforce diminished views of human life, human value, and the human being?
9. Does the technology primarily appeal to our basest inclinations?
   o Does it appeal to our pride?
   o Does it encourage materialism?
   o Does it promote narcissistic self-absorption?
   o Does it appeal to lust or promote sexual commodification?
   o Does it promote servitude or enslavement to fickle whims of fashion?
   o Does it support or perpetuate obsession with one’s body image?
10. Does the technology promote genuine human flourishing, or does it more likely promote technological or economic imperatives?

Approved by the House of Representatives
Passed unanimously
April 30, 2015, Ridgecrest, NC

Glossary of Terms as Understood by CMDA

• **Autonomy (as it relates to medical practice):** Autonomy, or more accurately, respect for patient autonomy, is the principle that articulates the reality that each person possesses his or her own beliefs, values, fears, and goals, which influence the understanding of what is good and harmful in regards to health care. Health care professionals should respect and integrate those elements in jointly making health care decisions. However, respect for patient autonomy is essentially a negative right, that is, it provides the patient with veto power over a proposed medical intervention that may be recommended by the patient’s doctor. It is the ability to maintain bodily
and personal integrity by respecting patient refusal from unwanted “touching” or interventions. It is not a positive right permitting a patient to request and receive any intervention he or she desires. Autonomy is, therefore, a limit or check upon medical professionals' primary ethical obligations of beneficence (to promote the good for a patient) and non-maleficence (to avoid as much as possible harm in the process of pursuing the good).

• Disease and Disability: Diseases are those states in which mental, anatomical or physiological functioning have decreased or deteriorated from baseline for an individual, or that operate outside of typical norms for the human species, producing a decreased ability for the person to function and survive compared to the majority of humanity. One definition of disability, as defined by the U. S. Americans With Disabilities Act of 1990, is “a physical or mental impairment that substantially limits one or more of the major life activities of the individual.” Lacking in a biotechnological enhancement should not be considered a disease or disability.

• Enhancement: For the purposes of this statement, an enhancement is an intervention that seeks to improve upon species-typical norms. It is a modification of a medically defined normal human trait, while lacking disease, dysfunction or defacement by injury, or congenital abnormality. In other words, an enhancement is an intervention to change that which is not broken. Examples include medication to augment cognitive performance, medication to make sleep unnecessary, recombinant erythropoietin or anabolic steroids to increase muscular performance or endurance in competitive sports, or biotechnological interventions to the human body that would confer novel capabilities. The use of “enhancement” as a medical term is discouraged because it is value-laden and morally presumptuous. The use of "enhancement" presumes that the net change of the intervention is an improvement, when this may not be the case, either in the outcome achieved, or in the balance between intended improvements versus other consequences or side effects of the intervention. It is also discouraged because of its lack of specificity. Training to improve a certain level of performance within species-typical norms may also “enhance” that function or performance, more in keeping with the process of Stewardship (see below). “Re-engineering” is recommended as a more accurate and objective description of these interventions.

• The Goals, or Telos, of Medicine: The goals of medicine are to cure disease, restore lost function, palliate symptoms, enable living with disease or disability, and prevention of disease through stewardship. Human re-engineering, however, is not included in or compatible with the goals of medicine.

• Healing and restoration: Those interventions which seek to restore structure and function to an individual’s baseline or species-typical norms. Healing and restoration are responses to injury or disease; they are not modification dictated solely by desire.

• Re-engineering: Efforts to alter the substrate, structure or function of a given genetic, anatomical or physiological state or function. Re-engineering technologies seek to “improve” upon traits that are within or supersede normal levels and make them "superhuman." Re-engineering efforts are not directed at healing or restoration but at change simply because change is desired. Re-engineering, a more objective term than “enhancement,” is a repudiation of normal human life and its Creator.

• Social Pathology: In this context, aspects of the social milieu that impose sinful, vain, covetous, or degrading expectations upon individuals to meet another individual’s, collective’s, or the larger society’s wishes or definitions for conformity, performance, or appearance. Social pathology either deliberately or unconsciously attempts to make individuals conform to an arbitrary, non-biblical, humanly-defined standard, or to feel guilty, a burden, inadequate, unacceptable or unlovable if one fails to so conform. Social pathology often leads to personal dissatisfaction or self-loathing. Examples of pathological social standards are found in fashion, advertising, media, and pornography, or anywhere there is excessive focus on one's appearance, cognition, or physical performance.

• Stewardship: Interventions that attempt to preserve and best utilize existing life and function within the scripturally articulated goals for human life as created by God. These elements are those that maintain normal function within the traits of the human species. Examples include rest,
appropriate nutrition, education, training, physical exercise, prayer, hygiene, vaccinations and other appropriate medical treatment. All of these depend upon normal underlying mental, spiritual, and physiological processes, without a requirement for re-engineering their fundamental nature or operation.

- **Technology**: “A distinct human cultural activity in which humans exercise freedom and responsibility in response to God by forming and transforming the natural creation, with the aid of tools and procedures, for practical ends and purposes.”

A corollary of this definition is that all technology should be used in obedience to God’s plans for His creation and our place in it. Biotechnology is a subset of technology which interacts with or modifies living cells and organisms.

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1 Modified from Hook, 2007; and Cheshire, 2011.

**Bibliography**

*Christian Perspectives*


Secular Perspectives


*Transhumanist Perspectives*


N.B. This bibliography, which draws from a wide range of viewpoints on the ethics of human enhancement and re-engineering, is provided for educational purposes. CMDA does not necessarily agree with the opinions cited.
Human Hybrids and Chimeras

Science has developed the capability to create novel organisms by combining cells or tissues (chimeras) or genetic information (hybrids) from different species. The creation of novel organisms that combine human and animal living cells or human and animal genetic material raises moral concerns not only regarding individual patients but also the whole of humanity and the human future.

CMDA believes that a distinct moral boundary separates human from nonhuman animal life. This boundary is not definable by cognitive, physical or genetic criteria alone. God established this boundary when he created humankind in his own image. God granted humankind alone a spiritual nature and gave humankind responsibility and dominion over all other creatures, which, by his design, reproduce according to their own kind. We must respect the created and clear boundary between humankind and animals.

Nonhuman animals are a valuable resource for medicine. From animals medical science has acquired knowledge about cellular and organ function, gained insights into genetics, and developed models of human disease and drug effects. For example, from animals we obtain transplantable heart valves that save human lives. CMDA recognizes valid ethical frameworks for each of these enterprises, which derive benefit for humankind from the anatomical, biochemical, genetic and physiological similarities that humans and nonhuman animals share as earthly creatures.

Ethical Guidelines

1. As Christians and as medical professionals, we are bound to actively seek the spiritual and physical well-being of all humankind.

2. The use of research and technology must be guided and limited by ethical principles. There is no unlimited or unrestricted technological imperative.

3. There are compelling moral reasons to refrain from applying biotechnology to create chimeras or hybrid organisms that are partly human and partly nonhuman. These reasons include:

   - Humankind alone was created in God’s Image.
     - We are not to desecrate the image of God by reducing a human being to animal status.
     - We are never to elevate animals to human status.
     - We are not to create intermediate or indeterminate species sharing human and animal genetic material.

   - Humankind alone has the unique capacity to enter into a personal relationship with God through Jesus Christ his Son. Because human dignity is not wholly reducible to cellular matter or fully determined by genes, some limited combinations of cellular or genetic material across species lines may be ethically permissible (see Appendix). However, there are certain human characteristics that are inviolate and should not be blended with animal characteristics. We must not compromise that which makes us human. Fundamentally this includes the ability to know God and may encompass such characteristics as human reasoning, free will, and sexuality. The formation of human organisms that have nonhuman progenitors or are capable of generating nonhuman offspring is an affront to God, his created order, and his image within us.

   - It is not permissible to use human subjects for research purposes without disclosure and informed and voluntary consent.
In matters this consequential, full disclosure and discussion should extend to society as a whole. Societal consent, however, does not determine moral acceptability.

Preventing harm to human beings is a moral mandate. The potential consequences of human chimera/hybrid research are so far-reaching and troublesome that the most stringent precaution is required. For example:

- Chimeras and hybrids will enable diseases to cross species lines, bypassing normal barriers and resistance, imperiling both the individual and the species.
- Transferring genes encoding disease may cause novel virulence, or create new diseases, gravely threatening the host species and public health.

We are stewards of the animal kingdom and owe to it our care and concern. Although it is permissible to use animals in experiments designed to improve human care, we must not violate the mandate of stewardship by engaging in cruel or needlessly destructive experiments.

The creation in the laboratory of creatures or species with novel sentience would place upon society moral obligations for which we are unprepared.

Moral problems are not resolved by terminating the life of the chimera prior to the emergence of any particular stage of development.

Moral problems are not nullified by anticipated scientific or medical gains.

**Conclusion**

CMDA endorses ethical chimeric and hybrid research and technology designed for the benefit of humankind, provided that these are safe and do not degrade the unique status of humankind.

CMDA opposes chimeric and hybrid research and technology that fundamentally alters human nature as designed by God.

**APPENDIX**

_Evaluative Guidelines for Chimeric and Hybrid Research_

Realizing this is a continually developing area of technology and it is not possible to identify and address all the potential variations, we suggest the following guidelines:

**I. CMDA approves the following as morally acceptable:**

- The use of recombinant DNA for research, environmental improvement, drug development, and medical treatment purposes.
- The following projects, provided they can be done safely and without defacing the Image of God:
  - Transgenic research and treatment of disease
    - Transfer of a limited amount of human genetic material or human-derived gene products into an animal or animal cell line
    - Transfer of a limited amount of animal genetic material or animal-derived gene products into a human or human cell line
  - Xenotransplantation research and treatment of disease
    - Transplantation of nonliving animal tissue into a human host to treat disease
    - Transplantation of living animal tissues or organs into a human host to treat disease
    - Transfer of human organs or tissue into a nonhuman host for temporary safekeeping
II. CMDA considers the following projects to be morally uncertain or questionable and in need of further reflection, broad dialogue, and study:
- Creation and cultivation of nonhuman animals possessing a distinctively human organ system other than a brain
- Transfer across species lines, from human to animal or from animal to human, of functioning central nervous system tissue, even if it does not appear to alter higher cerebral function
- Transfer across species lines, from human to animal or from animal to human, of cells or genetic material that might have the potential to alter higher cerebral function

III. CMDA, based on the current scientific understanding, considers the following project to be morally unacceptable:
- Transplantation which confers the reproductive capacity of one species to another
  - Engineering a nonhuman life form such that human gametes develop within its body
  - Engineering a human being having nonhuman gametes
- Mixing of human and nonhuman gametes
  - Fertilizing a human egg with animal sperm
  - Fertilizing an animal egg with human sperm
- Combining human and nonhuman gamete equivalents
  - Introducing a human nucleus into a nonhuman egg
  - Introducing a nonhuman nucleus into a human egg
  - Creating an embryo combining haploid sets of chromosomes from both human and nonhuman progenitors
- Mixing of human and nonhuman blastomeres
- Cross-species pregnancy involving humans
  - Placing a live human embryo or fetus into an animal
  - Placing a live animal embryo or fetus into a human
- Exchange of distinctive form
  - Redesigning an animal to bear distinctively human physical features
  - Redesigning humans to bear distinctively animal physical features
- Exchange of distinctive function
  - Engineering a nonhuman life form containing a human brain or a brain derived wholly or predominantly from human neural tissue
  - Redesigning humans to take on distinctively animal functional capacities, for example, to enhance performance

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Passed with 52 approvals and 2 abstentions
June 20, 2008, Chicago, IL

*Bibliography available on www.cmda.org
The term “chimera” has also been used in reference to certain natural phenomena occurring within a species. For example, humans commonly harbor some cells from the mother acquired during gestation (a process known as microchimerism). Rarely, the fusion of genetically distinct twin human embryos can result in the birth of one “chimeric” individual whose tissues comprise two populations of cells containing two sets of genetic information. The terms “chimera” and “hybrid” as used in this statement are meant to refer specifically to interspecies organisms combining human and nonhuman cells or genetic material.

2 I Cor. 15:38-40
3 Hebrews 1:3, Colossians 1:15-20, II Cor. 4:5-6
4 see pending CMDA statement on Research Ethics in Human Beings.
5 “Primum non nocere.” Hippocrates, Epidemics. Additionally, find reference to another document. [We discussed using a Scripture reference, but there are numerous ones; uncertain whether there is one key verse.]

GLOSSARY - Human Hybrids and Chimeras

Blastomere: A stage in the early development of the embryo occurring approximately days 2 to 7 after fertilization. In its later stages (days 5 to 7) the blastomere assumes the shape of a hollow ball called a blastocyst.

Central Nervous System: The brain and spinal cord – as opposed to the peripheral nervous system consisting of the nerves extending from the central nervous system to the tissues and organs of the body.

Chimera: A single individual having cells, tissues, or organs from two or more different species. (See Hybrid)

Chromosome Organized: Structure of DNA within the nucleus of the cell containing the genes and most of the DNA of the organism.

Cognitive: Of or relating to conscious intellectual activity. The process whereby we think or are aware.

DNA: The letters used to designate deoxyribonucleic acid, the nucleic acid that contains the genetic instructions used in the development and functioning of all known living organisms.

Encoding: The process of transforming information from one format to another. In genetics this refers to information from DNA of the nucleus being transformed into workable instructions to the cell.

Gamete: The sex cell. In the human a gamete would be a sperm or an oocyte (egg). Gamete equivalent A quantity of DNA sufficient to function as the equivalent or near-equivalent of a sperm or egg.

Gene: A segment of genomic (DNA) information that must be taken as a whole to define traits. The gene is the basic unit of heredity. The human cell contains about 25-30,000 genes.

Haploid Half: A haploid cell would contain only one member or set of the two paired chromosomes of a living organism. This occurs norm ally in the gamete (or sex cell) so that the combination of the egg and sperm (haploid cells) results in complete DNA information at fertilization.

Hybrid: A single individual having DNA from two or more different species. (See Chimera)
**Recombinant DNA:** A DNA sequence formed by the joining (transplanting, splicing) of the DNA from two unrelated organisms.  

**Species:** A species is one of the basic units of biological classification and a taxonomic rank—often defined as a group of organisms capable of interbreeding and producing fertile offspring.

**Transgenic:** Having a foreign gene from another species.

**Xenotransplantation:** *Xeno* from Greek, *foreign.* The transplantation of living cells, tissues or organs from one species to another. Such an act would form a chimera.
Human Life: Its Moral Worth

The moral worth of human beings is absolute and eternal. God has created humans in his image; therefore human life has intrinsic moral worth. The following concepts are essential to our understanding of a human being’s moral worth.

Image of God is the Scriptural term that refers to the transcendent dignity imparted by God to mankind at creation. The image of God is who we are, not something we possess. The image of God is intrinsic to the entire person as an embodied soul (or ensouled body). It is a gift of God that finds continuity in human procreation and finds expression in such aspects of our human nature as reason, volition, moral sense, God-consciousness, worship, etc. However, bearing the image of God does not require certain capacities such as self-consciousness, self-awareness, autonomy, rationality, ability to feel pain or pleasure, level of development, relational ability, etc. Bearing the image of God qualitatively separates humankind from the rest of creation and gives human beings their mysterious, unique, and infinite moral worth and dignity.

Every being of human origin is a person. A person is not a Homo sapiens with the superadded quality of “personhood.” Some, however, would attempt to withhold moral worth from human beings unless they “qualify” as persons. The status of “personhood” cannot be conferred by society.

The image of God confers upon each human being a sacred quality. The sacredness of human life calls forth respect and love for each individual as uniquely created in God’s image. Love and respect for human beings as created in God’s image require more than mere respect for autonomy or privacy. How we treat others reflects our attitude to God. “Whatever you did for one of the least of these brothers of mine, you did for me.”

The beginning and continuity of the moral worth of human life are concurrent with human life itself. Human worth begins with the one-cell human embryo and lasts lifelong. A living human being is an integrated organism with the genetic endowment of the species Homo sapiens. This includes the inherent active biological disposition for ordered growth and development in a continuous and seamless maturation process. It also includes the potential to manifest such fundamental traits as rationality, self-awareness, communication, and relationship with God, other human beings, and the environment. Thus a human being, despite the expression of different and more mature secondary characteristics, has genetic and ontological identity and continuity throughout all stages of development from formation of the human being until death. Human embryos are not “potential” human beings; rather, they are human beings with potential. Moral worth is not dependent on potential. A human being with a defect or disease is no less a person.

The image of God, intrinsic to each individual, imparts moral worth in all stages of human life. The image of God makes each individual uniquely worthy of service. Each person is known and loved by God, and the image of God in man endows every one with a capacity to know and love Him. The capacity for this personal relationship with God demonstrates the immense value God places on each human life. CMDA believes the proper response to being made in God’s image is one of gratitude and should be borne out in faithful relationship to God and others.

1The Image of God present in man is referred to in: Gen 1: 26-27; 5: 1-3; 9: 6; I Cor 11: 7; and Jas 3: 9. The Image of God is displayed resplendent, undiminished and uniquely in the person of Jesus: II Cor 4: 4; Col 1: 15; Heb 1: 3. The Image of God is being developed into Christ-like dimensions in his followers: Rom 8: 29; I Cor 15: 49; II Cor 3: 18; Eph 4: 24; Phil 3: 21; Col 3: 10.
2CMDA recognizes that Christian traditions have varied views of what constitutes the image theologically and the ways in which it has been affected by the fall into sin (Gen 3).

3Matthew 25: 40

4Ontology is the philosophical study of what is real or actual, of what exists. Ontological identity means identity existing in reality.

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Passed Unanimously
June 22, 2007, Orlando, Florida
Human Research Ethics

CMDA recognizes the mandate God gave to be wise stewards over our world (Gen 1:28). We also delight in responding to God’s call to alleviate suffering. Research on human subjects is often an appropriate way to accomplish these ends. Research on humans should never intend to harm the subject and any harm caused to the patient must only be allowed with the expectation or the achievement of a greater benefit for the patient.

Research involving human beings is invaluable, and it provides important new information as well as broad benefits for mankind. Scientific rigor and ethical principles – providing for the respect and dignity of human life – are paramount in this research. CMDA believes Scripture (Matt 22:37-40) provides the moral foundation that informs these ethical decisions.

There are recognizable and intangible benefits to research subjects. Some patients near the end of life, and healthy volunteers, knowing that they will not benefit personally from the research are willing to participate for the benefit of others.

Research involving human beings has a domestic and an international history of abuse (for example, the Tuskegee Syphilis Study and the Nazi atrocities of World War II) that must be remembered. Learning from the past moral violations in human research is essential to safeguard future endeavors. The Nuremberg Code, the Declaration of Helsinki, and the Belmont Report are historical documents that addressed past abuses of human beings.

Human research ethics involves institutions, investigators, sponsors, subjects, and data. Research ethics is necessary to provide guidelines and boundaries for research teams and sponsoring organizations in order to protect human subjects from harm. This is especially needed when research crosses biologic, economic, social, ethnic and cultural boundaries.

The participants – human beings made in the image of God (Gen 1:27) – must be treated as unique and special creations and the researchers must exercise compassion, dignity, fairness, and respect for human beings.

- Research should only be conducted if the proposed benefit outweighs the burdens and risks to the human subjects. Vulnerable populations – such as children and prisoners – must be granted additional protection
- Informed consent must be obtained in advance from the participant or appropriate proxy
- Participation must be voluntary, and researchers must make conscientious effort to avoid coercive situations. Coercive situations may arise in the context of disparities such as wealth, social (or institutional) class, education, age, gender, ethnicity and race
- Participants must be allowed to terminate their participation in the trial at any time without reprisal

The research team must be cognizant of its obligations and act appropriately. (1 Cor 4:27)

- Research studies must ask a question of significant importance for human benefit and health, and must be designed to obtain unbiased data and be sufficiently powered for statistical significance
- Research studies should be reviewed by an Institutional Review Board, and they must be assessed for predictable risks and burdens, maximizing the foreseeable benefits
• Potential conflicts of interest, at any level (e.g., institutional review board, the research subject, the publishing journal, and/or the sponsor) must be disclosed, and they must be adequately addressed
• Conflicts of interest arise when the researcher has a dual relationship with the subject (as investigator and treating clinician), and as such, the researcher must act in the best interest of the subject
• Placebo and non-treatment trials are not permitted when a proven therapy is available and omission of a proven therapy would result in harm
• All results, including beneficial and non-beneficial data, must be openly reported without bias
• Confidentiality of the subjects must be maintained
• Fabrication, falsification, and plagiarism are to be assiduously avoided and punished
• Responsibility and appropriate care for subjects suffering adverse research outcomes must be provided
• Authorship criteria and credentialing must be accurately reported

Research performed in any country or culture requires that:
• Researchers and host authorities share responsibility for the protection of the research subjects in accordance with their human dignity as bearers of the image of God.
• The research study must be responsive to the health needs of its people
• Research results and ensuing benefits should extend to the people of the host country
• Neither research location nor selection of subjects should be chosen to take advantage of a lower research standard

Research study information should be disclosed to the public when:
• Results are scientifically valid
• Research findings offer therapeutic implications for the study population or the study condition
• Important new data (positive or negative) have been discovered

Research study information may be withheld when research is incomplete and premature disclosure would compromise the study validity

Research studies must be discontinued when:
• Clear and unequivocal improvement or harm in the study group is identified
• Research protocols have been irrevocably compromised

Conclusion

CMDA endorses research using human subjects with proper consent if the studies are transparent in design and implementation, providing it is protective and non-exploitive. CMDA believes that human subject research, with the above conditions, respects God’s design of human beings made in His image.

Approved by the House of Representatives
Passed Unanimously
April 29, 2010. Ridgecrest, North Carolina
References:

1 Genesis 1:28 - God blessed them and said to them, “Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish of the sea and the birds of the air and over every living creature that moves on the ground.”

2 See CMDA Statement on “Biblical Model for Medical Ethics”

3 Matthew 22: 37-40 - Jesus replied: “‘Love the Lord your God with all your heart and with all your soul and with all your mind.’ This is the first and greatest commandment. And the second is like it: ‘Love your neighbor as yourself.’ All the Law and the Prophets hang on these two commandments.”

4 See CMDA Statement on “Human Life: Its Moral Worth”

5 Genesis 1: 27 - So God created man in his own image, in the image of God he created him; male and female he created them.

6 See CMDA Statements on “Fetal Tissue for Experimentation and Transplantation” and “Human Stem Cell Research and Use”

7 I Corinthians. 4:2 - Now it is required that those who have been given a trust must prove faithful.

8 Placebo-controlled trials are valuable in many research situations. However, it is not ethical to conduct non-treatment trials in conditions known to be progressive or lethal (e.g., syphilis and cancer) when effective treatments are available.
Human Sexuality

God created human beings with many dimensions, one of which is their unique sexual nature. As men and women, we are physical, intellectual, emotional, relational, and spiritual beings, and thus distinguished from the rest of creation.

Many levels of sexual expression are possible between men and women.

One important expression of sexuality is friendship; the sexual differences between men and women enhance meaningful, warm, and healthy relationships. A second important area of sexual expression is intimacy between husband and wife. God has designed the most intimate expressions of sexuality, including intercourse, specifically for the marriage relationship. The Bible describes the covenantal relationship of love which God has for His people; the husband-wife relationship is analogous. Since God holds the marriage relationship close to His heart, its violation is a serious offense to Him.

Our integrated nature means that intimate sexual expression profoundly affects all dimensions of our being. While sexual expression outside of God's design may provide temporary pleasure, God's guidelines are meant to protect us from disease, fear, exploitation, and ultimately dehumanization.

CMDA affirms the biblical principles stated above. These principles are clarified further by the following statements:

1. Sexual intercourse is to be reserved exclusively for heterosexual marriage.
2. Single men and women who engage in sexual intercourse are outside of God's limits and are practicing sin.
3. Married people who have intercourse with anyone other than their marriage partner are defiling a marriage union which God has sealed and are in sin.
4. Like single heterosexuals who engage in heterosexual sex, or married persons who engage in extra-marital sex, homosexuals who engage in homosexual acts are practicing sin.
5. We condemn the perversion of sexuality in pornography, rape, incest, and all other forms of sexuality that deviate from the biblical norm for Christian marriage.
6. Family life teaching and sexual education are God-given responsibilities of parents. The Church's task is to assist both parents and youth in understanding their sexuality in the context of biblical values. When appropriate, sexual education should include risk behavior information and instruction on protective techniques to inhibit the spread of AIDS and all other sexually transmitted diseases.
7. Education and protective techniques alone, however, will not stop the spread of AIDS. Our society needs to understand and acknowledge that there are compelling emotional, philosophical, medical, sociological, and historical reasons for practicing abstinence before marriage and fidelity within marriage.*
CMDA calls our world to affirm these biblical sexual morals. We recognize and acknowledge that many persons struggle with sexual temptation and sin, and that all of us have fallen short of God's standards. We testify that God is just, merciful, loving, and faithful, and that He will, if we ask Him, forgive us of our sins and bring us into an intimate relationship with Him.

* From the CMDA Statement on AIDS
Approved by the CMDA House of Delegates
Passed unanimously

Explanation

One's sexuality is an important part of each individual. This is true for each patient, and it is equally true for each physician and dentist. God has disclosed in scripture clear instructions about the wise and proper expression of our human sexuality. These apply equally to patients and to professionals.

Many areas of medical practice deal with issues involving sexual practice, e.g. contraception, sterilization, masturbation, artificial reproductive technology, abortion, sexually transmitted diseases, etc., as well as many psychosocial issues. Christian healthcare professionals should have a clear understanding of the teachings of scripture both about the principles of beautiful sexual expression within marriage and about immoral sexual activity and the consequences thereof.

While there is near unanimity among Christians about the boundaries of sexual morality, there is not agreement on how the Christian healthcare professional should respond to patients who are seeking treatment for the consequences of sexual immorality, or who seek assistance with ongoing sexual practices which violate God's teachings.

Since the time of Hippocrates, the medical profession has made clear pronouncements regarding boundaries of impermissible behavior between physicians and their patients. The basis for those boundaries was (and is) not based on morality. The boundaries were established because of the fiduciary nature of the unequal professional relationship. Healthcare professionals have more knowledge and authority in their area of expertise than do their patients. Each patient comes to a professional for advice and treatment, and he or she should be able to trust that the professional person will use that knowledge and authority to seek the patient's best interests. The professional therefore must be trustworthy and must not exploit the vulnerable patient for his or her own interests. This clear professional boundary is consistent with the moral boundaries found in scripture.

The CMDS statement on Human Sexuality was written to affirm biblical teaching about sexual practice and as a reminder to physicians and dentists about the proper role of sexuality in their personal lives and in their professional relationships.

Human Sexuality Courses in Medical School

Medical students do not face issues in human sexuality for the first time in their human sexuality block, offered during the first or second year. From the initial urges and curiosities stirred up as puberty unfolded through junior high, senior high, and college years, the average student has discovered drives and questions that have been legitimately or illegitimately fulfilled, answered or unanswered. Whether through conversation or readings, courses or experimentation, romance or manipulation, some knowledge has been obtained on the subject before the first porno flick awakens groggy MS-II students during the introductory presentation in Human Sexuality 101. Whether married or single, male or female, unresolved issues usually accompany the student into the halls of clinical medicine; to some extent these issues are addressed in one's medical education. For the Christian medical student, however, the moral issues are firmly entwined with the medical issues and answers that fail to address the former leave the latter only partially fulfilled.

When these courses are elective, the decision about whether to enroll or not is a matter of individual conscience. These issues are certain to present themselves in one way or another to many clinicians. Where courses are rejected for their coarseness, some supplemental strategy should be engaged. Perhaps those who attend could offer a weekend or refined insight for absentees.
Given the interface between one's spirituality and one's sexuality, any consideration of sexual issues that ignores their moral dimensions is truncated, unidimensional, and immature. While it is not the intention of this brief section to address these concerns that life poses, the wise medical student would be resourceful in building a library of worthy volumes for self-directed learning. The bibliography (Section 2.3.4) should aid such an investment. Both for personal as well as patient benefit, such supplemental reading is mandatory so that the medical student who belongs to God may be efficient and equipped for good work of every kind (II Tim. 3:17, NEB). Such serious reading for the Christian presumes, obviously, the study of scripture where these topics are addressed.

**Single Lifestyles**

For the practicing Christian, self-discipline may be the central concern for the single student. But then self-discipline has its dividends. Any medical student or dental student already knows that: they wouldn't sit where they now sit if that had not been true in undergraduate days. Sexuality education obviously has its place---but how does one teach self-discipline, the central dynamic to successful living?

Given the pressures (cultural, hormonal, romantic) to be sexually active today, only the focused, self-disciplined, self-protecting (to say nothing of Christ-honoring) individual can see beyond immediate gratification to the joy of genuine, everlasting intimacy. If self-discipline is the key to admission to the nation's top colleges and universities, in joining the Olympic team, in being selected for an elite service unit, in joining a traveling ensemble, etc., it is a major key to successful marriage.

A significant number of Christian undergraduate and graduate students have responded to the primal urges without sufficient moral reflection; i.e. they have become sexually active without the benefit of bonding. Repentance, forgiveness, and restored discipline is the Christian paradigm, lived daily with innumerable issues other than those sexual, but equally applicable to those sexual. Don't let the world around you squeeze you into its own mold. (Rom. 12:1; Phillips)

If marriage is one's goal, then regular prayer for God's match-making skills to be sovereign and sufficient, observable and obvious is mandated. Marriage made in Heaven are usually the result of prayers sent to Heaven. A good question to ponder in the meantime---how sexually active do you wish your bride (groom) to be before you pledge your troth? With how many partners?

Issues in sexuality have personal as well as patient implications. Personal integrity is one major part of any counseling strategy. The clinician who knows the sexual dividends of honoring God's moral code is in a strong position to commend it to patients.

**Marriage and Sexuality**

Whether sexual curiosity, sexual education, or sexual dysfunction is the issue, the physician both as clinician and as lover needs to explore each of the major sexual themes I depth for patient as well as personal benefit. Some patient sexual concerns are specialty specific and residency training should provide answers and treatment plans appropriate to the inquiry or patient complaint.

Since the Christian faith teaches that sexual intimacy is reserved for marital intimacy, and since the God that Christians worship is pure love at the core of His Being, married Christians should be awesome lovers since covenantal commitment bonds both together in the arms of eros-agape.

Medicine is a most seductive mistress, both as clinical challenge in speeding health to hurting patients and as a proud profession conferring status on each practitioner. But nowhere does one become even close to being indispensable in life save as spouse and/or parent. Drop dead and twenty applicants will be available within a week for the job. While balancing priorities in such a demanding profession is very difficult, it is absolutely critical if integrity and intimacy are to be preserved. Severe caution should be exercised if joining committees in the church or community significantly intrudes on marital or family life. Rotating priorities over a lifetime encourages marital intimacy and preserves some sense of harmony in life. Doing everything at once is a recipe for disaster.

A fulfilling sexual life in a solid marriage provides a counseling platform where clinical expertise can blend with personal experience for patient benefit. This does not mean that indiscreet sharing is advocated. Rather that the physician will know what is preached is practiced and what is practiced is prescriptive for others because it meets medical-moral criteria for mature sexual functioning and personal happiness.
Homosexuality

One of the most controversial issues in the modern university and in the mainline denominations is the treatment of homosexual individuals. Christian clinicians need to learn to walk the high road above prejudice, alienation, disease, and politically-correct ideology in order to treat these patients with respect and dignity. Since all human beings are created in the image of God and since all individuals are a sum of their total segments, patients with this orientation merit sensitivity and competence regardless of their presenting complaint.

Competent clinicians will understand the Kinsey scale of heterosexual-homosexual orientation in order to interpret patient disclosure. HIV positive patients merit the latest interventions as well as compassion. It is possible to hold tradition moral/Biblical values in one hand while respecting the rights of these patients in the other. One of the virtues in the Fruit of the Spirit cluster is gentleness (Gal. 5:23). One of the characteristics of the attractive Christian is the ability to explain the Christian faith with gentleness and respect (I Peter 3:15).

As this debate progresses or regresses, serious reading in authoritative as well as theologically astute sources will be necessary.

Abstracts

Keighley JV. Contraceptives and the unmarried. CMDS Journal 1982; XII(2):27-30

This is a report of a study commissioned by the Christian Medical Fellowship in Great Britain regarding premarital intercourse and the supply of contraceptives to the unmarried. It compared the results of a survey of a small number of Christian young people (date not specified) to those of a large study published in 1969 done in a housing project near London which found that "extra-marital intercourse is the norm in this society." The Christian young people reported a high level of chastity and a good understanding of the biblical view of sexual activity.

The author discusses the dilemma of the Christian physician who is requested to prescribe oral contraceptives by an unmarried patient. She analyzes the potential benefits and harms and concludes that writing the prescription may sometimes be the right thing to do.

Jung BR. Physicians should not prescribe the pill for their unmarried patients. CMDS Journal Sept/Oct 1994; XXV(5):38-39

In this opinion piece, the author states that Christian physicians should not accede to the request for oral contraceptives from any unmarried patient because he does not believe that Jesus would respond in that way, but would instead tell the woman to "Go now and leave your life of sin." While it is quicker and easier to give the prescription, he believes he is morally obligated "to bring objective Truth to bear on her lifestyle, hoping she sill listen" and he states that his investment of time and energy is worthwhile.

Bibliography

Human Sexuality Data


Two Roman Catholic theologians address such issues as personal sexuality, contraception, family planning, sterilization, artificial insemination, IVF, rape, and "pastoral approach to problems of conscience that arise from an effort to live effectively as sexual human beings."


More than a dozen authors address issues of sexuality from various Christian (Protestant and Roman Catholic) perspectives.

A standard college and university textbook that provides basic data. The section on AIDS is very dated. Used by discriminating students in several Christian colleges.


A Christian gynecologist starts with the presumption that sex is good, but like another good, fire, it can go out of control and injure or kill. After detailed discussion of STDs, including clinical and epidemiological information, he makes a strong case for teaching children that abstinence until marriage is normal, healthy, and achievable.


"The only comprehensive and methodologically sound survey of America’s sexual practices and beliefs" conducted by the National Opinion Research Center at the University of Chicago. Replaces the seriously flawed Kinsey surveys. Definitive. Authoritative.


This book "tells the married couple everything they want to know, to hope, to feel, to experience, and to sing about the gift of sex---and in a style that is as delightful as it is tasteful. The Penners are joyfully and genuinely Christian from start to finish." - Lewis Smedes

Sexuality Education / Parents


A Wheaton College psychology professor and his wife write a sensitive, informative book for parents who want to educate their children in a psychologically and Biblically valid way. Well-documented with studies and authorities.


A Christian pediatric endocrinologist clearly outlines the facts of sexual development, fertility, pregnancy and birth. He also discusses frankly issues of sexuality including sexual behavior in children, masturbation, homosexuality, practical sexuality, and marriage. Chapter two directly addresses how and when parents should discuss sexuality with their children.

Sexual Ethics

Resources available online


Among the 14 chapters in this book by two conservative Christian theologians are those addressing sexual morality, birth control, homosexuality, divorce and remarriage, as well as the more customary treatment of abortion and other issues of contemporary medical ethics.


One of the theological (Reformed) pioneers of modern medical ethics believes there are ethical issues at the junction of the "natural" communal aspects and the covenantal aspects of marriage and family. In this
chapter, he addresses the theological foundation for marriage, addresses some of those ethical issues, and looks at the religious and moral wisdom of the marriage service.


Twenty-seven leaders who participated in the 1984 Evangelical Colloquium on Women explore the key biblical passages which treat the subject of women’s roles in the professions, in the church and in marriage. Necessary reading for Christians interested in these vital issues. A variety of sides to these issues are presented.


A former Bible teacher at Westmont College interacts with sexuality experts and writes in an engaging style to explore the issues Christians are concerned about. Develops a good section on a theology of human sexuality.


A Fuller Seminary professor of theology explores the meanings of Eros and agape, distortions in human sexuality, and sexual issues of concern to both single and married people. A paperback that has enjoyed wide popularity.


An associate professor of psychiatry at the University of Manitoba addresses the issues of petting, masturbation, homosexuality, adultery, premarital pregnancy, the Playboy philosophy, etc. for the benefit of Christian readers.

Single Lifestyles


Eternity magazine’s Book of the Year. This Bible professor from Wheaton College explores what the Bible says about a woman’s role in the church and in the family.


Old love letters, journal entries, and memories provide a backdrop for the insights offered by this popular Christian author. Since the sexual drive in young adults is ever new, ever old, wisdom from one who has sought to bring every drive under the constraint of Christ could be engaging. It is.


Trained in psychology and having been a senior editor for Christianity Today, this Eastern College professor examines current theories about nature and nurture to seek a Christian understanding of our society’s contemporary role debate.

Medical Marriages

Resources available online


An analysis of the medical marriage, reviewing physician personality traits, gender differences, social pressures, sources of marital and professional conflict, communication strategies, sexual problems, etc., this excellent collection of essays provides one of the finest discussions of the medical marriage available.

Four essays from a CMDS psychiatrist who has spent a regular part of his practice seeing physician and dentist couples in distress. His research interests have included the particular stresses of the female physician. With wit, data, and clinical experience combined with an insider’s view of these distinctive stresses, this brief, practical study is without parallel.

**Homosexuality**

Resources available online


A premier book offering definitive help for the male homosexual who wishes to change and reviewing in the process the developmental, physiological, social-psychological, familial, interpersonal, and gender-identity aspects of his sexual orientation.


A Christian psychiatrist reviews the politicization of the homosexuality debate, including the pressure on the APA to change its nomenclature, the debate over a "homosexual gene", the concern about the possibility of change, etc.

**Schmidt TE. Straight and Narrow? Compassion and Clarity in the Homosexuality Debate. Downers Grove, IL: InterVarsity Press, 1995; 240 pp.**

Finally, a superb analysis of the biblical texts in response to currently popular revisionism by a Cambridge-trained New Testament scholar who teaches at Westmont College. Excellent critique of John Boswell’s ground-breaking, pro-gay interpretation of church history.

**Sterilization**


Three physicians, a theologian, a clinical ethicist, and a pastor address the issue of surgical sterilization from a conservative Protestant perspective. East to read, medically reliable, and theologically sound.

**Christian Bioethics April 1998:4(1) is a theme issue on “Sexual Ethics and Communal Judgments: On the Pluralism of Virtues, Values, and Practices” and focuses primarily on the ongoing Roman Catholic discussion of the legitimacy of voluntary sterilization in certain ‘hard cases.’**
Human Stem Cell Research and Use

The field of stem cell research offers great promise for the advancement of medical science. Adult stem cells are presently being used to treat a variety of illnesses. However, the isolation of human embryonic stem cells in 1998 and resultant research have raised moral concerns because current methods of procuring embryonic stem cells require the destruction of human life.

CMDA recognizes the potential value of stem cell technology\(^1\):
- We endorse the goals of stem cell research to treat human illness and relieve human suffering.
- We endorse retrieval and use of adult stem cells from a variety of sources – umbilical cord blood, placenta, amniotic fluid, adult organs, etc.
- We endorse human adult stem cell research and use if it is safe for human subjects.
- We endorse animal stem cell research provided it is not cruel to experimental animals.

CMDA has moral concerns regarding embryonic human stem cell research and use. We recognize the sacred dignity and worth of human life from fertilization to death.\(^2\)
- The destruction of nascent individual human life even for the benefit of others is immoral.
- We condemn specious arguments that “excess” embryos may be used as a source for embryonic stem cells, “because they would have been destroyed anyway and that good may come.” There is a moral difference between intentionally taking a human being’s life and the embryo dying a natural death.
- We are concerned that stem cell research will involve exploitation of women (especially poor women) by using them to produce the eggs necessary for stem cell research, thereby subjecting them to the risk of attendant procedures and potential complications.
- We are concerned that the instrumental production, use, commodification or destruction of any human being will coarsen our society’s attitude toward human life itself.

Conclusion

CMDA advances the following moral guidelines to direct stem cell research and therapy:
- No human life should be produced by any means for primarily utilitarian purposes – no matter how noble the ends or widespread the benefit.
- Technology and research must not involve the abuse or destruction of human life.
- We encourage the careful and ethical development of alternative methods for procuring stem cells that do not involve the destruction of human life.

CMDA encourages life-honoring stem cell research for the advancement of medical science and the benefit of all patients. In this pursuit, CMDA advocates the protection of all human life, for humans are made in the image of God.

\(^1\)At this time stem cells are classified either as adult or embryonic. Adult stem cells are derived from body tissues such as bone marrow, fat, heart, liver, lung, muscle, pancreas, skin, as well as from placenta and cord blood. Embryonic stem cells are removed from the developing embryo, resulting in destruction of the embryo.

\(^2\)See Sanctity of Human Life.

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Human Trafficking

As Christian healthcare professionals, we affirm that all humans have inestimable worth, having been created in God's image, and should not be trafficked by others. Accordingly, we grieve for victims of human trafficking and are compelled to oppose this evil.

Human trafficking is the contemporary practice of slavery. Human trafficking involves acts of recruiting, transporting, transferring, harboring or receiving a person through the use of threat, abduction, fraud, deception, force or other coercive means for the purpose of exploitation. Its victims include, at a minimum, persons in forced labor, forced marriage (including child brides), child soldiers, persons trafficked for the removal of eggs or organs, and adults and children kept in bondage for the purpose of commercial sexual exploitation. Healthcare professionals should be aware that human trafficking is a widespread yet often hidden problem and alert to the possibility that it may reach into their local communities. Its victims may be forced into migrant agricultural, domestic, restaurant, factory, or commercial sex work.

Victims of trafficking may come into contact with healthcare professionals when seeking treatment for bodily injuries such as fractures resulting from violence, torture or sexual assault; traumatic brain injury; sexually transmitted diseases including HIV, gonorrhea, syphilis, urinary tract infections or pubic lice; infectious diseases including hepatitis and tuberculosis; miscarriages or the sequelae of forced abortions; malnutrition; and sequelae of delayed diagnosis or lack of adequate medical care. Victims of trafficking have increased rates of post-traumatic stress disorder and suicide. Social harms from trafficking include the public burdens of dealing with its health consequences as well as the dissemination of infectious diseases into the general population. These problems represent only a partial list of the enormous medical and social consequences of human trafficking.

Healthcare professionals who do not directly treat victims of human trafficking nonetheless provide care and counsel to patients who may be end-users of human trafficking industries. Individuals who pay for commercial sex acts or purchase or view pornography become complicit with human degradation and commodification, which are at the root of human trafficking. The viewing of sexually explicit material is not victimless; rather, it promotes the economic demand that sustains an international sex industry that contributes to marital instability and divorce, enslaves its users and keeps its victims in bondage (see CMDA Statement on Human Sexuality).

The counsel of Scripture is unequivocally opposed to the dehumanization, commodification, and devaluation of human beings (see CMDA Statement on Human Life, Its Moral Worth). Accordingly, Christians historically have opposed human slavery and ministered to the oppressed and neglected.

As the body of Christ, and in the spirit of Isaiah 61:1 and Matthew 25: 35-40, Christian healthcare professionals should display the love of Christ in caring for victims of human trafficking. Victims may have difficulty establishing a relationship of trust; many have been betrayed by family members, and their predominant relationship may be with someone exploiting them. The Christian healthcare professional has an opportunity to demonstrate care and compassion through tangible acts that reflect the love that God has for them. The healthcare professional should treat the patient who may be a victim of trafficking in an empathetic, supportive and nonjudgmental manner with sensitivity to the victim's fear, fragile emotional state, and physical needs. In responding to victims of human trafficking, the healthcare professional should not express prejudice against the disadvantaged and marginalized, such as migrants, those forced into prostitution, the sexually abused, the disabled, the inarticulate, the poor, or the economically or socially deprived.

The primary obligation of the healthcare professional is to the welfare of the patient. The healthcare professional who has reason to suspect human trafficking is morally obligated to try to protect the patient from abuse or violence, and to respect the wishes of the adult victim in receiving care and in reporting trafficking. The healthcare professional may also be legally obligated to report to the appropriate
authorities. Since exposing the trafficker might result in retaliation, interventions should be carried out in such a way as to minimize the risk of harm to the patient or the patient's family. Healthcare professionals should recognize that children are exceptionally vulnerable to exploitation and warrant special protection and advocacy. Healthcare professionals are legally mandated to report instances of trafficking of minors.\(^2\)

The campaign to oppose human trafficking and assist its victims represents an opportunity for secular organizations and faith-based ministries to work together toward the common good. Public agencies that allocate funding to programs that provide medical services to human trafficking victims should not compel faith-based ministries to compromise their moral integrity as a condition of receiving funding by, for example, requiring that such ministries provide abortion services (see CMDA Statements on Rights of Conscience and Moral Complicity with Evil). As Christian healthcare professionals, our concern for preborn human beings is morally inseparable from our concern for victims of human trafficking.

**Conclusions**

- CMDA condemns human trafficking in all its forms and everywhere it is practiced.
- CMDA urges its members to be alert in identifying and caring for victims of human trafficking. Healthcare professionals should ensure that they are well-informed about the medical and spiritual needs of trafficked persons and about caregivers' legal obligations and available resources regarding reporting and referral.
- CMDA opposes policies and practices that defund or otherwise discriminate against faith-based agencies that care for victims of human trafficking yet on religious grounds do not provide or refer for abortion services.
- CMDA encourages its members to use their knowledge and expertise proactively to help prevent the crime of human trafficking from occurring in their communities and countries.

*Approved by the House of Representatives*

*48 approvals and 2 abstentions*

*MAY 2, 2013, RIDGECREST, NORTH CAROLINA*

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\(^2\) In some situations it may be ethically preferable to seek permission from a minor who is mature enough to consent prior to intervening, since exposing the trafficker could potentially place the victim in harm's way. However, since there is also a legal obligation to report trafficking of minors to law enforcement agencies, such consent should be obtained without deception, and every effort should be made that intervention does not further endanger the victim. In the case of an emancipated minor (a minor who is legally deemed an adult), legal obligations vary by jurisdiction.

**Appendix**

**Relevant Biblical Principles**

- All human beings are created in the image of God (Genesis 1:26) and are loved by God (John 3:16-17).
- God has compassion on the vulnerable, the oppressed, and the defenseless and requires that they be treated justly (e.g., Deuteronomy 10:18; Psalms 9:9, 10:17-18, 72:12-14, 103:6).
- God intends to break the yoke of slavery. God delivered His people from slavery in Egypt (Exodus 1-18) and continues through Christ to free His people from slavery to sin (Isaiah 61:1; Luke 4:16-20; Galatians 5:1,13).
- Scripture instructs us as Christians to love our neighbors as ourselves (Leviticus 19:18; Matthew 22:39b; Mark 12:31a; Luke 10:27b), defend the weak and fatherless, uphold the cause of the
poor and oppressed (Psalm 82:3; Isaiah 1:17), rescue the weak and needy, and deliver them from the hand of the wicked (Psalm 82:4).

- Scripture instructs us as disciples of Christ to show mercy and compassion (Zechariah 7:9; Isaiah 1:17) to others with the same love that He showed to the Church (Romans 5:8; Ephesians 5:25; John 13:15), for in serving others we are also serving Christ (Matthew 25:35-36,40).

- Scriptures calling for submission to authority do not condone slavery.
  - Some proponents of slavery have defended the practice by misinterpreting Colossians 3:22, which calls slaves to obedience. The intent of this verse is not to condone slavery, but rather to encourage all who are under human authority to a moral standard of integrity transcending earthly servitude (Colossians 3:23).
  - Scriptural instructions to obey the authorities (e.g., Romans 13:1-5; 1 Timothy 6:1-2) do not condone tyranny, injustice, abuse, or oppression (see CMDA Statement on Abuse of Human Life) but describe legitimate authority as established by God.
  - Slaves are instructed to gain their freedom if they have the opportunity (I Corinthians 7:21b).

Notable Historical Precedents

- Christians led the movement that abolished the African slave trade. The passion and perseverance of abolitionists such as William Wilberforce secured the passage of the Slave Trade Act of 1807 in London which abolished the slave trade in the British Empire.
- President Abraham Lincoln’s Emancipation Proclamation and the Thirteenth Amendment to the United States Constitution outlaw slavery and human trafficking.
- Numerous current U.S. and international laws rightly authenticate and proclaim human trafficking to be a serious crime. Among them are the European Convention for the Protection of Human Rights and Fundamental Freedoms of 1950, the U.S. Trafficking Victims Protection Act of 2000 (and its subsequent reauthorizations), and the Council of Europe Convention on Action against Trafficking in Human Beings of 2008, and legislation enacted by numerous nations around the world. Additionally, the United Nations Universal Declaration of Human Rights of 1948 declares in Article 4 that “[n]o one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.”

Further Resources

6. Recognize the signs of human trafficking, and be prepared to act. ED Manag 2011; 23(8): 93-95.


14. Samaritan's Purse international relief at http://www.samaritanspurse.org/index.php/Who_We_Are/About_Us


Imminent Death Organ Donation

CMDA affirms the sacredness of every human life, recognizing that life is a gift from God and has intrinsic value because all human beings are made in His image and likeness. For persons with illness that threatens life or health, organ transplantation may offer hope of a longer, healthier life. CMDA affirms ethical organ donation, meaning organ donation that is not coerced, in which organs are not purchased or sold, and through which vulnerable persons are not exploited or killed by vital organ procurement.

Ethical donation of solid organs is guided by the dead donor rule, according to which a potential organ donor must be dead before vital organs are removed for transplantation. Although medical criteria for the determination of death have been debated, decisions at the end of life nonetheless must distinguish ethically between acts of killing and allowing to die.\textsuperscript{1,2}

Proposals are undergoing evaluation in the U.S.\textsuperscript{3-8} and already are implemented in some other countries\textsuperscript{9-13} to increase the supply of potentially transplantable organs by procuring organs from patients who are imminently dying.\textsuperscript{14} Imminent death donation (IDD) by living patients could potentially apply to several types of donors:

1. The unconscious patient who is imminently dying from a devastating neurologic injury and irreversibly lacks decision-making capacity but is not brain dead.
2. The patient who is not actively dying but, as the result of a devastating neurologic injury, is chronically dependent on life-sustaining technology, and who, through an advance directive (made when the patient had full decision-making capacity) or substituted judgment by a legal surrogate, has made a decision to withdraw such technology. Organ donation would precede or occur simultaneously with such withdrawal. Such a patient might be:
   (a) Permanently unconscious
   (b) Minimally conscious
   (c) Cognitively disabled or demented
   (d) Neuromuscularly weak but cognitively unimpaired
3. The conscious, altruistic patient with decision-making capacity who is approaching death as the result of a progressive or devastating neurologic disease and requests assistance in an earlier death in order to donate organs before circulatory collapse renders them nonviable for transplantation.
4. The patient who has been diagnosed with a terminal disease, is dissatisfied with his or her present or anticipated future quality of life, and requests assisted suicide (so called “assistance in dying”) before the disease advances to its final stages.

In each case, death would be accomplished or hastened by the act of organ procurement.\textsuperscript{15} The rationale for these proposals includes the following arguments:

1. It has been argued that the donor’s autonomy to choose the manner and timing of death and to donate organs should be respected.\textsuperscript{7,16-18} However, this argument raises a number of concerns:
   - Imminently dying patients are vulnerable and may not be truly autonomous. Illness may deprive the potential donor or surrogate of the capacity to make informed decisions or resist coercive efforts under the guise of persuasion, which may be subtle or prey upon the patient’s despair.
• The claim that procuring vital organs from the imminently dying honors the donor’s autonomy may be driven by underlying utilitarian or economic motives.
• Individual autonomy is neither incontestable nor an absolute principle. If autonomy were absolute, then a healthy person would have the right to sacrificial assisted suicide by donation of vital organs. The claim of autonomy must always be balanced with the principles of beneficence, nonmaleficence, and justice, as well as the need to preserve the integrity and trustworthiness of the medical profession.
• Elevation of the patient’s autonomy to absolute mastery that extends to being killed or assisted in suicide so long as the act is voluntary is a distorted sense of freedom that denies both the giftedness and sacredness of life, over which medicine has a stewardship responsibility, and God’s providential purposes for that life.\(^{19,20}\)
• Whereas the patient’s autonomy encompasses the right to receive medical attention and the negative right not to receive a recommended treatment, it does not include the positive right to receive any particular treatment requested that may be outside the physician’s expertise, skills, or judgment.
• According a positive right to premature death to those who are autonomous would place at serious risk others who are less fully autonomous, such as patients with dementia, intellectual disabilities, or impaired consciousness.\(^{19}\)
• Assisted suicide is a moral evil; using organs thus obtained may involve complicity if such use incentivizes or presumes to justify the practice (see CMDA statement on Moral Complicity with Evil).

2. It has been argued that the practice of medicine has evolved in such a manner as to legitimize and even require physician assistance in, and hastening of, medical death when patients no longer consider their lives to be worth living.\(^{16}\) However,
• Whereas technologies have evolved, unchanged are the moral conditions at the bedside, which include the reality of illness, the vulnerability of the patient, and the promise of the healthcare professional to endeavor to heal and not to harm.
• Public opinions that may currently be in vogue are not a valid test of truth.

3. It has been argued that the donor’s altruism in donating organs for the purpose of saving another’s life should be honored.\(^{15}\) However,
• Patients who die as a result of physician-assisted suicide or who may request that their deaths be accomplished in the very act of procurement (“donation euthanasia”) are not ethically appropriate sources of organs for transplantation, because they deny the sacredness of life of the dying patient. To accede to such a request is unacceptable, because it communicates that the patient’s life has no further meaning.
• To codify imminent death donation of solid organs would open the door to abuses and coercion and thereby place at risk the most vulnerable.

4. It has been argued that procuring organs from the imminently dying is an act of compassion on behalf of other patients in need of transplantable organs.\(^{16}\) However,
• Procuring organs from the imminently dying ignores good palliative medicine and compassion for the dying patient.
• Assisted suicide and euthanasia violate both the Hippocratic Oath and the Hippocratic directive, “First, do no harm.”\(^{20}\)

5. It has been argued that organs should be procured from the imminently dying or in conjunction with euthanasia because, when retrieved from patients with a functional circulation, they are more viable and lead to better outcomes for the transplant recipient
than ischemic organs retrieved from patients without circulation at the time of retrieval.\textsuperscript{10} However,

- Organ procurement is not an end to be gained at all costs or through any means. Organ procurement should be performed within a covenantal relationship among patient, physician, and society, eschewing a utilitarian ethic of the greatest good for the greatest number as determined by secular ethical systems that may be susceptible to influence by financial, social, or political interests.
- The argument that the dying patient should relinquish his or her organs sooner presumes that the interests of the potential transplant recipient are of greater importance than and should overrule the needs of the dying patient, and thus that the dying patient is someone of lesser value. This attitude comes very close to asserting a claim of ownership of the dying patient’s organs. Human beings’ organs are not the property of the state, healthcare institutions, or the transplantation industry.

6. It has been argued that the currently-accepted practice of withdrawing life-sustaining medical interventions is already equivalent to euthanasia;\textsuperscript{5,13} therefore, a more aggressive agenda of ending life sooner for the utilitarian purpose of obtaining organs is justified. However,

- CMDA affirms that there is a meaningful ethical distinction between euthanasia and allowing a patient to die of natural causes. When life-sustaining treatment is withdrawn, the proximate cause of death is the underlying disease.
- Proposals to procure organs in the imminently dying would necessitate revocation of the “dead donor rule.”\textsuperscript{18}
- It is ethically impermissible to kill some people to benefit others.

7. It has been argued that physicians whose religious beliefs or moral conscience prevents them from using their knowledge and skill to terminate their patient’s lives are duty bound to refer their patients to others willing to perform such an act, or else should be forced to resign from the practice of medicine.\textsuperscript{9,21,22} However,

- Medicine is a healing vocation into which many healthcare professionals enter as a calling (See CMDA statement on Professionalism) and is fundamentally unlike a service industry defined by a job description. The most exemplary and trustworthy healthcare professionals are those who identify with and live out the moral ethos of their healing vocation. To impose on healthcare professionals, who are committed to healing, a legal duty to kill would dangerously violate their moral integrity and severely damage the trustworthiness of their profession.\textsuperscript{23}
- Whereas the state can legitimately limit healthcare professionals in doing what they believe to be good, the state does not have the legitimate authority to force healthcare professionals to commit acts that they believe to be morally wrong.\textsuperscript{24}

8. The opinion has been asserted that time-honored moral prohibitions against taking innocent life, such as those expressed in the Hippocratic Oath and the Bible, “have no legitimate bearing on the practice of 21st century medicine” because there is no scientific test (accepted by atheists) for the existence of God.\textsuperscript{21,25} However,

- Nor can any scientific test limited to empirically-verifiable factual data prove that atheism is correct or disprove the existence of God. Additional sources of knowledge are needed to discern moral values.
- Medicine, of all the professions, should affirm the value of human life and embody an ethic of healing rather than a rush to death. The healing orientation of medicine benefits all of society.
• Atheism also is a belief system, but in comparison to theism, atheism provides an impoverished ethical basis for the healing mission of medicine, as it rejects the sacredness of human life and accommodates the view that humans are nothing more than biological machines with interchangeable parts.26

Conclusion
Donation euthanasia and procurement of organs from the imminently dying are incompatible with the ethical principles of the Christian Medical & Dental Associations. Specifically:

• Christian physicians affirm that God, in His mercy, has provided the possibility of organ transplantation for many patients in need and that this life-saving technology comes with great moral responsibility.
• CMDA upholds the ethical practice of uncoerced solid organ donation, including single kidney or partial liver donation from living patients and vital organ donation from patients determined to be deceased by whole brain or circulatory criteria (see CMDA statements on Death, Overview on Human Organ Transplantation, Organ Transplantation after Assisted Suicide or State Execution, and Organ Donation after Circulatory Death).
• CMDA upholds the “dead donor rule” as an inviolable boundary for the ethical removal of vital organs for transplantation and opposes efforts to circumvent or abolish it.
• CMDA emphatically rejects in practice and in public policy organ donation by acts of medical killing, including
  o Assisted suicide in the patient who has been diagnosed with a terminal illness or a severe disability and requests donation of vital organs, the removal of which would cause or hasten the donor’s death.
  o Euthanasia with intent to obtain transplantable organs.
• Under no circumstances should healthcare professionals be encouraged or coerced to participate in the hastening of death for the purpose of organ procurement, nor be required to be complicit in such killing by referral to others who will comply (see CMDA statement on Healthcare Right of Conscience).

Unanimously approved by the House of Representatives
May 4, 2017
Ridgescrnt, North Carolina

References


**Immunization**

**Personal Safety and Public Health**
Since the pioneering work of Edward Jenner and others in developing a vaccination for smallpox over 200 years ago, immunization has been of great benefit to individuals as well as the public. Immunization practices have prevented outbreaks of communicable diseases and resultant deaths or disability and continue to prevent an ever-increasing variety of illnesses.

The immunization process is based on safely activating the body’s own defense system against a specific disease. As with other medical treatments, it carries a small but real risk of an adverse reaction.

CMDA agrees with current medical opinion that immunizations are of great benefit to the individual and society. The decision to immunize an individual relies on the similar decision-making process used for that of any other medical treatment.

CMDA recognizes that immunization benefits society by protecting public health and that individual members of society have reciprocal obligations to the society in which they live.

CMDA acknowledges the right of an individual to refuse immunization except in extraordinary public health circumstances. This decision may be motivated by moral or religious convictions, known risk, misinformation or fear. Christians need to base their decisions on accurate information. Those who model their lives in imitation of Christ should reflect on their obligation to take personal risk for the good of others.

CMDA supports the current scientific literature that validates the general practice of immunization as a safe, effective, and recommended procedure.

**Immunization and Potential for Moral Complicity with Evil**
The use of medical information and technology obtained through immoral means raises concerns about moral complicity with evil*. Some currently available vaccines were developed using tissue from aborted fetuses, while others use technology or knowledge acquired from the use of aborted fetuses. We need to consider carefully whether it is morally permissible to benefit from knowledge or technology obtained from the intentional destruction of human life.

We attempt to determine whether our participation is appropriately distanced or inappropriately complicit by consideration of the medical facts and of our conscience as informed by the revealed Word of God.

CMDA provides the following examples to help determine whether it is permissible to manufacture, administer or receive a specific vaccine:

- Using technology that was developed without any intentional destruction of human life or other evil is morally ideal. Most vaccines in use to date fall into this category.
- Using technology developed from tissue of an intentionally aborted fetus, but without continuing the cell line from that fetus, may be morally acceptable.
- Continued use of a cell line developed from an intentionally aborted fetus poses moral questions and must be decided as a matter of conscience, weighing the clear moral
obligation to protect the health of our families and society against the risk of complicity with evil.

- Using a vaccine that requires the continued destruction of human life is morally unacceptable.

CMDA encourages the use of and endorses the further development of medically effective and ethically permissible alternatives that do not raise the question of moral complicity.

See CMDA Statement on Moral Complicity With Evil

Approved by the House of Delegates
Passed unanimously
June 12, 2002

Amended by the House of Representatives June 11, 2004 2 abstentions.
Limits to Parental Authority in Medical Decision Making

Children are a gift from God to the family. Parents are entrusted with the responsibility to love, nurture, protect, and train for their children. In our society, when parents fail to carry out their fundamental responsibilities, the state is empowered to intervene to protect vulnerable children.

As physicians and dentists, we are obligated professionally to counsel parents regarding the health and safety of their children. In addition, we are obligated legally to report to the appropriate authorities instances of parental abuse or neglect.

We recognize that between the extremes of ideal child rearing and of abusive or negligent child rearing, there is a wide range of parental actions and choices which remains a matter of discretion. In regard to these discretionary matters, we must respect parental authority by working through the parents to improve the child’s welfare.

Some parents, acting on philosophical or religious beliefs may compromise appropriate medical care for their children. In professional encounters with these parents and children, we should attempt to honor their values and beliefs whenever possible. Nevertheless our obligation remains to oppose parental decisions that may significantly harm their children.

Approved by the House of Delegates
Passed with 51 approvals, 2 against
Malpractice
The Christian Medical & Dental Associations affirm the following:

We are committed to providing excellent care to our patients and we hold ourselves to the highest possible standard.

We recognize that neither medicine nor dentistry is an exact science, and that all clinicians are subject to error. We further recognize that it is likely that we have all unintentionally practiced below the standard of care* at some time. We believe that the excellent practice of medicine and dentistry requires a willingness to recognize and learn from our professional mistakes and mal-occurrences.

We should take responsibility for bad outcomes that have been caused by our provision of substandard care. We lament that the climate of our culture discourages us from following biblical mandate of confessing, seeking forgiveness, and pursuing reconciliation. We believe that a patient who has been injured by substandard care may be entitled to restitution.

We oppose harassment or frivolous cases filed for vindictive or monetary reasons. We oppose the settlement of any case without the full involvement and informed consent of the doctor.

We recognize that a judicial judgment of professional liability does not necessarily mean that the clinician is incompetent or deserving of practice restriction. Nor does it suggest that we should withhold our compassion and love from that colleague. We should judge neither ourselves nor others too harshly because of an adverse malpractice judgment.

A malpractice suit can cause significant suffering to the individual professional. It may adversely affect his or her physical and emotional health, family and spiritual life, and Christian witness. We should protect our own physical, emotional, and spiritual health through Scripture, prayer, and appropriate counsel from others. In turn, we should volunteer our support and help to our colleagues when they are in need. Compassion and empathetic guidance from others may have a profound influence on the outcome. The manner in which Christian clinicians handle this difficult professional problem can be a unique opportunity to be a distinctive witness for Christ.

*The "standard of care" refers to those acts which a reasonable physician of like training or skill would do in the same or similar situation. The standard of care is not the optimal or best care possible when viewed with the knowledge of an adverse outcome, nor does it take account of less than perfect acts or results.

Approved by the House of Delegates
Passed unanimously
May 2000. Orlando, Florida
**Explanation of Statement**

**Background**

The scientific approach to medical and dental care has increasingly led to an expectation, by both laypersons and professionals that everything will turn out well - and often it does. Sometimes, however, things do not turn out well. Bad outcomes may occur because the disease held the upper hand; or because the professionals involved made an error, avoidable or unavoidable. But sometimes it is because the healthcare professionals just plain did not perform up to standard.

Claims of professional liability for malpractice by physicians and dentists use the tort system to seek recompense. This system involves an adversarial court proceeding in which the plaintiff's attorney must prove 4 things: (1) the practitioner had a professional obligation; (2) the practitioner did not perform up to the standard of care; (3) the plaintiff suffered harm, and (4) there is a causal relationship between the practitioner's failure and the harm suffered.

Claims of professional malpractice against healthcare professionals have increased in recent decades, as have the monetary amount of awards given when the court finds professional liability. This has resulted in major increases in costs in several areas, including an increase in the cost of professional overhead, an increase in the cost of medical care because of extra testing that is done ("defensive medicine"), as well as the actual cost of the litigation.

In addition to the financial cost, there has been a significant increase in the emotional cost to healthcare professionals. The potential, the threat, and the actual lawsuit can all bring emotional turmoil to clinicians, their staff, and their families.

**Secular Perspective**

There has been much discussion, some research, and multiple proposals to improve this uncomfortable situation. "Tort reform" has been considered, but with little actual change occurring.

While there is a very appropriate concern about the frequency of "medical mistakes", there is often confusion and conflation of error, claims of malpractice, and actual professional liability. Many errors occur which are not the result of malpractice and/or which do not result in patient harm. Many claims are made which do not represent instances of malpractice. But unfortunately, it is likely that considerable malpractice occurs which does not result in claims or compensation.

Changes in healthcare finance and delivery have exacerbated this entire area of concern. Many forms of managed care lead to diminished professional autonomy about specific treatment decisions. It is feared that this may lead to diminished quality of care, and potentially to increased malpractice, actual or perceived.

Healthcare professionals have responded in different ways to the increased stress of practice brought about by these changes. Some have ignored the issue and have continued to practice patient-centered care. Some have changed to a less risk-prone specialty or retired earlier than they might have. Others have succumbed to the stress with depression, chemical abuse, or other potentially destructive things.

**Christian Perspective**

It is tempting to think that Christian healthcare professionals will be somewhat immune to the devastation of malpractice because they will all continue to conscientiously do what is in the patient's best interest. But even excellent dedicated physicians, believers or not, can be affected by this dark cloud of malpractice. And some believers will respond with the same feelings of fear, devastation, shame, isolation, and self-destruction as do non-believers. But this needn't be so. Believers have a Comforter to help them in any sort of trouble. And believers have a community who can be supportive.

The Christian Medical and Dental Associations deliberated for some time in the development of the above position statement, hoping and praying that it will be of benefit to their Christian colleagues, and to themselves.

**Abstracted Articles**

190

"Cost containment pressures impose fiscal responsibilities upon physicians that can conflict with their fiduciary commitment to patients. Should the law permit health care providers to adjust standards of care according to patients' financial resources?" The author addresses this question by bringing the reader through the conflict between fiscal and fiduciary responsibilities and the inadequacies of current law, and then introduces the concept of "rebuttable presumption." She concludes, "To exonerate those physicians whose inadequate care was economically unavoidable is not necessarily to endorse inferior care for the poor. It may indeed encourage physicians to make maximal use of existing resources, since the cost-constraints defense applies only where there is no alternative to substandard care. Further, the defense may help to shift the entire issue to the level at which it belongs. Society as a whole must reconcile competing and conflicting values: equality, freedom, beneficence, and fiscal prudence. The conflicts are stubborn, yet scarcity renders difficult choices inevitable."


In this article, the author responds to the position put forth by E. Haavi Morreim in her essay entitled, "Cost Containment and the Standard of Medical Care" (published in the California Law Review, however, a condensed version appeared in the Feb/Mar 1988 issue of the Hastings Center Report and is abstracted above.) He rebuts Morreim's main argument, that the law is too rigid to accommodate a reduced standard of care and thus should be changed, and concludes, "radical reform of the law is not required to accommodate cost containment incentives in an appropriate fashion. The law is fully capable in present law and application of recognizing the gradual (or abrupt) emergence of cost incentives. Any dramatically different approach, such as that proposed by Morreim, would likely create more problems than it would solve."


In response to an inquiry as to whether the Canadian Medical Protective Association (CMPA) should provide psychological support for physicians involved in lengthy legal proceedings, the author wrote to 788 physicians involved in 424 lawsuits regarding stressors associated with a lawsuit, such as a sense of betrayal at being sued despite one's best efforts and the maze of the legal system, and what, if any, beneficiary services could be provided. After evaluating the responses, the author concluded, "It seems to me that...CMPA's members will likely be better served not by the development of a new approach, but rather by better use of what we already have."


In this study, the authors identified the self-reported factors that prompted families to sue following a perinatal injury by interviewing mothers of infants who had experienced permanent injuries or deaths. From the most frequently given to the least, they are: advised by others, needed money, realized there was a cover-up, child would have no future, wanted information, wanted revenge or to protect others. They found that "families give many reasons for filing a claim. Obtaining money may not be the only goal for some families who file suit."


In this article, the authors, an economist, a lawyer and a physician, discuss replacing the current malpractice tort system with a no-fault compensation system. They begin by citing the Harvard Medical Practice Study, undertaken by the authors and several of their colleagues (this study is also abstracted and dated 13 May, 1992 in JAMA), which demonstrated that while only one-sixth of claims filed are paid, "the tort litigation/insurance system paid one claim for every 15 tort incidents." The conclusion of this study was that while there were numerous false positives (meritless claims filed), there were many more false negatives- "negligent injuries that did not lead to tort claims." If a no-fault compensation system were adopted, "victims of medical injuries, both negligent and nonnegligent, are compensated." The authors then cover the financial aspects and benefits of a no-fault system and implementation strategies.
This study, the basis of an article published in the 6 May, 1992 issue of JAMA (also abstracted) analyzes the "actual economic consequences of medical injuries" in order to open a discussion on alternatives to malpractice litigation. The authors interviewed patients who had suffered adverse events in New York hospitals and then "estimated the costs of a simulated no-fault insurance program that would operate as a second payer to direct insurance sources and would compensate for all financial losses attributed to medical injury." They conclude that the study "indicates that a no-fault program would not be notably costlier than the more than $1 billion New York physicians now spend annually on malpractice insurance."


"[Assumptions about quality in health care and its defense] are rooted in the past, a past in which the doctor ruled. Strangely, those assumptions have survived the revolutions that now deny the doctor the sole authority to judge and guide care. The doctor no longer really controls health care, as in the days of solo practice, but, when it comes to quality, the doctor is still held accountable. When the researchers study quality, they focus on the behavior of the physician. When the Quality Assurance Committee meets, it reviews the performance of the physician. When the payers and the regulators turn on their searchlights, they want doctors in their glare. Control is shifting, structure is shifting, the pattern of care is shifting; but accountability is not."


In an litigious society, fear of being named in a malpractice suit can adversely change how a Christian physician conducts his practice. However, according to the author, "with few exceptions, the threat of malpractice often appears to be more significant than it actually is." This is not to undermine the serious nature of malpractice, but "few treat it today as if it is a public crisis." To illustrate his point, the author states, "the average physician can commit 500-600 acts of malpractice before suffering an adverse jury decision." The author concludes that these facts are not "intended to encourage poor standards of care, nor is it intended to imply that significant unrecognized malpractice is rampant. Rather...it is important not to allow the fear or malpractice to dominate the practice of medicine to the extent that it interferes with our Christian witness or causes emotional injury to ourselves and our families." This article is first in a series of three by the same author.


In this second of three articles on malpractice, the author explains what frequently causes law suits and important legal terms that ones needs to be familiar with. He also informs on "the best ways to prevent lawsuits" including clear documentation and having rapport with the patient. He concludes, "Even the finest Christian physician will be sued, and even the most competent doctor will malpractice. Fortunately, the joy of Christianity is the realization that perfection is neither attainable nor expected. But if we understand what prompts malpractice suits and what we can do to avoid them, we will mitigate the change of litigation."


In this last article in a series of three, the author addresses a very important issue of malpractice to Christian physicians- that of the spiritual and emotional trauma felt while in the midst of a lawsuit. He states, "Very little attention has been paid to the emotional and spiritual impact of a suit on the life of the physician who is sued. If there is a 'conspiracy of silence' in medicine, it is surely the silence of shame, fear, and isolation felt by the physician blamed by others for the severe injury or death of a patient...however, in the litigious society in which we practice, there is no opportunity to share our feelings, and certainly no opportunity to admit our guilt." He then introduces the Medical Malpractice Ministry or 3M, a ministry developed for the Christian physician for the purposes of healing and support. 3M includes personal counseling by physicians who have been sued and this article contains excerpts from these physicians as they recount their experiences. The author concludes, "In the end, it is not the
malpractice suit that matters, but rather what we do with the pain we experience, what we learn from the ‘fire’ God uses to refine our faith...What an opportunity we have!"


The rise of managed care has brought many changes in the way doctors carry out their practices. The threat of decreased autonomy coupled with increased responsibility has made malpractice once again the hot topic. In this article, the author details major managed care malpractice cases, addresses professional liability issues, and discusses the impact of managed care on health care standards. She finishes by naming new challenges that now face physicians and concludes, "Health care professionals today have the power to make decisions, lobby in a political sense, and act as advocates for patients. What each health care professional does with that power, and what he or she does to avoid professional liability, is an individual choice. May God grant each clinician the wisdom needed to meet the clinical, ethical, and legal challenges that will continue with the growth of managed care."


Two recent verdicts, Fox vs. Health Net and Goodrich vs. Aetna, in which 89 million and 120 million were respectively awarded to the plaintiff indicate that "many of the barriers to managed-care litigation that appeared firm in 1993 are today under siege." In this article, the authors discuss punitive damage awards, changes in the law that support managed care organization (MCO) suits, and "how physicians, insurers, employers, attorneys and patients may be affected by a rash or verdicts in which punitive damages are awarded." The authors conclude, "Whatever its net effect, a crisis in the litigation of cases involving managed care, should it come, will be ugly and costly….Attention to the far-reaching implications of a surge in managed-care litigation should highlight the attractiveness of a more sophisticated approach-namely, carefully crafted regulatory oversight that is responsive to the need to reconcile the protection of patients and quality assurance, on one hand, with the cost containment that consumers demand from managed care, on the other."


"Medical malpractice and the problems associated with it remain an important issue in the US medical community. Yet relatively little information regarding the long-term history of malpractice litigation can be found in the literature. This article addresses 2 questions: (1) when and why did medical malpractice litigation originate in the United States and (2) what historical factors best explain its subsequent perpetuation and growth?

Medical malpractice litigation appeared in the United States around 1840 for reasons specific to that period. Those reasons are discussed in the context of marketplace professionalism, an environment that provided few quality controls over medical practitioners. Medical malpractice litigation has since been sustained for a century and a half by an interacting combination of 6 principal factors. Three of these factors are medical: the innovative pressures on American medicine, the spread of uniform standards, and the advent of medical malpractice liability insurance. Three are legal factors: contingent fees, citizen juries, and the nature of tort pleading in the United States. Knowledge of these historical factors may prove useful to those seeking to reform the current medical malpractice litigation system."

Bibliography


Typically, multiple malpractice suits against a doctor raises flags of incompetence and carelessness. However, this study concludes, "Among Florida family physicians, the frequency of malpractice claims increased with evidence of greater medical knowledge."
Medical Futility
As Christian physicians and dentists, we recognize the limitations of our art and science. We realize that not all medical interventions will offer a reasonable expectation of recovery or achieve the therapeutic goals agreed upon by the physician and the patient or the patient's surrogate. We believe that it is our duty to acknowledge the limits of medicine to our patients and their families.

We believe that clinicians should present the range of therapeutic options to their patients and recommend against therapy that does not offer a realistic expectation of benefit. To do otherwise engenders false hope in our human abilities and represents poor stewardship of medical resources.

However, the term medical futility should not be used when the real issue is one of cost, convenience, or distribution of medical resources. The determination of medical futility should not be made without the Christian physician realizing the heavy responsibility of no longer being able to prolong the life that God has created.

Because the physician-patient relationship is at heart a covenant, clinicians should work with their patients to reach treatment decisions that are mutually acceptable. They should not terminate treatment unilaterally on the basis of medical futility. However, they are not obligated to provide treatment that is contrary to their clinical judgment or moral beliefs. If a conflict cannot be resolved by further discussion or consultation, transfer of care is appropriate.

When transfer of care is not possible and the requested treatment is outside accepted medical practice, the clinician may be justified in withholding or withdrawing the treatment. In all situations, the clinician should serve as a healing presence of love, care and compassion. Our personal commitment to patients and their families is never futile.

Approved by the House of Delegates
Passed with 61 approvals, 10 opposed, 4 abstentions

Explanation

Background
The concept of futility has been used for a long time in the practice of medicine, but only recently has it taken on major importance and at the same time generated major differences of opinion. On the surface, it seems like it should be a clear concept. A treatment is futile when it cannot provide benefit. However, the problem with the concept of medical futility is that it entails a value judgment about what is a benefit, and people differ in what they value as a benefit.

Prior to the 1960's, physicians were quite paternalistic; they made decisions about what should be done to their patients without their patients consent. Physicians held the power to write both prescriptions and hospital orders and the authority to make decisions about their use. In the 1960's and 70's, societal interest in individual rights, minority rights, consumer rights, etc. led to a professional emphasis on patients rights. [see Explanation of statement on Patient Refusal of Therapy] While physicians retained the power to prescribe, patients gained the authority to participate in medical decisions and to consent or refuse treatments recommended by their physicians. This major change in decision-making authority
came gradually, encouraged by many court decisions that declared patients had a right to refuse treatments that they felt were too burdensome or risky, even life-prolonging treatments.

Some individuals have claimed that the redistribution of power from physicians to patients with regard to medical decision making gives patients not only the negative right to refuse physicians' recommendations but also the positive right to expect treatments even if physicians do not feel they are appropriate. Thus, some patients or their families have demanded the initiation or the continuation of specific treatments that physicians believe are not beneficial. Some physicians responded by saying, "The treatment you are requesting is futile," relying on the truism that "there is no moral obligation to provide futile treatment." In two cases--those of Baby K, a child born with anencephaly, and Helga Wanglie, an 85 year-old woman in a persistent vegetative state--hospitals took families to court seeking permission from a judge to withdraw over the families' objection life support they considered futile. In both cases, the judges ruled in favor of the families, and the hospitals and physicians were directed by court order to continue treatments they deemed futile. The controversy over medical futility is thus another manifestation of the paternalism/respect-for-patient-autonomy struggle within the practice of medicine.

The concept of futility in medical practice is complicated even further when the fact of a placebo effect is considered. Often the presence of a treatment, any treatment, may seem to have a benefit for the patient. In calling a treatment futile, the clinician must take care not to remove the element of hope which may be engendered by the application of any treatment. At the same time, he or she must not encourage hope when there is no reasonable expectation of any physiological benefit.

Definitions

While everyone knows what the word 'futility' means, there is not agreement on what it means in the practice of medicine, or when it should be invoked. The word means "completely ineffective." However, its application is complex because this definition includes both qualitative and quantitative components. It is a combination of low (as in zero) probability and low (as in none) benefit. But the practice of medicine and dentistry are imprecise. And futility is often invoked by clinicians when there is actually a very small percentage chance that the proposed treatment could work, or the possibility that it might achieve a small effect which the clinician believes is not worth the burden, risk, cost, or effort. So the professional often claims futility when he or she does not want to provide, for various reasons, the treatment under consideration.

Debate continues in the medical literature about such matters as (1) the definition of futility, (2) what clinical situations exist where there is a professional consensus that further treatment is futile, (3) whether physicians are obligated to even discuss treatment options which they consider to be futile, and (4) the process of dealing with a patient or family that is requesting treatment which is deemed futile by the responsible physician.

Futility should be clearly separated from rationing. Futility is the withholding of non-beneficial treatment, whereas rationing is the withholding of potentially beneficial treatment because it is not worth the cost. This distinction seems clear on paper, but may become blurred in the clinical setting where some individuals may make rationing decisions by claiming that the treatment is futile.

Christian Perspective

Christian physicians and dentists recognize that they are stewards of health knowledge and resources. All healing comes from God. He allows us to use our intellect and our abilities to facilitate healing in many clinical situations. Still, there are many situations when all the clinical skills and resources available will not change the course of events. In those situations, we are still called to minister to our patients.

CMDS addressed the issue of medical futility by reaffirming the covenantal nature of the patient-physician relationship, and encouraging shared decision-making. Part of the clinician’s responsibility is to use clinical judgment in making recommendations, and occasionally to try to dissuade a patient from a course of action which will not be in his or her best interests because it would cause unnecessary suffering without reasonable expectation of benefit.

The statement on Medical Futility offers guidance on resolution of conflict about treatment decisions, and defines a very narrow window through which the clinician may unilaterally withhold or withdraw treatment
deemed to be futile. In all situations, however, Christian physicians are reminded of the importance and worth of their commitment to their patients.

Abstracts


Technological advances have not only allowed us to live longer, it have given us the ability to save in increasing numbers those born too early. However, the author asks if it appropriate to provide intensive neonatal care for all low birth-weight babies? He discusses two differing philosophical views regarding the worth of a newborn infant and proposes two indications for the withdrawal of treatment, “First, the treatment is futile. Secondly, the patient is actively dying.” He advises, “I want to emphasize the fact that withdrawal of intensive support is not the same as withdrawal of care. There is a minimum level of care with all newborns deserve….In fact, I regard providing terminal care to a newborn infant as really not different in kind from providing terminal care to a dying elderly patient.”


“Demands by patients or their families for treatment thought to be inappropriate by health care providers constitute an important set of moral problems in clinical practice. A variety of approaches to such cases have been described in the literature, including medical futility, standard of care and negotiation. Medical futility fails because it confounds morally distinct cases: demand for an ineffective treatment and demand for an effective treatment that supports a controversial end (e.g., permanent unconsciousness). Medical futility is not necessary in the first case and is harmful in the second. Ineffective treatment falls outside the standard of care, and thus health care workers have no obligation to provide it. Demands for treatment that supports controversial ends are difficult cases best addressed through open communication, negotiation and the use of conflict-resolution techniques. Institutions should ensure that fair and unambiguous procedures for dealing with such cases are laid out in policy statements.”


Much has happened since the concept of futility was first introduced in philosophical literature and currently the discussion is waning. In this article, the authors review the futility debate, from the first attempts to define futility to the fight between the autonomy of patients and doctors. They conclude, “the fall of the futility movement reminds us that using a descriptive concept as the foundation for a policy is highly problematic and does not relieve us for our obligation to talk to patients and their families and to explain why we think further treatment will have no benefit. The judgment that further treatment would be futile is not a conclusion – a signal that care should cease; instead, it should initiate the difficult task of discussing the situation with the patient. Thus, the most recent attempts to establish policy in this area have emphasized processes for discussing futility rather than the means of implementing decisions about futility. Talking to patients and their families should remain the focus of our efforts.”


"The claim that a treatment is futile is often used to justify a shift in the physician s ethical obligations to patients. In clinical situations in which non-futile treatments are available, the physician has an obligation to discuss therapeutic alternatives with the patient. By contrast, a physician is under no obligation to offer, or even to discuss, futile therapies. This shift is supported by moral reasoning in ancient and modern ethics, by public policy, and by case law."

"Given this shift in ethical obligations, one might expect that physicians would have unambiguous criteria for determining when a therapy is futile. This is not the case. Rather than being a discrete and definable entity, futile therapy is merely the end of the spectrum of therapies with very low efficacy. Ambiguity in determining futility, arising from linguistic errors, from statistical misinterpretations, and from disagreements about the goals of therapy, undermines the force of futility claims."
"Decisions to withhold therapy that is deemed futile, like all treatment choices, must follow both clinical judgments about the chances of success of a therapy and an explicit consideration of the patient's goals for therapy. Futility claims rarely should be used to justify a radical shift in ethical obligations."


"The notion of medical futility has quantitative and qualitative roots that offer a practical approach to its definition and application. Applying these traditions to contemporary medical practice, we propose that when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of published empiric data) that in the last 100 cases a medical treatment has been useless, they should regard that treatment as futile. If a treatment merely preserves permanent unconsciousness or cannot end dependence on intensive medical care, the treatment should be considered futile ... Although exceptions and cautions should be borne in mind, we submit that physicians can judge a treatment to be futile and are entitled to withhold a procedure on this basis. In these cases, physicians should act in concert with other health care professionals, but need not obtain consent from patients or family members."


"The notion of futility generally fails to provide an ethically coherent ground for limiting life-sustaining treatment, except in circumstances in which narrowly defined physiologic futility can be plausibly invoked. Futility has been conceptualized as an objective entity independent of the patient's or surrogate's perspective, but differences in values and the variable probabilities of clinical outcomes undermine its basis. Furthermore, assertions of futility may camouflage judgments of comparative worth that are implicit in debates about the allocation of resources. In short, the problem with futility is that its promise of objectivity can rarely be fulfilled. The rapid advance of the language of futility into the jargon of bioethics should be followed by an equally rapid retreat."

**Veatch RM. Why physicians cannot determine if care is futile. JAGS 1994; 42:871-874**

"I have become convinced that it is impossible for the bedside clinician to determine if medical care is futile. I mean this in both the empirical, scientific sense of not being able to make the determination and in the more normative sense of it being unethical to attempt to make such determinations."

**Hook CC. Medical futility. Chapter 6 in Dignity and Dying. Grand Rapids, MI: Eerdmans, 1996:84-95**

Written by a CMDS Ethics Commission member, this chapter gives a good overview of the history and content of the "futility debate". It also gives specific procedural guidance to assist clinicians as they confront patients or families who request interventions which the physician does not feel are appropriate. The conclusion is "In all situations, caregivers should serve as a healing presence of love, care, and compassion. Our personal commitment to patients and their families is never futile."

**Halevy A, Brody BA. A multi-institutional collaborative policy on medical futility. JAMA 1996; 276(7):571-574**

All the major hospitals in the Houston, TX area have joined together to develop a procedural policy outlining how they will respond to the situation where a patient or surrogate requests medically "inappropriate treatment." The article describes flawed definitions, flawed processes, and lack of an ethical framework which have been evident in previous attempts at futility policies. They then go on to give the wording and the justification for their joint effort.

**Ethics Committee of the Society of Critical Care Medicine. Consensus statement of the SCCM's Ethics Committee regarding futile and other possibly inadvisable treatments. Critical Care Medicine 1997;25(5):887-91**

"Treatments that are extremely unlikely to be beneficial, are extremely costly, or are of uncertain benefit may be considered inappropriate and hence inadvisable, but should not be labeled futile."

"Policies to limit inadvisable treatment should have the following characteristics: (a) be disclosed in the public record; (b) reflect moral values acceptable to the community; (c) not be based exclusively on prognostic scoring systems; (d) articulate appellate mechanisms; and (e) be recognized by the courts."
Council on Ethical and Judicial Affairs, AMA. Medical futility in end-of-life care. JAMA 1999;281(10):937-41

What constitutes futile interventions remains a point of controversy in the medical literature and in clinical practice. In clinical practice, controversy arises when the patient or proxy and the physician have discrepant values or goals of care. Since definitions of futile care are value laden, universal consensus on futile care is unlikely to be achieved. Rather, the AMA Council on Ethical and Judicial Affairs recommends a process-based approach to futility determinations. The process includes at least 4 steps aimed at deliberation and resolution including all involved parties, 2 steps aimed at securing alternatives in the case of irreconcilable differences, and a final step aimed at closure when all alternatives have been exhausted. The approach is placed in the context of the circumstances in which futility claims are made, the difficulties of defining medical futility, and a discussion of how best to implement a policy on futility.

Bibliography


In this article, the author responds to the thoughts of the above authors and discusses the concept of futility and the goals of medicine.


"The issue of patient autonomy is irrelevant, however, when CPR has no potential benefit. Here the physician's duty to provide responsible medical care precludes CPR..."


"Physicians should not offer treatments that are physiologically futile or certain not to prolong life, and they could ethically refuse patient and family requests for such...


"The authority to make a judgment about the balance of the harms and benefits of attempted resuscitation for the patient remains with the physician...We conclude that physicians must be able to employ reasonable, socially validated value judgments to restrict the alternatives offered to patients..."

Hackler JC, Hiller FC. Family consent to orders not to resuscitate. JAMA 1990; 264(10):1281-83

"Policies should be changed to allow physicians to write a DNR order over family objections when (1) the patient lacks decision-making capacity, (2) the burdens of treatment clearly outweigh the benefits, (3) the surrogate does not give an appropriate reason..., and (4) the physician has made serious efforts to communicate with the family and to mediate the disagreement."

Younger SJ. Futility in context. JAMA 1990; 264(10):1295-96

"...I think it is crucial that physicians inform patients and families when resuscitation efforts will not be made."


"The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient...However, if, in the judgment of the treating physician, CPR would be futile, the treating physician may enter a DNR order...the physician must first inform the patient...[and] should also be prepared to discuss appropriate alternatives..."

Lo B. Unanswered questions about DNR orders. JAMA 1991; 265(14):1874-75

"Framing the discussion of CPR in terms of futility is alluring because decisions seem objective, conflicts over values and goals are hidden, and physicians can take decision-making power."
"Forging a consensus about matters of clinical and social importance requires trust and honesty, and the current posture of the debate suggests that no one trusts anyone to make these decisions. The truth is, however, that we must trust ourselves to make them together...conversing openly and respectfully with each other."

The Journal of the American Geriatrics Society (JAGS) August 1994 issue (vol 42, no 8) reports on a March 1993 Congress of Clinical Societies devoted to the question of FUTILITY:

- Fins JJ. Futility in clinical practice: report on a Congress of Clinical Societies. pp 861-65
- Callahan D. Necessity, futility, and the good society. pp 866-867
- Lantos JD. Futility assessments and the doctor-patient relationship. pp 868-870
- Veatch RM. Why physicians cannot determine if care is futile. pp 871-874
- Brody H. The physician’s role in determining futility. pp 875-878
- Nelson JL. Families and futility. pp 879-882
- Schneiderman LJ. The futility debate: effective vs beneficial intervention. pp 883-886
- Youngner SJ. Applying futility: saying no is not enough. pp 887-889
- Murphy DJ. Can we set futile care policies? pp 890-893
- Cranford RE. Medical futility: transforming a clinical concept into legal and social policies. pp 894-898
- While LJ. Clinical uncertainty, medical futility and practice guidelines. pp 899-901
- Ackerman TJ. Futility judgments and therapeutic conversation [editorial]. pp 902-903
- Pearlman RA. Medical futility: where do we go from here? [editorial]. pp 904-905


"Patients do not have a right to treatment that falls outside the bounds of standard medical practice...But the concept of medical futility is a tarbaby. It cannot do what it is asked to do... ...both the doctor’s judgment and that of the patient (or family) are essential to the decision making process... This can be achieved only by an open and frank dialogue."


The author responds with some support and some criticism to the first published report (in the same issue - Paris et al, pp 41-5) of the clinical details of a legal case in which physicians and hospital were found not liable for stopping treatment over the objections of family members.
Miraculous Healing

In the Old and New Testaments God intervened in the course of human events with acts of miraculous healing. This is illustrated by a favorable medical outcome not fully explained in medical terms, attributable to the direct intervention of God. In the time of Jesus and the early church this was an essential part of ministry.

Furthermore, Christ gave His disciples the power to heal miraculously. Scripture does not teach that sickness is necessarily due to personal sin, that the absence of healing is due to a lack of faith, or that perfect health is God's will for all. Disease and death are realities of life.

God’s nature does not change. We believe in the healing power of Christ today. God created the natural laws that govern health, illness, and the process of healing. We believe that God works both within and sometimes outside of these natural laws to heal people. We believe that all healing is accomplished by God's hand. Sometimes it is clear that scientific principles are used to facilitate that healing; sometimes the connection with known science is not so clear. We need to give God the credit at all levels of healing, whether we understand the science behind it or not.

Whether in illness or health Jesus desires relationship with us. Furthermore, God utilizes all situations for "the good of those who love Him." For the Christian this life is not all in all because eternity with God awaits hereafter. Even in dire circumstances, hope exists.

We promote specific interventional prayer, requesting God’s healing as part of the treatment of disease, according to biblical instruction. We also encourage the use of all ethical means of standard medical care. As God increases medical knowledge, we are better able to use this knowledge to facilitate healing processes that God has designed.

Through our faith in Christ, knowledge of medicine, and compassion for His people, we choose to glorify God in all situations and assist in healing whenever possible. Healing is a gift of God's sovereignty, through His magnificent design and His specific intervention.

Approved by the House of Delegates
Passed with 59 approvals, 2 abstentions

Explanation of Statement

Background

Do miracles occur? Can we explain them? Should we even try? What is the role of prayer in the practice of medicine today? These issues are of importance and interest to all healthcare professionals, and even more so to professionals who adhere to a faith tradition which has a history of miraculous healing.

Secular Perspective

Contemporary North American society claims to be tolerant of all worldviews. However, in reality, this pluralism often leads to segregation. For example, there is now an intolerant wall of separation between church and state, distorting the original intent of that federal doctrine which was to protect the church from being dominated by the state. It is now almost totally forbidden to discuss religious views in any forum which has any connection to public funding or administration.
Similarly in the practice of medicine there has been a growing separation of science from faith. Ancient medicine had its roots in faith. Early healing was done by priests, and later, healers were assumed to minister to the body. However, beginning with Francis Bacon, there developed a revered trust in science, i.e. "the natural", and a distrust of faith which represents to many "the supernatural". Religious belief in relation to healing has been largely reduced to an irrational, mystical, even silly status.

The good news is that in the 1990's renewed tolerance has led to a resurrection of interest in alternative or complementary approaches to healthcare, including an acceptance of the importance of "spirituality" in healthcare. The bad news is that some of this revival is driven by an interest in varied practices - some may be safe and/or effective, some may be ineffective or even harmful, others may be fraudulent, and still others may be based on occult spiritual beliefs and activities.

**Christian Perspective**

The Bible is a book about healing. Scripture clearly gives many examples of God's inexplicable and supernatural intervention in human events, especially in miraculous healings. Some of the recorded healings are physical, some are spiritual, some are both, and in some it is not clear. The causes of the conditions which are healed are sometimes physical (e.g. blindness, lameness), sometimes spiritual (the result of sin, or the result of demonic spirits) and sometimes not clear.

Jesus instructed the 70 disciples to "heal the sick" (Luke 10:9). James encouraged believers to call their elders so they could be anointed with oil (James 5:13-18), implying to some that this sanctioned both the use of prayer and physical therapeutic modalities.

Christian physicians and dentists need to have a good understanding of science and of its limits. They should also have an appreciation for God's inexplicable intervention.

The Christian Medical and Dental Associations have encouraged clinicians to incorporate "faith flags" into their practices as a way to let their patients know of their belief, and to open the door to those occasions when a more in-depth discussion of spiritual matters may be appropriate.

The Ethics Commission drafted this statement on "Miraculous Healing" to underscore our belief that God works both within and sometimes outside of natural laws as He goes about His healing.
Moral Complicity with Evil
Moral complicity with evil is culpable association with or participation in wrongful acts. Evil is defined as anything immoral or wrong based on Biblical principles. Questions about moral complicity with evil can arise in regard to an individual’s relationship to or involvement with past, present or future evil.

Moral complicity may occur with the use of information, technology or materials obtained through immoral means. This complicity may involve using, rewarding, perpetuating, justifying, or ignoring past or present evil. Moral complicity may involve enabling or facilitating future immoral actions of patients or professionals.

We must strive to never commit evil ourselves, nor should we participate in or encourage evil by others. While it may be impossible at times to completely distance ourselves from the evil actions of others, we are responsible to determine whether our action is appropriately distanced or inappropriately complicit. This determination is based on the revealed Word of God. In the absence of clear Biblical teaching, this determination is based on conscience as informed by the Holy Spirit, using but recognizing the innately fallible nature of human reason and prudence.

Biblical Guidelines
1. We must avoid every kind of evil (I Thessalonians 5:22)
2. We may never do evil that good may come. (Romans 3: 8)
3. We must hate and oppose evil. (Romans 12: 9)
4. We should separate ourselves from evil. (II Corinthians 6: 17)
5. We cannot totally separate ourselves from evil. (I Corinthians 5: 9 & 10)
6. We should overcome evil with good. (Romans 12: 21)
7. We should seek wisdom. (James 1: 2-5)

Applications
1. Intent. Our motives must be always to promote good, never evil.
2. Magnitude. Some evil acts are so heinous that any association with them is unacceptable.
3. Timing. Passage of time may diminish complicity with prior evil acts, though it does not diminish the evil nature of the original act.
5. Knowledge. Knowledge that an original act was evil and knowledge that a subsequent act is associated with that act are both required for culpability.
6. Certitude. A greater degree of certainty that the original action was evil increases complicity.

Conclusions
CMDA believes moral complicity with evil does not exist when all the following conditions are satisfied:
1. our intent is for good;
2. the association with the past or present evil is sufficiently uncertain, or the act is sufficiently distanced from the original evil act; and
3. the action does not reward, perpetuate, justify, cooperate with, or ignore the original evil.
References:

1For example, the potential for moral complicity exists in the use of (a) research data from unethical experiments, (b) textbooks or drawings made using tortured or executed prisoners, (c) vaccines made from aborted fetal tissue, etc.

2For example, enabling a patient to engage in immoral activity (sexual immorality, suicide, drug abuse, criminal activity) or facilitating an immoral procedure by another professional (cloning; genetic enhancement; referral for or assisting in abortion or unethical reproductive technologies) may involve some culpability.

Approved by the House of Representatives
Passed unanimously.

The Non-Traditional Family and Adoption

In spite of proliferating alternative definitions of the family, CMDA supports the Biblical model of the traditional family—an exclusive, committed, lifelong union of a man and woman living in an integral loving relationship with or without biological or adopted children.* Most current scientific studies** affirm that the Biblical model provides the optimal environment for the health of children, family, and society.

We believe the unique contributions of both father and mother are important for wholesome child development. However in our fallen world there are many wounded families in which one partner is absent. We encourage the Church to fulfill its Biblical mandate to support single parents in providing a nurturing environment for their children. In a situation of remarriage, it is possible to re-approximate the Biblical model for the family.

Adoption is an act of love that provides a beneficial environment for a child and reflects God’s act of love in adopting us into His family. CMDA enthusiastically encourages and supports adoption of children or frozen embryos into the traditional family. In addition, there may be circumstances in which a single person***, while not meeting the optimal Biblical model of the family, might adopt a child and provide a loving and nurturing environment that would outweigh the potential difficulties inherent in this situation. CMDA does not support adoption into family models other than these.

Advancements in reproductive technology have likewise created complex ethical issues. CMDA believes it is morally inappropriate to use reproductive technologies**** to produce children outside the boundaries of the traditional Biblical family model.

*The following alternative family forms do not meet this Biblical model: same-sex couples, domestic partners, polygamy, polyandry, incestuous unions, open marriages, and the like.

** See Annotations for Homosexuality Statement

***A single person living according to Biblical standards. See statements on Human Sexuality and Homosexuality.

****See statements on Assisted Reproductive Technology.

Approved by the House of Representatives
Passed unanimously.
**Opioids and Treatment of Pain**

The goals of medicine are to restore health, prolong life, relieve pain, and ameliorate suffering. Among the medications available to relieve pain are opioids, which in the United States are controlled substances, that act on opioid receptors in the central and peripheral nervous system to produce a morphine-like analgesic effect. Opioids are addictive, and dose escalation or transition to potent illicit opioids such as heroin, or non-prescription fentanyl, can result in fatal overdose due to their suppression of respiration. Excessive prescribing of opioids with the intent to relieve or avoid undertreatment of pain, unlawful diversion of opioid prescriptions, direct-to-consumer marketing, and illicit recreational use for its euphoric or dissociative effects have contributed to a grave crisis of opioid abuse.1,2

**Definitions**

Pain is defined by the International Association for the Study of Pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”3 Pain has a physical basis. Nociceptive pain occurs in response to ongoing tissue damage, whereas neuropathic pain is caused by disrupted neural pathways or altered neural thresholds for sensory perception.4 Suffering is a state of distress in response to pain, unpleasant bodily symptoms, anxiety, or anguish. Suffering is multifaceted and encompasses mental, emotional, social, existential, and spiritual components.5,6 Suffering is unique to the individual and his or her particular response to a past, current, or anticipated future situation. Suffering magnifies the existential experience of pain.5,6

**Biblical**

1. Pain and suffering are unavoidable aspects of human life as a result of sin (Genesis 3:16-19; Romans 8:18-27).
2. Pain can have purpose in protecting from harm.4,5,7
3. Pain or suffering should not be desired or sought as an end in itself (the whole counsel of Scripture).
4. Suffering is a mystery; it has a spiritual dimension and, even when it seems otherwise meaningless, can provide an opportunity for intimacy with God (Job 42:5; Luke 22:39-46; Philippians 3:10, 4:11-13; 2 Corinthians 11:23-30; Hebrews 4:14-16).
5. Those who have suffered may thereby be equipped to comfort others (2 Corinthians 1:3-7, Galatians 6:2).
6. Suffering may be used by God to refine moral character (Isaiah 48:10, John 9:3, Romans 5:3-5). Reflection on suffering, in humility before God, may produce growth and maturity (James 1:2-4; 2 Corinthians 1:3-7, 4:8-9, 12:9).
7. God can use suffering to conform Christians to Christ’s image (Romans 8:28-29).
8. In heaven, pain and suffering will be abolished (Revelation 21:1,4).

**Medical**

1. Almost all pain can be mitigated, but not all pain and suffering can be relieved by medical intervention.8-13
2. Pain is sometimes a necessary condition of medical or surgical treatment in the pursuit of healing.10-11
3. Appropriate uses of opioids include analgesia during surgical procedures, short-term treatment of acute pain, treatment of cancer pain, and management of pain or dyspnea in the terminally ill.8-13

4. Opioids are rarely indicated for the treatment of chronic nonmalignant pain.8

5. Many effective options other than opioids are available for the treatment of specific types of pain.8-13 These include, but are not limited to:
   a. Healthy lifestyle, including restorative sleep, appropriate nutrition, and exercise
   b. Control of chronic medical conditions
   c. Nonsteroidal anti-inflammatory drugs (NSAIDS)
   d. Acetaminophen
   e. Lidocaine patches and other topical modalities
   f. Voltage-dependent calcium channel α2δ subunit inhibitors, for example, gabapentin or pregabalin
   g. Tricyclic antidepressants, for example, amitriptyline, nortriptyline
   h. Select SSRI and SNRI, for example, duloxetine
   i. Anticonvulsants, for example, carbamazepine
   j. Corticosteroids
   k. Local injections, without or with radiology guidance, using local anesthetics or corticosteroids, biologics, and viscosupplementation
   l. Nerve and spinal cord stimulators
   m. Biofeedback
   n. Acupuncture
   o. Manual therapy

6. Ministering to the spirit by prayerful reflection and contemplating Scripture, individually and in the community of faith, are important components of healing and ameliorating suffering.14,15 (Philippians 4:6,7; James 5:12-16)

7. Effective treatment of pain may involve a multimodal approach, which may include physical exercise, physical therapy, massage, medically appropriate osteopathic and chiropractic manipulation, and counseling to reframe one’s thoughts so as not to focus excessively on symptoms.8-13

8. Caution and patient warning are strongly recommended when prescribing opioids for patients who consume alcohol or in combination with benzodiazepines or other sedative medications because of the danger of a combined suppressive effect on respiration.16,17

9. Prior to prescribing opioids for a given patient, screening for opioid dependence and addiction is recommended, including checking applicable prescription records or databases. Education about opioid prescribing is a component of medical licensure in many states.8,18 Additionally, ongoing monitoring of the patient’s access and use of opioids is helpful to promote patient safety.

10. As a general rule, with limited exceptions, the first line of treatment of pain should not be opioids.8-13

11. Proper and adequate control of pain is desirable as an important component of medical care.

12. Opioids cause constipation, urinary retention, impairment of judgment, and may cause delirium or increase a patient’s sensitivity to pain (opioid-induced hyperalgesia).8,10,11,19

13. Opioids should not be stopped abruptly for patients with long term use, but rather tapered.8

14. The bureaucratization of pain management can lead to excessive or inadequate prescription of analgesics (for example, unintended consequences from viewing pain as the “fifth vital sign”).20-23

**Ethical**
1. Healthcare professionals are obligated to respond to their patients’ pain and suffering by actively listening, by applying their knowledge and expertise in an effort to relieve pain and suffering, and by providing compassionate care. They are to provide education for the patient and family or other caregivers.

2. Prescribers should be knowledgeable about the medications they prescribe.

3. Healthcare professionals have the responsibility to learn about current methods of pain management, to develop treatment plans that utilize the range of multiple available diagnostic and therapeutic services to treat the underlying cause, and to refer when the patient’s condition is beyond their expertise (for example interventional radiology, pain services, palliative care, appropriate surgical specialists, etc.).

4. Healthcare professionals should be sensitive to the shame or guilt that some patients on chronic opioids may experience and avoid adding to it.

5. It is ethical, permissible, and recommended to inquire if the suffering patient has a personal faith or belongs to a faith community, as it may be advisable to recommend that the patient access appropriate resources.

6. Not all patients are able to find meaning in their pain and suffering or have the spiritual or community resources to grapple with their circumstances. The Christian physician should be willing to encourage such patients to explore options that may provide meaning and purpose.

**Conclusion**

- CMDA recognizes that treatment of pain and suffering is a critical component of medical therapy. Opioids are but one small part of the multimodal treatment of pain.
- Christian healthcare professionals who know the unique hope Christ offers to suffering humanity, should be alert to signs that a patient’s request for opioid medication for pain may signify or be a part of a deeper need.
- Christian healthcare professionals should work to relieve pain and suffering for their patients using a multimodal approach, which may include encouraging their patients to seek support from a suitable faith community.

See also:
- CMDA Statement on Pain Management
- CMDA Statement on Double Effect
- CMDA Statement on Suffering
- CMDA Statement on Professionalism

**References**


*Unanimously approved by the House of Representatives
April 21, 2020
Bristol, Tennessee (and virtual locations)*
Organ Donation After Circulatory Death (DCD)

Donation after Circulatory Death (DCD) criteria have the goal of increasing the supply of available organs for transplantation. Various DCD protocols have been implemented, for example, for potential donors with devastating brain injuries who have no reasonable prognosis for neurologic recovery yet who do not meet the conditions for determination of death by whole brain criteria. CMDA supports the ethical practice of DCD to enable the altruistic act of organ donation for transplantation for the purposes of saving and prolonging life, treating disease, and relieving pain and suffering (see CMDA statement on Organ Transplantation). However, CMDA has grave concerns about the implementation of DCD protocols in actual practice. (See Appendix)

Therefore, CMDA advises that the following strict criteria must be met for the ethical practice of DCD:

1. The donor candidate must have terminal or end-stage pathology that would allow for planned withdrawal of life-sustaining medical treatment or ventilatory support, with the expectation that natural death is likely to occur soon thereafter (see CMDA statements on Euthanasia and Vegetative State).

2. Patients with disabilities who are not imminently dying should not be presented with premature options for organ donation. The disabled, the frail, and the elderly should not be led to believe that they have a duty to relinquish their organs as if their lives were of inferior value (see CMDA statement on Disabled Persons).

3. Psychological assessment to evaluate for possible depression and taking a spiritual history are recommended for any conscious patient who expresses a preference for withdrawal of life-sustaining treatment for donation of organs.

4. The patient's care and treatment decisions at the end of life should be free from external pressure from organ solicitations. Discussions whether to remove life-sustaining medical treatment or ventilator support must occur prior to initiating organ donation requests. Such decisions must be independent of donor status and made prior to and separate from the organ procurement organization contacting the patient, the patient's surrogate or family. The patient must not be coerced into a decision to hasten death.

5. Consent for donation can be withdrawn at any time prior to withdrawal of life-sustaining support. No coercion shall be used to maintain consent.

6. Quality palliative care and spiritual care must be provided prior to and during the dying process. Support to the family during this process is also crucial.

7. Any narcotics or sedatives administered must be justified by their being effective in the provision of the patient's comfort and not for the purposes of preserving a more usable transplant or hastening the time of death.

8. Any procedures performed for the sole purpose of preserving donor organ viability that would cause the patient distress or discomfort are prohibited. These include some pharmacological agents and the placement of vascular cannulae.

9. The diagnosis of death, whether by whole brain or circulatory criteria, must be based solely on the medical condition of the patient and made independently of any influence by the organ procurement organization.

10. The surgical staff responsible for organ procurement shall in no way participate in the weaning process or certification of death.

11. The dead donor rule must be scrupulously followed, i.e., at the time of organ retrieval the donor must meet valid criteria for death. Ethical organ retrieval occurs after the brain is dead but before
transplantable organs have lost viability. It is ethically permissible to declare death either by the
criterion of whole brain death or permanent cessation of circulatory function, in the latter case
provided circulatory arrest has been present for a minimum of 5 minutes and the brain is not
hypothermic or chemically or metabolically suppressed. Criteria for determination of death
should be consistently applied and not relaxed with the intent of creating an opportunity for
organ procurement.

12. Interventions performed for the purpose of maintaining or improving the quality of transplantable
organs must not be the proximate cause of the death of the donor. CMDA opposes the use of
interventions prior to the declaration of death that would intentionally deprive circulation to the
patient's heart or brain, for example, inflating an occlusive balloon in the thoracic aorta during
extracorporeal membrane oxygenation procedures to prevent oxygenated blood from reaching
the heart and brain, since such interventions could directly cause the patient’s death.

13. Physicians and other healthcare professionals who find DCD protocols to be morally
objectionable or otherwise harmful to the patient must not be coerced to participate but should be
allowed the freedom to recuse themselves without threat of reprisal (see CMDA statement on
Healthcare Right of Conscience).

14. Hospitals should be free to implement DCD protocols based on ethical criteria more stringent
than those of organ procurement organizations without being penalized or disenfranchised from
collaborative organ procurement and transplantation networks.

Conclusions

• CMDA affirms the importance of sufficient ethical safeguards in the determination of death prior
to organ procurement in order to protect and respect the dignity of patients and to uphold the
moral integrity of the medical profession.

• CMDA opposes abandoning the dead donor rule as a means of increasing the supply of
transplantable organs. The dead donor rule is a fundamental moral principle that never should be
transgressed for the sake of competing interests. Procuring life-sustaining vital organs from
patients who have not yet died is incompatible with the ethical practice of medicine.

• CMDA finds proposals that would broaden DCD eligibility to include cognitively intact patients
with irreversible neuromuscular paralysis who are not imminently dying yet who autonomously
consent to donate their organs after electing to discontinue ventilator support to be morally
problematic.

• CMDA finds the practice of DCD as an avenue to euthanasia and physician-assisted suicide to be
ethically unacceptable; this may include proposals that would extend DCD eligibility to those
who are not terminal but who despair of their perceived quality of life.

• CMDA is concerned that unethical DCD practices could, by association, discredit the ethical
practice of organ procurement. Publicized abuses of DCD could damage the public’s trust in
transplant medicine and the public's willingness to volunteer as future organ donors.

• CMDA opposes policies and procedures that shift clinical emphasis from the care of patients
toward their use as a means to others’ ends. Subordinating the best interest of the patient to a
purportedly higher utilitarian good is antithetical to Christian love and the ethical professional
practice of medicine.

Appendix

The recommendations in this statement are based on the following aspects of DCD that CMDA
considers to be morally problematic or subject to potential abuses.

A. Whether death has occurred may be empirically unverifiable.
1. Within DCD time constraints, no empirical test for ascertaining death can directly verify that complete and irreversible cessation of brain function has occurred in an individual patient. However, ethically responsible decisions can still be made in situations where complete certainty is not possible. CMDA recommends holding to the 5- minute rule, even though it is somewhat arbitrary, since, based on current scientific understanding, it is reasonable to conclude that, after 5 minutes of total cerebral ischemia in adults, cerebral function is permanently and irreversibly destroyed. Five minutes of circulatory arrest, therefore, is a sufficient surrogate indicator of destruction of the brain leading to death. The 5- minute rule may be insufficiently short in pediatric patients.

2. At the time of declaration of circulatory death, the use of medications that suppress neurologic functions to facilitate the organ procurement procedure may render ambiguous the physical signs of brain death. However, neurological assessment is unnecessary for the clinical determination of death once circulation and cerebral perfusion have ceased for at least 5 minutes.

B. Imminently dying can be difficult to define.

1. Once life-sustaining treatment or ventilatory support is withdrawn, the time to cessation of cardiac function varies and can be unpredictable. However, well-chosen clinical measures can improve the accuracy of predicting which patients with irreversible brain injuries are more likely to die shortly after withdrawal of circulatory or ventilatory support.

C. The potential for spontaneous autoresuscitation may render the determination of death uncertain.

1. Cardiac autoresuscitation rarely can occur after several minutes of asystole. However, if autoresuscitation were to occur after 5 minutes of asystole, it is still reasonable to conclude that irreversible death of the brain has occurred. This situation is analogous to the patient accurately declared dead by whole brain criteria who nonetheless still has a beating heart and circulation.

2. Animal research demonstrating that hearts from DCD donors under certain conditions can be resuscitated and potentially rendered suitable for transplantation appears to undermine the validity of cessation of circulatory function as a criterion for DCD. However, even if circulatory function were to be restored after the declaration of death, the loss of brain function after 5 or more minutes of total cerebral ischemia is irreversible.

3. DCD has been questioned on the basis of whether circulatory failure is truly irreversible. However, DCD may be defended by the distinction between permanent cessation of circulatory function, meaning that function will not be restored because it will neither return spontaneously nor return as a result of medical intervention (an ethically valid decision not to resuscitate has been made), in contrast to irreversible cessation of circulatory function, meaning that it cannot be restored by any known technology.

D. Some DCD protocols may transgress a moral boundary.

1. DCD protocols that inappropriately shorten the time requirement for asystole may circumvent the dead donor rule. There is a crucial moral distinction between procurement of vital organs from an imminently dying patient and procurement of vital organs from a dead patient (see CMDA statement on Death). CMDA finds the removal of solid organs from potential DCD donors who are not dead to be morally problematic and inherently open to abuse.

2. Given the availability of two clinical criteria (whole brain and circulatory) by which to determine death, the choice of which to apply might appear to be made on the basis of the intent to recover organs rather than the medical condition of the patient. It is necessary to distinguish morally, and in practice to separate, (a) the decision to withdraw life-sustaining treatment, (b) the decision to donate organs, and (c) the determination of death. The clinical
determination of death in DCD should be based on the prolonged absence of circulation to the brain and not the intent of treatment withdrawal or organ procurement.

E. DCD options might enable abuses.

1. Increasing attention to DCD technologies might, over time, shift the emphasis in clinical practice from doing what is best for the dying patient to giving preference to the utility of procuring organs for the benefit of others.

2. Ongoing ethical evaluation of evolving DCD medical practice options is needed as the technology evolves.

3. Ongoing ethical scrutiny of the social forces and economic industries that shape organ procurement policies and procedures is also needed.

Approved by the House of Representative
Passed unanimously
April 24, 2014, Green Lakes, WI

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1 Also known as Donation after Circulatory Determination of Death (DCDD), which is a form of Non-Heart Beating Donation (NHBD).
5 The inventor of the extracorporeal membrane oxygenation (ecmo) procedure was quoted as saying, "The unknown, yet unlikely, potential to resuscitate the brain of these potential DCD donors with extracorporeal support would be prevented with an aortic occlusion balloon." Jeff Evans, Protocol changes may increase donor organs. Surgery News 2008; 4(10): 1,10.
8 The United Network for Organ Sharing Minimum Procurement Standards for Organ Procurement Organizations, section 2.8.A, lists as suitable DCDD candidates end-stage musculoskeletal disease, pulmonary disease, and high spinal cord injury. See http://optn.transplant.hrsa.gov/PoliciesandBylaws2/policies/pdfs/policy_2.pdf
9 DCDD donation may occur in patients that do not have a neurological injury, but a disease that renders them ventilator dependent (i.e. amyotrophic lateral sclerosis). See: http://optn.transplant.hrsa.gov/PublicComment/pubcommentPropSub_309.pdf
12 The OPTN/UNOS Ethics Committee indicated at its November 2012 meeting that it plans to consider proposals to extend DCD eligibility to high spinal cord alive and aware donors as well as recovering a single or double kidney from living donor patients who are expected to become DCDD candidates. Published at: http://optn.transplant.hrsa.gov/CommitteeReports/board_main_EthicsCommittee_11_14_2012_11_32.pdf

18 Bernat JL. How the distinction between "irreversible" and "permanent" illuminates circulatory-respiratory death determination. *Journal of Medicine & Philosophy* 2010; 35(3): 242-255. PMID 20439357


Organ Transplantation after Assisted Suicide or State Execution

CMDA affirms the sanctity of every human life, recognizing that life is a gift from God. For individuals with life-threatening disorders, organ transplantation may offer hope of a longer and healthier life. CMDA affirms ethical organ procurement (organ procurement that is not coerced, in which the organs are not purchased or sold, and through which vulnerable persons are not exploited). Organ procurement is not an end to be gained at all costs or through any means. Medicine primarily entails a covenantal relationship between physician and patient, and secondarily with society. This is not merely a utilitarian calculus of the greatest good for the greatest number. The ends, even if they represent a perceived good, are not justified if the means are not God-honoring and according to his biblical statutes.

Persons killed through assisted suicide and prisoners executed by the state are not appropriate sources of organs for transplantation. In both situations coercion is present and renders the decision to donate organs illicit. Assisted suicide is a moral evil; using organs thus obtained may involve complicity in that evil if such use incentivizes such practice or justifies this moral evil. In the case of executed prisoners coercion is overt and inherently subject to abuse. In the case of assisted suicide those utilizing the organs do not have valid informed consent.

Christian physicians appropriately argue in the public square for the dignity of all persons based on the sanctity of life given by God. While we may work to inform and encourage living donor or cadaveric organ transplantation, we may not encourage organ transplantation after assisted suicide or state execution.

Approved by the House of Representatives
Passed with 43 approvals, 3 abstentions
April 26, 2012. Ridgecrest, NC

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1 See CMDA statement CMDA Overview on Human Organ Transplantation
2 See CMDA statement regarding the Sanctity of Human Life
3 See CMDA statement on Valid Informed Consent as Compassionate Care in Shared Decision-Making
4 See CMDA statement on Physician Assisted Suicide
5 The Christian Medical & Dental Associations has no statement on capital punishment
CMDA Overview on Human Organ Transplantation

CMDA affirms the ethical use of human organs for transplantation. Organ transplantation offers the opportunity for selfless, altruistic acts of service to our fellow humans. Since clinical demand exceeds the supply of available transplantable organs, well-reasoned policies and responsible stewardship are needed to realize the good of human organ transplantation while avoiding the harms of donor exploitation or unjust recipient distribution.  

Cadaveric human organ transplantation necessitates that the donor be dead. [See CMDA statement on Death.] The definition of death should not be enlarged for the purpose of increasing the supply of available organs. Such expansions include, but are not limited to, infants with anencephaly and persons who are in persistent vegetative or minimally conscious states. 

Consent for organ procurement must be free of force, fraud, or coercion by individuals, groups, organ procurement agencies, government or others. 

Living donor transplantation has additional unique issues. 

CMDA encourages increased educational efforts to inform the public of all aspects of organ donation and transplantation.

Approved by the House of Representatives  
Passed with 43 approvals, 1 opposed, and 1 abstention  
April 28, 2010. Mt. Hermon, California

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6 CMDA statement on Allocation of Transplant Organs pending  
7 CMDA statement on Organ Procurement pending
Pain Management
Historically, physicians have sought to alleviate pain and suffering. With the scientific and technological advances that have occurred in recent decades, clinicians have increasingly focused on the control or cure of disease. As a result, the traditional compassion of medical care has often been diluted or neglected.

This attitude of compassion was taught by Jesus in the parable of the Good Samaritan and was demonstrated in His ministry to those who were ill. As Christian physicians and dentists, we are compelled by love for our Lord Jesus Christ and love for our neighbor to include effective pain management in our ministry to our patients.

Pain management is important for all patients, but is especially important in patients with chronic or terminal illnesses. The total management of pain involves four areas: physical, emotional, social, and spiritual pain.

Physical pain should be treated by using all effective modalities. However, we understand pain to be an important symptom alerting the patient to a need or a potential problem. Therefore it may not always be appropriate to remove this symptom completely.

When pain cannot be completely eliminated, it is the clinician's responsibility to help the patient cope with the residual pain and to live as fully as possible. In patients who are imminently dying, it is acceptable to use increasing doses of analgesics to the level necessary to control severe pain without the intent of shortening life, but with the realization that in some instances control of pain might hasten death.

Emotional pain may include fear of pain, disability or death; frustration; worries of what will happen to those left behind; and feelings of being a burden on loved ones. Social pain may include a feeling of abandonment by loved ones or caregivers, and a fear of lack of access to medical resources. These aspects of pain can be addressed by a compassionate and supportive presence.

Spiritual pain may include a sense of isolation from God, fear of death, and feelings of guilt and anger. Management should include an affirmation of God's enduring love for us and an opportunity for repentance, reconciliation, and acceptance of His offer of eternal life.

As Christian physicians and dentists, we desire to address the physical, emotional, social and spiritual pain of our patients in order to more fully reflect the love and compassion of our Lord.

Approved by the House of Delegates
Passed with 56 approvals, 2 opposed, 1 abstention
April 30, 1993. Danvers, Massachusetts
**The Problem**

There are many legitimate goals for the practicing clinician including patient education, disease prevention, diagnosis of illness, restoration of health, relief of symptoms, preservation or restoration of function, and postponement of death. Physicians and dentists are taught that the relief of symptoms should be a secondary goal; the primary goals should be diagnosis and cure. It is better to treat the disease process directly so that the symptoms will abate than it is to only treat the symptoms, especially pain, thereby masking the illness. This is one reason that the treatment of pain is sometimes inadequate. Sometimes, however, a chronic condition has been diagnosed and it cannot be reversed, so treatment of the symptoms, especially the pain, may become the primary goal. Other times, diagnosis of an acute problem is clear and treatment is underway, but the pain is overwhelming, so that its relief should then become the primary goal.

Another reason that pain relief may be inadequate is that it is difficult for the clinician to assess the severity of a patient's pain. Pain is subjective; there is no way to directly measure its intensity. Clinicians are concerned about the overuse or inappropriate use of narcotic analgesics for fear of chemical dependence. All practicing physicians can remember being tricked into writing a narcotic prescription for a patient who claimed to have a migraine headache or some other painful condition and who was later found to be a substance abuser. Sometimes our rationality gets in the way of our compassion.

For these and perhaps other reasons, pain management has not been a priority in medical and dental education. As a result, clinicians are often not prepared to give expert pain relief in those situations where it is indicated.

The hospice movement in Europe and North America has emphasized the relief of symptoms, including pain, in patients who are terminally ill. Dedicated physicians in this discipline have greatly enhanced our understanding of the mechanisms of and management of chronic pain. They have also learned that chemical dependence on narcotics is a rare occurrence in patients with chronic pain. Experts in pain management state that in only a very small percentage of patients is it not possible to give adequate pain control without danger of addiction. Even though this expertise has developed and is available in most settings, some clinicians are still reluctant to use sufficient medication for the above reasons. Inadequate pain relief is often cited as a reason that physician-assisted suicide or euthanasia should be made legally available.

**A Christian Response**

Clinicians who model themselves after Jesus should be dedicated to clinical competence, and they should also have an extra dose of compassion. They should ensure that their patients receive the best pain management available either by becoming experts in pain management themselves or referring patients to an expert when needed.

Christians have an additional issue which sometimes interferes with adequate treatment of pain. We recognize that we live in a fallen world, and one of the results of “the fall” is “the curse” of pain (Gen. 3:16). In the past, some Christians were vocal in their opposition to the use of analgesia or anesthesia to relieve the pain of childbirth. Some Christians believe that we must tolerate some pain. Since scripture indicates that sometimes pain is allowed in our lives as a means of instruction or correction, some believe that we should not be too vigorous in our attempts to eliminate pain. Most Christian clinicians, however, have responded to a call of ministry through medicine; a call which includes the compassionate treatment of all conditions. God has called us to relieve suffering and has allowed us to develop the means to do it, and we must therefore be good stewards of those abilities and resources.

**The Principle of Double Effect**

We owe a debt to Roman Catholic moral thought for the principle of double effect which is often invoked in discussions about pain relief. This principle deals with both the intentions and the results of actions.

If one action can have both good and bad effects, it is ethically permissible to do the act with good intention (e.g. use of morphine for pain relief), even if the bad effect (potential for respiratory depression leading to earlier death) can be anticipated. The act must be done with good intentions. The bad effect
must not be intended, but is merely tolerable. In addition, there must be a reasonable proportion between the good and the bad effects; e.g. this potentially lethal use of morphine would be tolerable for pain relief in a person who is dying, but would not be acceptable for pain relief in an otherwise healthy person who is passing a kidney stone.

This principle is felt by many to justify the liberal, but judicious, use of narcotics in terminally ill patients, but does not justifying intentional mercy killing.

Abstracts


This retrospective study evaluated the use and adequacy of pain management in elderly and minority cancer patients admitted to nursing homes in 5 states using data from the Systematic Assessment of Geriatric Drug Use via Epidemiology (SAGE) database. “Pain assessment was based on patients’ report and was completed by a multidisciplinary team of nursing home personnel that observed, over a 7 day period, whether each resident complained or showed evidence of pain daily.” This study showed a total of 4003 patients reported daily pain, with the greatest percentage of those being in the age category of 65-74 years. Of patients with daily pain, more than a quarter did not receive any analgesic agent and patients older than 85 years were also more likely to receive no analgesia. This study also noted “other independent predictors of failing to receive any analgesic agent were minority race, low cognitive performance and the number of other medications received.” The authors concludes, “Daily pain is prevalent among nursing home residents with cancer and is often untreated, particularly among older and minority patients.”


“Palliative medicine is an emerging medical discipline in the United States, modeled after similar efforts in Great Britain, Australia, and Canada. Increasingly, academic medical centers are starting clinical programs in palliative medicine including inpatient consultation services. A description of the essential components of a palliative medicine consultation is presented, based on the author’s experience of more than 600 patients encounters at the Medical College of Wisconsin in Milwaukee. A palliative medicine consultation consists of 6 features: assessment and management of physical symptoms; assisting patients to identify personal goals for the end-of-life care; assessment and management of psychological and spiritual needs; assessment of the patient’s support system; assessment and communication of estimated prognosis; and assessment of discharge planning issues.”


The American Pain Society is the U.S. Chapter of the International Association for the Study of Pain. Its position statement recognizes the following six points:

1. The fierce debate over euthanasia and physician-assisted suicide illuminates a broad public concern that “terminal illness is often accompanied by severe pain and other symptoms that make death seem preferable.”

2. Clinicians, with the proper training, can provide adequate pain relief for more than 90% of dying cancer patients. However, current treatment often falls short. Studies show that a substantial portion of patients, particularly those in minority groups, receive inadequate analgesic treatment and suicidal wishes correlate to unrelieved pain or untreated mood symptoms (such as anxiety and depression), both of which are readily respond to clinical treatment.

3. Despite the best intentions of clinicians, pain and symptom control is often suboptimal because the entire healthcare system has been designed around cure of disease rather than palliation.” Programs designed to teach and improve palliative care must contain several essential components such as clinician education, accountability of all professionals of the organization to
the treatment of pain to all ages, and improved pain visibility for prompt attention, among other things.

4. Efforts to ensure pain management is available to all who need it must take priority over legalization of physician-assisted suicide. "Experience in The Netherlands, where there has been relatively little effort to improve pain and symptoms treatment, suggests that legalization of physician assisted suicide might weaken society's resolve to expand services and resources aimed at caring for the dying patient.

5. Health care providers who aggressively treat pain with analgesic drugs and when needed, terminal sedation, must be protected even if death is the unintentional consequence. Regulation and appropriate documentation together can justify the use of treatments that when administered, knowingly depress respiration and hasten death in some way. Such treatment is based on ethical principle should not be considered as euthanasia or physician assisted suicide.

6. More research needs to be done within the scope of symptom treatment in addition to the current focus on finding cures.


Using articles found on MEDLINE from 1980 to 1995 dealing with pain assessment and treatment and quality improvement and education, the APS's Quality of Care Committee developed the following guidelines that are necessary components of any quality improvement program.

1. Recognize and treat pain promptly
2. Make information about analgesics readily available
3. Promise patients attentive analgesic care
4. Define explicit policies for use of advanced analgesic technologies
5. Examine the process and outcomes of pain management with the goal of continuous improvement

The authors included three articles and one study describing the results of comprehensive implementation of the above guidelines in a large cancer hospital. They showed improved pain relief and increased patient satisfaction.


"Physician-assisted suicide and euthanasia (PAS/E) have been outside the bounds of acceptable behavior for physicians for hundreds of years and remain illegal in all jurisdictions except Oregon and The Netherlands. The morally, legally and professionally acceptable alternative is excellent end-of-life care. In this article, the arguments in favor of PAS/E are discussed briefly and rebutted. The arguments against this practice are outlined and supported. Because pain (and fear of pain) at the end of life is one of the driving forces behind the recurrent debate about legalization of PAS/E, the medical professional as a whole, and pain specialists in particular, have an obligation to use all available means to relieve pain."


"Few things a doctor does are more important than relieving pain. Yet the treatment of severe pain in hospitalized patients is regularly and systematically inadequate....It is generally agreed that most pain, no matter how severe, can be effectively relieved by narcotic analgesics. Why this inconsistency between what is practiced and what is possible?" After this introduction, the author goes on to discuss the issues of side effects and irrational fear of addiction. She documents the low incidence of addiction and other serious side effects in the management of chronic pain.

She discusses "prn" dosing and the alternative of regular dosing for the management of chronic pain, including the advantages and disadvantages of each. She proposes an intermediate, a prn order for a
range of doses, with the patient asked at specific intervals if he or she needs medication, and whether a small or large dose.

She concludes by saying "Pain is soul destroying. No patient should have to endure intense pain unnecessarily. The quality of mercy is essential to the practice of medicine; here, of all places, it should not be strained."

Hill CS. When will adequate pain treatment be the norm? JAMA 1995; 274(23):1881-1882

After noting the concerted efforts to improve pain control made by major organizations such as the World Health Organization the Agency for Health Care Policy and Research (USPHS), the author wonders why there have been only limited results. He believes that past educational efforts have been insufficient. He endorses a practice guideline for quality improvement developed by the American Pain Society to monitor results of pain control. If this does not prove adequate, he believes that patients must be empowered to demand adequate pain relief, regardless of the cause or the methods required to achieve relief. He concludes, "In all situations, relief of pain, either acute or chronic, must be the standard of success."


After extensive study, a working group concluded that QI programs to improve pain management should include 5 key elements: (1) assuring that a report of unrelieved pain raises a "red flag" that attracts clinicians attention; (2) making information about analgesics convenient where orders are written; (3) promising patients responsive analgesic care and urging them to communicate pain; (4) implementing policies and safeguards for the use of modern analgesic technologies; and (5) coordinating and assessing implementation of these measures.

Bibliography


In an effort to improve cancer pain relief in developing countries, the WHO proposed in 1986 a 3-step analgesic ladder using inexpensive drugs.


A good review of analgesic procedures, plus tables of comparative doses of non-narcotic and narcotic analgesics along with recommendations for their use. Behavioral approaches and supportive care are also discussed.


After discussing the multi-factorial aspect of pain, the author gives an update on analgesics, routes of administration, and other procedures including neuroaugmentation, phsyiatric approaches, neurosurgery, and psychological approaches.


The authors look at how pain impacts the physical, psychological, social, and spiritual well-being of patients. They then apply the four primary ethical principles to pain management, and conclude with 10 practical implications.

The authors cite several published guidelines for the management of pain in children, but lament that they are inadequately utilized. They recommend administrative interventions such as standards for pain assessment and management in hospital quality-assurance programs.


These comprehensive 140 page (acute) and 250 page (cancer) state-of-the-art guides to the management of pain are available at no charge from AHCPR, Executive Office Center, Suite 501; 2101 East Jefferson Street; Rockville, MD 20852


Recognizing that the suffering of extreme pain may cause seriously ill patients to request assisted suicide or euthanasia, the author asserts that Hospice presents such patients with a better, alternative option. Such a program seeks to acknowledge and relieve patients physical, psychological, spiritual, and social pain, thereby allowing them "the freedom to see death and dying in the context of a complete life experience [by being] freed from the physical symptoms that bind them to the present."


Pain is a common symptom in cancer and one experienced by patients and family caregivers. A neglected area of pain management is enhancing the individual's ability to derive meaning from pain and suffering associated with illness. Because pain is often a metaphor for impending death, the meaning derived from pain may contribute to the ultimate meaning of death for the individual. This article provides case examples and analysis of the search for meaning in cancer pain.
Parental Consent for Minors Seeking Abortion

Authority in the family, as established by God, rests with the parents* for the protection and benefit of the children. Current law acknowledges and generally supports parental authority in medical decision-making, but makes a notable exception in the case of pregnant minors. State laws that allow pregnant minors to seek abortion* without parental consent undermine God’s design for the family and are ultimately detrimental to society.

- Especially in a time of crisis an adolescent needs to receive the love, wisdom, guidance, and support of parents and family.

- Under the duress of societal disapproval, peer pressure, guilt and fear, a pregnant youth and her partner may be tempted to secretly avoid the help of family at the very time when they are most vulnerable and family involvement is most needed.

- An adolescent may not fully appreciate the inherent moral, spiritual, physical, and emotional dangers of abortion or its associated long-term risks. This calls into question her ability to give truly informed consent.

- Sexual partners, incestuous family members, sexual predators, or others may successfully coerce a minor to have an abortion in order to avoid their personal responsibility and the consequences of their behavior. The requirement of parental consent helps protect the minor from such coercion.

Minors who are in situations that may adversely affect their future need the support and counsel of their parents. We realize that not all adolescents are in a family that provides support and counsel as indicated in this statement. However, we believe that authority in the family is established by God. We therefore encourage the requirement of parental consent in the case of minors seeking abortion.

*CMDA believes the term parent includes guardians.
*Refer to Abortion Statement.

Approved by the House of Delegates
Passed unanimously
Parental Rights

CMDA affirms that children at all stages of development are precious human beings bearing the image of God. Children are loved by God, belong to their families, and share in their communities. The family is the normal environment wherein children are to be cherished, protected, and prepared to take on adult responsibilities. Families are prior to the state, which has the obligation to protect children and the family structure. As the family is foundational to a well-functioning society, mothers and fathers both have the responsibility to rear their children. Parental rights are an extension of parental responsibility. Parents' claim to authority over their children, while basic, is not unlimited. The state also has a legitimate, though limited, interest in the welfare of minor children as well as in public health, for which reason laws and policies have been established to balance these interests with parental rights.

CMDA members, as healthcare professionals, have important roles in caring for children and families by providing medical and dental care as well as education regarding health issues. Healthcare professionals caring for children are ethically obligated to honor parents' wishes regarding medical treatment decisions, except in certain situations when there is clear evidence that doing so would risk imminent harm. In duly considering the best interests of the child and family, prevention of harm to children should be the primary guiding principle. This guidance is based on the following parameters:

The Parent-Child Relationship before God

1. The parent-child relationship is established by God.
   A. Parental responsibilities assigned by the Creator include nurturing, disciplining, teaching the child correct behavior, and imparting a knowledge of and respect for the Creator (Deut 4:9, Deut 6:6-7, Pr 23:15, Pr 29:15, Ps 78:5-6). The rights of parents to make decisions for their minor children are derived from these God-given responsibilities.
   B. Parents are responsible for making decisions on behalf of minors, because the young have neither the developmental capacity nor the life experiences to make wise decisions (Pr 22:15, 1Cor 13:11).

2. All human beings are created in God’s image (Gen 1:27), thus both parent and child have equal value in God’s eyes.
   A. A child is a gift from God to parents (Pr 17:6, Ps 127:3-5, Ps 128:3).
   B. A child is a person from conception, not a product or extension of a parent, nor the property of the state (Ps 139:13, Jer 1:5).
   C. Although having children is a scripturally supported good and a mandate for humanity (Gen 1:28, 9:7), no person may presume to have an unassailable right to become or continue to be a parent on his or her own terms (Gen 16:1-12, 30:1-2).

3. Parental rights do not extend to actions that do not benefit but cause harm to their children (Jer 7:31, Jer 19:5).

Parental Rights and the State (government at all levels)

1. God, who established the family, has also established government to protect the innocent (Rom 13:1,4). Both of these human institutions—the family and the state—are humanly imperfect and degraded by the Fall and thus should be subject to checks and balances.
   A. Scripture assigns primary responsibility, including the right to make decisions for minor children, to parents (see references in 1A and 1B above). The United States Supreme Court has generally upheld the right of parents to make decisions for their minor children (Appendix). Parents should have the freedom of conscience to rear their children with the beliefs they hold true.
B. Regrettably, not all parents act in their children's best interests, and when children are at immediate risk of harm, it is sometimes necessary for the state to overrule parental authority or, in cases of great harm or potential death, physically remove children from their parental home. The state may also mandate actions it considers necessary for the general welfare, ignoring parental objections. State action in these cases is legitimate, provided that its authority is not abused (see CMDA statement on Immunization).

C. Although the state has the duty to prevent harm, historically governing authorities have at times been the cause of harm to children. Examples include, but are not limited to:
   i. Scripture documents the persecution of believers, even children, because of their faith in God (Ex 1:22, Matt 2:16, Acts 16:16-24).
   ii. The first victims of the 20th century Nazi Holocaust were physically and mentally disabled children, who were euthanized in the mistaken belief that their elimination would improve the genetic "hygiene" of the public.
   iii. Rogue states have deployed chemical weapons, including nerve agents, against their own people, including children.
   iv. Government forces in some countries turn a blind eye to, or, in some instances, perpetrate child trafficking, including recruitment of child soldiers, forced labor, and commercial sexual exploitation.
   v. Courts have ruled against parents who opposed their minor children’s desire to receive puberty-blocking drugs or undergo sex change surgery or removed from the home children whose parents homeschooled them, on the mistaken logic that “misgendering” children by denying them access to specific medical procedures or providing religious instruction in the home constitutes child abuse.
   vi. Governments have subjected families to mandated abortions.
   vii. Governments have supported, tacitly or explicitly, or by funding, research that creates and destroys children at the embryonic stage of development.

At such times, healthcare professionals share in the obligation to protect the vulnerable, draw public attention to these harms, and articulate reasons why those responsible should be held accountable.

D. The state determines the age at which a person is no longer considered a minor and, therefore, has the right to make medical decisions independently of his or her parents. Emancipated minor laws alter this age on a case-by-case basis, setting aside parental authority for those minors considered “emancipated.” These “emancipated minors” may still be in need of adult guidance.

Recommendations

1. Healthcare professionals caring for children should begin with the assumption that a child's parents (whether biologic, adoptive, or legally appointed guardians) are concerned about the child's welfare and intend to make decisions that are in the best interest of the child.

2. When parents disagree with medical recommendations and the child's welfare is not at immediate risk, healthcare professionals should continue to provide compassionate care and work with the parents in ongoing mutual dialogue in the prayerful hope that they will come to trust the professional's recommendation.

3. When parents disagree with medical recommendations and the child's welfare is at immediate risk, healthcare professionals should, when necessary, intervene with assistance from the state on behalf of the child. Parental rights, as understood both scripturally and legally, do not extend to
causing harm to a child from abuse or neglect or the refusal of life-saving or health-preserving care (see CMDA statement on Limits to Parental Authority in Medical Decision-Making).

4. It is appropriate that the minor patient be allowed to participate in medical decision-making to the extent that he or she has the capacity to understand the nature and rationale of treatment. Assent to treatment should always be sought for adolescents and mature minors.

5. When a minor patient disagrees with his or her parents regarding a medical decision, healthcare professionals should consider the developmental cognitive capacity and values of the patient and strive for consensus toward the medical recommendation. When consensus cannot be reached and the medical team has concerns about the appropriateness of the legally authorized decision-maker's judgment, external review or legal action may be required.

6. It should not be assumed that laws alone can protect children. Professionals must exercise moral responsibility in order for ethical principles and just laws to have their intended effect. The healthcare professional who has knowledge of harm to a child has a responsibility to alert and cooperate with state agencies to protect the child.

7. Removal of a child from the parents' care should be undertaken only when there is evidence of serious physical or psychological harm to the child and should not be based solely on the parents' religious beliefs, moral teaching, or educational choices.

8. Procedures for which there is no legitimate medical indication proven medical benefit include:
   a. Female genital mutilation, which causes is known to cause permanent physical and psychological harm.\(^8\)
   b. Gender reassignment hormonal or surgical interventions in children with gender dysphoria (see CMDA statement on Transgender Identification).

9. When state actions or mandates affecting children usurp parental authority unjustly, are incompatible with medical ethics, or risk harming children, then healthcare professionals have a duty to express concern proportionate to the seriousness of the harm, to educate, and to apply their knowledge and skill to advocate for and protect the children under their care.

Unanimously approved by the House of Representatives
April 26, 2018
Ridgecrest, North Carolina

Appendix: Selected Legal Cases with Excerpts

*Meyer v. State of Nebraska*, 262 U.S. 390 (1923)

. . . The American people have always regarded education and acquisition of knowledge as matters of supreme importance which should be diligently promoted. The Ordinance of 1787 declares:

'Religion, morality and knowledge being necessary to good government and the happiness of mankind, schools and the means of education shall forever be encouraged.'

Corresponding to the right of control, it is the natural duty of the parent to give his children education suitable to their station in life; and nearly all the states, including Nebraska, enforce this obligation by compulsory laws.


*Pierce v. Society of Sisters*, 268 U.S. 510 (1925)

. . . As often heretofore pointed out, rights guaranteed by the Constitution may not be abridged by legislation which has no reasonable relation to some purpose within the competency of the state. The fundamental theory of liberty upon which all governments in this Union repose excludes any general power of the state to standardize its children by forcing them to accept instruction from public teachers only. The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations. . . .


*Prince v. Commonwealth of Massachusetts*, 321 U.S. 158 (1944)

It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder. . . . But the family itself is not beyond regulation in the public interest, as against a claim of religious liberty. Reynolds v. United States, 98 U.S. 145 ; Davis v. Beason, 133 U.S. 333 , 10 S.Ct. 299. And neither rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well being, the state as parens patriae may restrict the parent's control by requiring school attendance,9 regulating or prohibiting the child's labor,10 and in many other ways. 11 Its authority is not nullified merely because the parent grounds his claim to control the child's course of conduct on religion or conscience.


Constitutional interpretation has consistently recognized that the parents' claim to authority in the rearing of their children is basic in our society, and the legislature could properly conclude that those primarily responsible for children's well-being are entitled to the support of laws designed to aid discharge of that responsibility.


Indeed, it seems clear that, if the State is empowered, as parens patriae, to "save" a child from himself or his Amish parents by requiring an additional two years of compulsory formal high school education, the State will, in large measure, influence, if not determine, the religious future of the child. Even more markedly than in Prince, therefore, this case involves the fundamental interest of parents, as contrasted with that of the State, to guide the religious future and education of their children. The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

https://www.law.cornell.edu/supremecourt/text/406/205

_Cleveland Board of Education v. LaFleur_, 414 U.S. 632 (1974)

This Court has long recognized that freedom of personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause [p640] of the Fourteenth Amendment. _Roe v. Wade_, 410 U.S. 113; _Loving v. Virginia_, 388 U.S. 1, 12; _Griswold v. Connecticut_, 381 U.S. 479; _Pierce v. Society of Sisters_, 268 U.S. 510; _Meyer v. Nebraska_, 262 U.S. 390. See also _Prince v. Massachusetts_, 321 U.S. 158; _Skinner v. Oklahoma_, 316 U.S. 535. As we noted in _Eisenstadt v. Baird_, 405 U.S. 438, 453, there is a right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."

https://www.law.cornell.edu/supremecourt/text/414/632

_Moore v. East Cleveland_, 431 U.S. 494 (1977)

. . . Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition. 12 It is through the family that we inculcate and [431 U.S. 494, 504] pass down many of our most cherished values, moral and cultural. 13

Ours is by no means a tradition limited to respect for the bonds uniting the members of the nuclear family. The tradition of uncles, aunts, cousins, and especially grandparents sharing a household along with parents and children has roots equally venerable and equally deserving of constitutional recognition. 14 Over the years millions [431 U.S. 494, 505] of our citizens have grown up in just such an environment, and most, surely, have profited from it. Even if conditions of modern society have brought about a decline in extended family households, they have not erased the accumulated wisdom of civilization, gained over the centuries and honored throughout our history, that supports a larger conception of the family. Out of choice, necessity, or a sense of family responsibility, it has been common for close relatives to draw together and participate in the duties and the satisfactions of a common home. Decisions concerning child rearing, which Yoder, Meyer, Pierce and other cases have recognized as entitled to constitutional protection, long have been shared with grandparents or other relatives who occupy the same household - indeed who may take on major responsibility for the rearing of the children. 15 Especially in times of adversity, such as the death of a spouse or economic need, the broader family has tended to come together for mutual sustenance and to maintain or rebuild a secure home life.


_Smith v. Organization of Foster Families_, 431 U.S. 816 (1977)

Thus the importance of the familial relationship, to the individuals involved and to the society, stems from the emotional attachments that derive from the intimacy of daily association, and from the role it plays in "promot[ing] a way of life" through the instruction of children, Wisconsin v. Yoder, _406 U.S. 205_, 231-233 (1972), as well as from the fact of blood
relationship. No one would seriously dispute that a deeply loving and interdependent relationship between an adult and a child in his or her care may exist even in the absence of blood relationship. 51 At least where a child has been placed in foster care as an infant, has never known his natural parents, and has remained continuously for several years in the care of the same foster parents, it is natural that the foster family should hold the same place in the emotional life of the foster child, and fulfill the same socializing functions, as a natural family. 52 For this reason, we cannot dismiss the foster family as a mere collection of unrelated individuals. [431 U.S. 816, 845] Cf. Village of Belle Terre v. Boraas, 416 U.S. 1 (1974).

But there are also important distinctions between the foster family and the natural family. First, unlike the earlier cases recognizing a right to family privacy, the State here seeks to interfere, not with a relationship having its origins entirely apart from the power of the State, but rather with a foster family which has its source in state law and contractual arrangements. The individual's freedom to marry and reproduce is "older than the Bill of Rights," Griswold v. Connecticut, supra, at 486. Accordingly, unlike the property interests that are also protected by the Fourteenth Amendment, cf. Board of Regents v. Roth, 408 U.S., at 577, the liberty interest in family privacy has its source, and its contours are ordinarily to be sought, not in state law, 53 but in intrinsic human rights, as they have been understood in "this Nation's history and tradition." Moore v. East Cleveland, ante, at 503. . . .


Quilloin v. Walcott, 434 U.S. 246 (1978)

We have recognized on numerous occasions that the relationship between parent and child is constitutionally protected. See, e. g., Wisconsin v. Yoder, 406 U.S. 205, 231 -233 (1972); Stanley v. Illinois, supra; Meyer v. Nebraska, 262 U.S. 390, 399 -401 (1923). "It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." Prince v. Massachusetts, 321 U.S. 158, 166 (1944). And it is now firmly established that "freedom of personal choice in matters of . . . family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment." Cleveland Board of Education v. LaFleur, 414 U.S. 632, 639 -640 (1974).

We have little doubt that the Due Process Clause would be offended "[i]f a State were to attempt to force the breakup of a natural family, over the objections of the parents and their children, without some showing of unfitness and for the sole reason that to do so was thought to be in the children's best interest." Smith v. Organization of Foster Families, 431 U.S. 816, 862 -863 (1977) (STEWART, J., concurring in judgment). But this is not a case in which the unwed father at any time had, or sought, actual or legal custody of his child. Nor is this a case in which the proposed adoption would place the child with a new set of parents with whom the child had never before lived. Rather, the result of the adoption in this case is to give full recognition to a family unit already in existence, a result desired by all concerned, except appellant. Whatever might be required in other situations, we cannot say that the State was required in this situation to find anything more than that the adoption, and denial of legitimation, were in the "best interests of the child."


In defining the respective rights and prerogatives of the child and parent in the voluntary commitment setting, we conclude that our precedents permit the parents to retain a substantial, if not the dominant, role in the decision, absent a finding of neglect or abuse, and that the traditional presumption that the parents act in the best interests of their child should apply. We also conclude, however, that the child's rights and the nature of the commitment decision are such that parents cannot always have absolute and unreviewable discretion to decide whether to
have a child institutionalized. They, of course, retain plenary authority to seek such care for their children, subject to a physician's independent examination and medical judgment.


The fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate simply because they have not been model parents or have lost temporary custody of their child to the State. Even when blood relationships are strained, parents retain a vital interest in preventing the irretrievable destruction of their family life. If anything, persons faced with forced dissolution of their parental rights have a more critical need for procedural protections than do those resisting state intervention into ongoing family affairs. When the State moves to destroy weakened familial bonds, it must provide the parents with fundamentally fair procedures. [Footnote 7] . . .


"The best interests of the child," a venerable phrase familiar from divorce proceedings, is a proper and feasible criterion for making the decision as to which of two parents will be accorded custody. But it is not traditionally the sole criterion—much less the sole constitutional criterion—for other, less narrowly channeled judgments involving children, where their interests conflict in varying degrees with the interests of others. Even if it were shown, for example, that a particular couple desirous of adopting a child would best provide for the child's welfare, the child would nonetheless not be removed from the custody of its parents so long as they were providing for the child adequately. See Quilloin v. Walcott, 434 U. S. 246, 255 (1978). Similarly, "the best interests of the child" is not the legal standard that governs parents' or guardians' exercise of their custody: So long as certain minimum requirements of child care are met, the interests of the child may be subordinated to the interests of other children, or indeed even to the interests of the parents or guardians themselves. See, e. g., R. C. N. v. State, 141 Ga. App. 490, 491, 233 S. E. 2d 866, 867 (1977).

"The best interests of the child" is likewise not an absolute and exclusive constitutional criterion for the government's exercise of the custodial responsibilities that it undertakes, which must be reconciled with many other responsibilities. . . .


The Due Process Clause guarantees more than fair process, and the "liberty" it protects includes more than the absence of physical restraint. Collins v. Harker Heights, 503 U. S. 115, 125 (1992) (Due Process Clause "protects individual liberty against 'certain government actions regardless of the fairness of the procedures used to implement them'")(quoting Daniels v. Williams, 474 U. S. 327, 331 (1986)). The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests. Reno v. Flores, 507 U. S. 292, 301-302 (1993); Casey, 505 U. S., at 851. In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the "liberty" specially protected by the Due Process Clause includes the rights to marry, Loving v. Virginia, 388 U. S. 1 (1967); to have children, Skinner v. Oklahoma ex rel. Williamson, 316 U. S. 535 (1942); to direct the education and upbringing of one's children, Meyer v. Nebraska, 262 U. S. 390 (1923); Pierce v. Society of Sisters, 268 U. S. 510 (1925); to marital privacy, Griswold v. Connecticut, 381 U. S. 479 (1965); to use contraception, ibid.;
Eisenstadt v. Baird, 405 U. S. 438(1972); to bodily integrity, Rochin v. California, 342 U. S. 165 (1952), and to abortion, Casey, supra. We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment. Cruzan, 497 U. S., at 278-279.

. . . Our Nation's history, legal traditions, and practices thus provide the crucial "guideposts for responsible decisionmaking," Collins, supra, at 125, that direct and restrain our exposition of the Due Process Clause. As we stated recently in Flores, the Fourteenth Amendment "forbids the government to infringe ... 'fundamental' liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." 507 U. S., at 302.


. . . it cannot now be doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children.

. . . the Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a "better" decision could be made.

https://supreme.justia.com/cases/federal/us/530/57/case.html
Patient Refusal of Therapy

As Christians, we believe that human life is a gift from God and that all individuals are accountable before God for their lives. This accountability includes decisions to accept or refuse therapy.

As Christian physicians and dentists, we will assist patients, families, and clergy in making decisions within the framework of patients' values and beliefs. A patient may refuse therapy that violates his or her moral values or religious beliefs. However, the right to refuse therapy is limited by the harm it may cause to innocent third parties.

For the Christian, to be absent from the body is to be with the Lord. Physical death need not be resisted at all costs. In certain circumstances, medical treatment only prolongs pain and suffering and postpones the moment of death. It may then be appropriate for a patient with decision-making capacity to refuse medical interventions.

The patient's decision should be made after thoughtful consideration of his or her responsibilities to God, family, and others. When the patient refuses life-prolonging therapy, we will respect that choice and compassionately support his or her medical, social, and spiritual needs.

Approved by House of Delegates
Passed with 50 approvals 5 opposed, 3 abstentions

Explanation

Background

Prior to the 1960's, whether a particular patient with a particular condition should be treated with a particular treatment was a decision made primarily by that patient's physician or dentist. The professional stance was paternalistic in that the clinician benevolently imposed his or her values on the subordinate patient. This was not only common practice, it was accepted by both patients and professionals as the way things were and the way they ought to be. Several things have happened in our culture which has changed that acceptance, including: (a) the development of more treatment options, many of which are invasive, burdensome, and expensive, and some of which have less than ideal efficacy; (b) the emergence of the legal doctrine of "informed consent"; and (c) the rise of individual rights as manifested by increased emphasis on minority rights, consumer rights, patient rights, etc. One of the results of the social ferment of the 1960's is that "medical paternalism" has become a pejorative term and "patient autonomy" has become dominant. The individual patient's values now most often take precedence over the values of the individual clinician or the profession as a whole. Thus at the same time that there are more (and more difficult) decisions to be made, the ultimate authority for making those decisions has shifted from the physician or dentist to the patient. As will be discussed later, this shift has been a mixed blessing.

Patient Refusal of Therapy

During this time of transition, there was a public perception that physicians were often too aggressive in treating patients beyond the time when it was reasonable to limit treatment and accept the inevitability of death. In the 1970's, patients and families began to not only question the wisdom of prolonged aggressive treatment, they also began to challenge some treatment decisions in court. Karen Quinlan's family was the first (1976) to go to an appellate court level (New Jersey) to request the discontinuation of treatment which was felt by physicians to be necessary to sustain life. That landmark court decision to accede to
such a request was the first of 50 or more handed down from appellate judges over the next 15 years which eventually established several legal precedents including: (a) competent patients have the right to refuse even life-sustaining treatment; (b) incompetent patients have the same right, and that right may be exercised by a surrogate; (c) the family is the presumptive surrogate for an incompetent patient; (d) there is no legal difference between withholding and withdrawing a treatment; (e) it is not necessary to go to court to make these decisions; (f) a physician or hospital, acting in good faith, will not be held liable for following such requests; and (g) artificially administered fluids and nutrition are treated the same under the law as any other treatment modality. Of course, everything legal is not necessarily ethical from a Christian perspective.

Advance Directives

Most of the contentious cases have involved patients who had lost their decision-making capacity because of illness or injury. Advance directives have been devised as a way for persons, while still competent, to communicate to family or physician what they would want to have done if they should become unable to make their own decisions. These directives may address treatment goals, the values underlying treatment decisions, specific treatment modalities, or who should act as surrogate decision-maker.

In 1967, Louis Kutner proposed a written document he called a Living Will in which a person could express his or her treatment wishes. His proposal attracted little attention or support until 1976 when the public discussion of Karen Quinlan caused many to desire a way to record their wishes. In 1976, California became the first state to enact a law (The Natural Death Act) recognizing the validity of an advance directive. Subsequently nearly all jurisdictions have passed such enabling legislation. Many states have prescribed wording, others merely give legal recognition to the concept. The completion of Living Wills has been encouraged by many medical and lay organizations, including The Society for the Right to Die (now called Concern for Dying).

Living Wills are documents giving instructions about goals of treatment. Most are written in a negative tone, e.g., “... If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying ...” Some include instructions about specific treatment modalities which the patient declines. Some are worded in a positive way to say what treatments the person would want to have under certain conditions. One format called the Medical Directive, is designed to allow the person to choose which of 12 different treatment modalities he or she would or would not want to have in each of 4 different clinical situations.

A Values History is a detailed document through which a person can convey the information necessary to make a treatment decision. For example, a person might indicate that the ability to communicate with others (or to recognize others, or to listen to music, etc.) is more valuable to him or her than continued living.

Another form of advance directive is a proxy statement, i.e. the designation of what individual the person would trust to make medical decisions if he or she should lose decision-making capacity. The most popular form is a Durable Power of Attorney for Health Care. Such documents may or may not include specific directions for the proxy to follow. The assumption behind a proxy statement is that the person named to act as the agent knows the patient's values, goals, and/or specific treatment wishes.

The 1990 Patient Self-Determination Act was passed by Congress as an amendment to the Omnibus Budget Reconciliation Act. It requires all health facilities which accept federal funds to ask each patient on admission if he or she has an advance directive, and then to give information about advance directives to all who do not have one but would like to learn about them.

In spite of enabling legislation and popular support, only 10-15% of the adult population in the U.S. have completed an advance directive. Reasons for reluctance include denial of the need for such documents, suspicion of unnecessary "legal documents", concern that the motive behind societal encouragement of advance directives is to decrease health care costs, and suspicion that Right to Die advocates are trying to impose their values, which are often contrary to a Right to Life philosophy. In addition, some have expressed concern that signing an advance directive requesting some limitation of treatment in some circumstances may be misinterpreted as a request for no treatment at all, or that it might result in the withholding of measures needed to ensure comfort and dignity.
Secular vs Christian Perspectives

Several assumptions underlie the use of advance directives: (a) treatment decisions require valid consent, (b) not everything that can be done must be done, (c) it is prudent to anticipate loss of decision-making capacity, (d) it is helpful to provide guidance for surrogate decision-makers, (e) both verbal discussion and written documentation are helpful. These assumptions fit squarely and solidly with the secular concept of decision-making where the wishes of the autonomous individual are dominant.

When advance directives were first proposed, many Christians were opposed to them fearing that acceptance of these documents could be used by “right to die” proponents to facilitate the premature withdrawal of treatment from handicapped individuals, or even that they could lead to euthanasia. Upon further reflection, most Christians are now comfortable with these assumptions; none is in conflict with biblical teaching. However, Christians ground these assumptions in a framework also shaped by scripture. Biblical freedom (with the decision-making responsibility that flows from it) is distinctly different from the common contemporary understanding of autonomy. Autonomy today typically means both that decisions critically affecting a patient’s life should be made by the patient, and that whatever decision a patient makes is right simply by virtue of the fact that the patient has made it. A Christian perspective challenges both of these claims:

First, the biblical writings do affirm that even the crucial decision for or against Christ with its definitive implications for one’s eternal life is a matter of personal responsibility—not to mention important decisions that affect life in this world. However, while affirming and protecting the individual, a biblical outlook also emphasizes the significance of community, which is rarely commended in an autonomy-based approach. The best treatment refusal decisions are typically made together with one’s physician, taking into account the well-being of family, friends, and others, and not merely oneself.

Second, while the biblical writings do suggest that we must allow people to refuse even life-sustaining therapy—because it is their decision to make—all such decisions are not necessarily right. Contrary to autonomy-based thinking, a biblically based decision to limit treatment, whether through a patient refusal of therapy or through an advance directive, is constrained by the addition of other assumptions not generally considered in a secular perspective. Added to the assumption of (f) the patient’s freedom (properly understood) are such concerns as (g) the sanctity of life, (h) the sovereignty of God, and (i) the stewardship required regarding our bodies and our resources.

Some evangelical Christians remain fearful of advance directives feeling that they are too vague, or that they give too much authority to a surrogate or a physician who might then act differently from what the patient wants. The importance of such worries and the potential for various differences between the secular and the Christian perspectives led the Christian Medical and Dental Society to develop statements on Patient Refusal of Therapy and Advance Directives.

Abstracts


This article is a concise review of the ethical and legal foundations of informed consent followed by practical guidelines on how to assess an individual patient’s capacity to consent. In order to honor the patient’s right to accept or refuse recommendations, the clinician must be able to carefully assess the decision-making capacity of each patient. Patients must be adequately informed about treatment options and must be given the opportunity to demonstrate their highest level of mental functioning. The legal standards for competence include four skills: communicating a choice, understanding relevant information, appreciating the current situation and its consequences, and manipulating information rationally. Competence is a legal concept which must be formally determined by a court. The clinician’s role is to gather enough information to decide whether a formal adjudication of incompetence is required. Sometimes it is possible to restore the patient’s decision-making capacity through treatment.

In this book, these scholars from the Reformed tradition attempt to "discern the shape of Christian obedience and integrity in the midst of the dilemmas and problems of medical care." Chapter 10, entitled "Death and Covenental Caring", includes the following four biblically-grounded general principles which Christians can use in addressing dilemmas of life and death: (1) a Christian need not regard the mere prolongation of biological life as intrinsically beneficial; (2) a Christian need not strive to endure irremedial and intense suffering when it eclipses the good of relationships with God, self, and others; (3) a Christian should not be devastated by the state of dependency that sometimes characterizes sickness and dying; and (4) end-care decisions Christians make for themselves must not be grounded exclusively in how these decisions affect them personally. They then go on to discuss the question of competence, Living Wills, a Christian Living Will, and the advantages and possible disadvantages of a Christian Living Will. They conclude the chapter by distinguishing between allowing to die and killing (including the special issue of fluids and nutrition) and give a covenental basis for caring.

**Autonomy, religious values, and refusal of lifesaving medical treatment. Wreen MJ. Journal of Medical Ethics 1991; 17(3):124-130**

Autonomy is the value most often offered as justification for honoring a rational patient's refusal of therapy. There are some cases, however, where we intuitively question the validity given to the primacy of autonomy (e.g. when the patient refuses for trivial, whimsical, or irrelevant reasons). Some attempt to justify over-riding such refusals by questioning the rationality of the patient, and others would honor the refusals by adding to autonomy the values of privacy and bodily integrity. The author then proposes and defends his thesis that religious values are different from individual autonomy, privacy, or bodily integrity, and that they are "special" when offered as reasons for refusal of treatment.


After outlining the legal history and background, the author summarizes the decisions of the Missouri Supreme Court and the U.S. Supreme Court and their implications. He concludes that "[t]he Cruzan decision (1) definitively recognizes the right to refuse medical care as a constitutionally guaranteed right, (2) ensures this right applies to artificial nutrition and hydration, (3) strongly implies that living wills, durable power of attorney, and other clear statements of patient preferences are protected as necessary to the exercise of a fundamental right, and (4) does not mandate extensive state regulation of surrogate decision-making for incompetent patients."


From the conclusion: "In our society it is not the physician 'playing God' who decides when, if ever, life-sustaining treatments may be withheld or withdrawn. It is the individual patient (or proxy) who assesses the proportionate benefits and burdens of the proposed treatment and then determines if it should be undertaken or foregone. as the long and unbroken tradition of [Roman Catholic] moral theology established, such action is not 'playing God', but a reasonable acknowledgment that there are limits on what humans have to endure to preserve life. When God created us 'a little lower than the angels', we were not endowed with immortality. Moreover, the unfortunate expression playing God implies that by determining the proportionate use and the disproportionate abuse of technology, a physician or other decision-maker idolatrously assumes the omniscience or the omnipotence reserved to God alone. But the cornerstone of moral theology - the natural law tradition - allows ample room for human participation in God's 'eternal law'. We do that by the exercise of recta ratio, a right reason which carefully weighs all of the moral dimensions of a possible course of action in the sincere and faith-filled hope of doing good and avoiding evil.... "


While acknowledging the biblical foundation for the reverence of human life, the author contends that such a reverence for life may actually incite us to take inappropriate measures in resisting death. He asserts that, "[w]hile we should indeed oppose euthanasia, we must also present a thoroughly biblical and ethical approach to death. Otherwise, a 'pro-life' orientation will mistakenly become 'anti-death'. We must complement our theology of life with a clearly articulated theology of death." Central to such a theology is the belief that death, although an enemy, has been defeated in Christ; as a result, one must not fervently hold on to this life at all costs but may instead accept the inevitability of death by embracing the hope of..."
eternal life in Christ. In making the decision not to receive aggressive medical care, the author maintains and demonstrates that one must consider both the medical context and the associated spiritual and emotional factors involved.


In consideration of the question of whether forgoing treatment is an ethically defensible option for patients, the author contends that an appeal to the Bible yields a manner of thinking which is instructive for decision-making in this area. He asserts that a biblical focus is inherently "God-centered," "reality-bounded," and "love-impelled." He maintains that such a focus may serve to counter the common pressure to overtreat or undertreat by providing a biblically-based, ethically sound model for end-of-life treatment decisions. He envisions two questions as being central to the decision to forgo treatment. Because the biblical notion of freedom holds that individuals must be free to make choices which shape their lives both now and in eternity, one key question is whether or not the patient is indeed willing to forgo a treatment option. A second key question is whether a desire to forgo treatment indicates that a patient is accepting the prospect of a death which is unavoidable or is actually intending death. This distinction is important, as the Bible indicates that although we are not to fear death, neither are we to choose it as a means to avoid suffering.

Bibliography

Ramsey P. On (only) caring for the dying. Chapter 3 in The Patient as Person. New Haven, CT: Yale University Press, 1970

This book by a conservative Protestant theologian has become a classic in medical ethics, and this chapter on palliative care is one of the best pieces written on really caring for people as they die. His analysis of moral questions in terminal care includes a good discussion of "ordinary vs extraordinary" treatments, and his assertion that some things are morally obligatory and others are not. His thesis is that people need only comfort and company during this process.


This Catholic theologian urges that we face our awesome responsibility of making decisions. He invokes the Judeo-Christian tradition as he attempts to steer a middle ground between medical vitalism (that preserves life at any cost) and medical pessimism (that kills when life seems frustrating, burdensome, "useless").


A psychiatrist and a philosopher give clear descriptions of valid consent and competence, then present a useful distinction between rationality and competence.


The introduction to this 200-page classic gives a good description of valid consent and its underlying values, followed by 13 well thought out implications. These are then explained and expanded in the chapters that follow.


The author examines the history and practice of "one-way trust" in the doctor-patient relationship and criticizes doctors for encouraging patients to relinquish their autonomy. He encourages more open and honest communication which respects the rights and needs of both sides.

Drane JF. Competency to give an informed consent. N Eng J Med 1984; 252(7):925-927

Rather than selecting a single standard of competency, the author suggests and describes a sliding scale that requires an increasingly more stringent standard as the consequences of the patient's decision embody more risk.

This pediatrician-ethicist assesses the problems of treatment refusal by parents and offers advice to physicians who must balance the child's best interest against the parents' right to make decisions for their children.


The authors use their concept of rationality to defend some situations when it may be ethically justified to over-ride the refusal of a seemingly competent patient when he or she makes a seriously irrational decision.


The author suggests that the traditional yes-or-no concept of competence be reconceived in terms of the conditions that are necessary for patients and physicians alike to be fully responsible for their decisions.

Miller R. The ethics of involuntary commitment to mental health treatment.


The author addresses the difficult question of treating the mentally impaired individual against his or her will.

McCullough LB, Chervenak FA. Management of ethical conflict and crisis in gynecologic and obstetric practice. Chapter 7 in, Ethics in Obstetrics and Gynecology (same authors); New York: Oxford University Press, 1994; pp 241-265

After discussing a framework for defining ethical issues in OBGYN and describing efforts at prevention of conflict in earlier chapters, the authors address the question of how the clinician should respond when fetal best interests suggest an intervention which the pregnant woman refuses.
Physician-Assisted Suicide

We, as Christian physicians and dentists, believe that human life is a gift from God and is sacred because it bears God's image. Human life has worth because Christ died to redeem it, and it has meaning because God has an eternal purpose for it.

We oppose active intervention with the intent to produce death for the relief of pain, suffering, or economic considerations, or for the convenience of patient, family, or society.

Proponents of physician-assisted suicide argue from the perspective of compassion and radical individual autonomy. There are persuasive counter arguments based on the traditional norms of the medical professions and the adverse consequences of such a public policy. Even more important than these secular arguments is the biblical view that the sovereignty of God places a limit on human autonomy.

In order to affirm the dignity of human life, we advocate the development and use of alternatives to relieve pain and suffering, provide human companionship, and give opportunity for spiritual support and counseling.

The Christian Medical & Dental Associations oppose physician-assisted suicide in any form.

Approved by the House of Delegates
Passed unanimously
May 1, 1992. St. Louis, Missouri.

Explanation

Physician-assisted suicide occurs when a physician helps a person take his or her own life by giving advice, writing a prescription for lethal medication, or assisting the individual with some device which allows the person to take his or her own life. The physician lends expertise, the person does the act.

Voluntary euthanasia occurs when another person, out of compassion, does an action with the intention of ending the life of a suffering patient at his or her request. Non-voluntary euthanasia is a similar compassionate act, but in circumstances where the patient is unable to make a voluntary request (e.g. an unconscious, retarded or demented adult; an infant or child). Involuntary euthanasia is a compassionate act to end the life of a patient who is perceived to be suffering and could make a voluntary request, but has not done so.

Distinction between active euthanasia and passive euthanasia is not helpful, and often confusing. It is clearer to limit the term euthanasia to situations in which one person acts to cause the death of another (which is what many people mean by active euthanasia). According to this understanding, acts of discontinuing treatment with the realization that patients will die of their disease do not constitute euthanasia. Thus using the term passive euthanasia to describe such acts is a misnomer. When discontinuation is done with the intention of ending the life of someone who is not already unavoidably in a dying process, it is morally objectionable for many of the same reasons that euthanasia is objectionable. But since discontinuation in other situations is morally acceptable, it is helpful not to refer to discontinuation under any circumstances as a form of euthanasia.

Secular Perspective

Societal changes of the 1960's - 1980's have led to a focus and emphasis on an individual's right to self-determination. While this includes some increased acceptance of suicide as a rational option for an individual who feels that life has become too burdensome, the act of suicide is still often viewed by others
as a tragic and lonely experience. This is especially true when the means of self-destruction involves violence (e.g. guns and other self-inflicted wounds, hanging, jumping from heights, etc.). Thus there has been a move to depersonalize suicide by involving others (assisted suicide) and to sanitize it by making it a medical procedure (physician-assisted suicide and euthanasia).

Proponents of legalization of euthanasia offer several reasons why society should allow physicians to be involved in these acts: some people have no loved one who can help them; some people are unwilling or unable to help their loved ones commit suicide; physicians know the prognosis so are better able to assess the appropriateness of a request; physicians have access to and know how to use lethal drugs; medical expertise can prevent botched up suicide attempts; physicians know how to obey standards; and, physicians can be more objective because they are not emotionally involved.

Legal Perspective

Euthanasia has been openly practiced by physicians in The Netherlands since 1984, and such acts were decriminalized in 1993, although legal and judicial oversight continues. The best estimates are that about 3% of all deaths in that country are induced by physicians. There is public debate about extending the availability of euthanasia to children and incompetent adults, and there is a professional inclination to change the system to physician-assisted suicide rather than direct physician involvement.

The Northern Territory of Australia legalized physician-assisted suicide and physician-administered euthanasia in 1995.

Attempts in several states in the U.S. to pass legislation allowing physician-assisted suicide and/or euthanasia failed by narrow margins in the late 1980's and early 1990's. In 1994, the state of Oregon passed a voter initiative to allow physician-assisted suicide with restrictions, but it has not gone into effect at the time of this writing because of legal challenges.

Case law (as opposed to statutory law) in the U.S. addressed the issue of physician-assisted suicide in early 1996. The 9th Circuit Court of Appeals in San Francisco and the 2nd Circuit Court of Appeals in New York declared unconstitutional state laws in Washington and New York (respectively) which prohibited physician-assisted suicide. Different legal arguments were used in the two cases. It is anticipated that these judicial rulings will be appealed to the U.S. Supreme Court.

Professional Perspective

Physician-assisted suicide and euthanasia were explicitly proscribed in the Hippocratic Oath. Although this was a minority opinion when introduced 2500 years ago, the Hippocratic ethic gradually became the dominant influence for practitioners of modern medicine and dentistry. Practitioners have adopted the role of healer with the goals of healing when possible, and relief of suffering. While there have doubtless been individual physicians and dentists over the centuries who have occasionally helped their patients to die, this activity has clearly remained outside the boundaries of acceptable medical treatment.

There is professional concern that acceptance of physician involvement in either direct or indirect induced death would seriously undermine the trust that is a necessary component of the physician-patient relationship. If euthanasia becomes accepted, a physician might be tempted to end a patient's life without a request, either out of compassion, or out of self-interest (e.g. when the care of a patient becomes too difficult or burdensome). In addition, there is concern that there might be less impetus to continue work on the significant gains made in good palliative care in the past 20 years.

Christian Perspective

What is fundamentally wrong with euthanasia from a biblical perspective is that it involves the killing of human beings who are necessarily made in the image of God (Genesis 9:6). Physician-assisted suicide is wrong for similar reasons, in that people kill human beings (themselves) with the assistance of others who thereby become accessories to killing. As discussed further in the Explanation of the Statement on Patient Refusal of Therapy, patient autonomy (or better: freedom) must be understood within the limits of God's sovereignty and does not include the right to dispose of that which is not one's own (you are not your own—I Cor. 6:19).

Christians are indeed called upon to be compassionate and to relieve suffering, but not at any expense. If happiness were what life is all about, then suffering would be the ultimate evil to be avoided at all costs.
The cross would represent the epitome of what is to be avoided. Its crushing load on Jesus back and the nails driven through his hands and feet graphically display the burden of the fallenness of the world that Jesus had to bear, in fact, chose to bear. Yet, those who follow Jesus are not called to avoid such suffering but to suffer this fallenness with him, to take up crosses of their own.

The basic question, then, is whether God or suffering is going to set the agenda of one’s life---and death. Christian physicians and their patients will not find God's way by trying to avoid all suffering at any cost. They will find it by remaining true to God’s biblically-revealed character and will, especially in the midst of suffering. The ultimate test of what is setting the agenda of our lives may well be how we deal with suffering in the face of death.

Such was the case for Jesus in the garden of Gethsemane. He was overwhelmed with sorrow to the point of death (Mark 14:34) and zealously prayed to be spared from the suffering that he knew would only get worse. Yet he affirmed that his primary commitment was to the larger purposes of God, whatever suffering they might entail. The absence of suffering is, generally speaking, something good---which is why Jesus prayed for it. But it is not the highest good---which is why he was willing to forgo it.

Yielding to the call of compassion to kill or assist in the killing of a patient is misguided for another reason as well. It is all too easy to underestimate the fallenness (self-centeredness) of human nature, particularly when the people in view seem to have the needs of others at heart. The statements of so-called mercy killers in the past have often been telling in this regard. I killed her because I could not bear to see her suffer generally means what it says---that first and foremost the action reflected the killer’s need to be free from his or her own discomfort. Barriers to killing patients or assisting them to kill themselves not only protect society in general and patients in particular but also protect physicians and surrogate decision-makers from their own weaknesses---from subtly self-centered decisions that may well haunt them for the rest of their lives. The CMDs statements on Physician-Assisted Suicide and Euthanasia are designed to uphold such protections while affirming more constructive expressions of compassion.

Abstracts


The 5 main reason for the growing public support of the legalization of physician-assisted suicide (PAS) are:
1. “The compelling force of heartrending individual cases”,
2. “The notion that the only substantial objections to legalizing assisted suicide or active voluntary euthanasia are based on religious grounds”
3. “Physicians are doing it anyway, so we might as well legalize it- and regulate it”
4. “There is no significant difference, the argument runs, between the termination of life support and active intervention to promote or to bring about death; in both instances the result is the same”
5. “If a right to physician-assisted suicide were established, we are assured it would only apply to the 'terminal ill’”

The author examines these reasons and discredits their authority in this debate. He concludes, “Today few people chuckle when PAS is classified as a medical procedure, or even when it is called a health care right, or even when we are told, at a time when tens of millions of Americans lack adequate health care and Congress has refused to do anything about it, that PAS is the one health care right that deserves constitutional status.”


After recounting the personal experiences of his family during the terminal illness of his father the author examines the title question. He writes, “the physician-assisted suicide movement is sweeping across the land…As in the years leading up to the Roe v. Wade decision, today the church and the medical profession are ill-prepared for the debate and in denial that physician-assisted suicide could happen here.” He then lists key points in this debate that physicians should be aware of so as to “take the lead in educating the church and the public on this issue.”

Death and dying issues are influenced by one’s world view. Hence, Christians must respond from within the theological environment. The author writes, “In the face of death and dying issues, we must hold together what humanity tends to pull apart: death as friend and foe, suffering as challenge to persevere and opportunity to overcome, and the dual affirmation of divine providence and human stewardship. These theological assertions do not solve every dilemma a physician or family of a dying patient faces. But they do provide a framework that can guide us to make wise decisions amidst the complexity and ambiguity we often face in death and dying issues. [On] the other hand they preserve us from playing God in biomedical ethics, but on the other hand they also prevent us from abdicating our responsibilities as human stewards made in the very image of an all-powerful God.”


Author Droge, in his book A Noble Death, concludes that it is possible Paul committed suicide or at the very least condoned it based on a passage in Philippians. The author takes another look at the Biblical passage and refutes Droge’s claims. He concludes, “In Philippians 1:19-26, Paul acknowledges that death can look very attractive. The desire to die can be strong. But Christians should turn aside from that temptation, as he did, and find ways to love others and glorify God.”


The author begins with a personal story about a cancer patient who had unsuccessfully tried to commit suicide and details the family’s reaction while the patient was in critical care and after the patient had recovered from his attempt. Highlighting the different changes in attitude, the author writes that neither the individual, the family, the doctor or society is capable of coherently deciding about physician-assisted suicide. He concludes, “There is not one this side of heaven who has the ability to make the correct decision regarding when our life should be extinguished. Until we find such a one, in this question of physician assisted suicide, as in other policy decisions, society should err on the side of the precious nature of human life rather than that of personal choice.”


This article discusses the role of psychiatrists in physician assisted suicide and the questions of when a psychiatrist should evaluate a patient who has made such a request and if assisted suicide is “ever justified for patients whose intractable suffering is caused by a mental disorder, not a terminal illness.” The authors point out several limitations in psychiatric evaluations - only a small percentage are confident that within one session one can ascertain whether mental illness is determining the request for assisted suicide, the label competent or incompetent is not as easy as such because there is no established threshold for determining “whether a person is competent to choose suicide”, and bias of the particular psychiatrist (ones who do not believe in physician assisted suicide will likely not evaluate patients). The authors conclude that “our present knowledge base is inadequate for assessing the efficacy of psychiatric interventions when patients request physician-assisted suicide…. Psychiatrists rarely work with medically ill or dying patients. Their expertise and comfort in this role must be improved if such consultation is to be effective.”


This national survey gathered data about physician-assisted suicide and euthanasia by mailing questionnaires to 3102 physicians in the 10 specialties “in which doctors are most likely to receive requests from patients for assistance with suicide or euthanasia.” The authors conclude, “A substantial proportion of physicians in the United States in the specialties surveyed report that they receive requests for physician-assisted suicide and euthanasia, and about 6 percent have complied with such requests at least once.”

Sulmasy DP, et al Physician resource use and willingness to participate in assisted suicide. _Archives of Internal Medicine_ 1998;158:974-78.

This article focuses on the “relationship between general internists’ tendency to conserve medical resources and their willingness to participate in physician-assisted suicide (PAS).” The authors assessed
the relationship by coupling the evaluation of conservation of medical resources of physicians with a
scenario of a terminally ill patient requesting PAS. The authors conclude, “While the characteristics of
their practices do not affect PAS, physicians who tend to practice resource-conserving medicine are
significantly more likely than their resource-intensive counterparts to provide a lethal prescription at the
request of a terminally ill patient.”

Kaplan KJ, Schwartz MB. Watching over patient life and death: Kevorkian, Hippocrates and

Jack Kevorkian has accelerated the right to die debate with his widely publicized assisted suicides. This
article explores his philosophic base from Greek philosophy, culture and medicine and contrasts it with a
biblical view from 12th century Jewish physician, Moses Maimonides. The authors conclude, “Our
contemporary culture is obsessed over the terminality of a patient because it is afraid to face the fact that
as mortals, we are all terminal. We are obsessed with control because we sense that we really have very
little control over the most important things in our lives. ‘Helping a patient die’ is not the same as ‘helping
a patient commit suicide.’ Rather, it is to help the patient through the dying process when his time to leave
this world has come. Is not Kevlorkain as phobic about death as the medical establishment he opposes?
Shall the physician’s role be to bring death or to apply as best he can the many methods, physician and
psychological, of relieving pain and bringing the patient comfort? As Maimonides acknowledges, the
physician can help bring a patient into the world. He need not abandon the patient when he leaves the
world, instead aiding him in the dying process with a similar application of technical skill and compassion.”

Orr RD, Bishop L. Why psychiatrists should not participate in euthanasia and physician-assisted

“Public and professional discussions have recently raised the question of whether the longstanding
proscription against physician-assisted suicide for terminally ill patients should be eliminated or changed.
In this article, we review the history of the centuries-long debate, and repeat the arguments stated for and
against such a change. We present our opposition to such a change based on the adverse consequences
which would occur in the patient-doctor relationship, and the very likely extension of the practice from only
terminally ill patients to some who are suffering but not dying, including patients with intractable mental
suffering. We review the 10-year social experiment with public toleration of euthanasia in the Netherlands,
and note its considerable expansion beyond the clear guidelines. We then discuss why we believe
psychiatrists should continue to oppose the legalization of physician-assisted suited. In addition to our
concern about the extension to assisted suicide for mental suffering, we point out the adverse affect such
changes would have on both the psychiatrist’s and the patient’s perception of the role of the therapist in
other suicide situations, and the difficulty of uncovering a competent patient’s motivation for a request for
such assistance.”

Engelhardt HT. Physician assisted suicide reconsidered: Dying as a Christian in a post-Christian

“The traditional Christian focus concerning dying is on repentance, not dignity. The goal of a traditional
Christian death is not a pleasing, final chapter to life, but union with God: holiness. The pursuit of holiness
requires putting on Christ and accepting His cross. In contrast, post-traditional Christian and secular
concerns with self-determination, control, dignity, and self-esteem make physician assisted suicide and
voluntary active euthanasia plausible moral choices. Such is not the case with in the context of the
traditional Christian experience of God, which throughout its 2000 years has sternly condemned suicide
and assisted suicide. The wrongness of such actions cannot adequately be appreciated outside the
experience of that Christian life. Traditional Christian appreciations of death involve an epistemology and
metaphysics of values in discordance with those of secular morality. This difference in the appreciation of
the meaning of dying and death, as well as in the appreciation of the moral significance of suicide,
discloses a new battle in the culture wars separating traditional Christian morality from that of the
surrounding society.”


“Aquinas’s conception of the relationship of faith and reason calls into question the arguments and some
of the conclusions advanced in contributions to the debate on physician assisted suicide by David
Thomasma and H. Tristram Engelhardt. An understanding of the nature of theology as based on
revelation calls into question Thomasma’s theological argument in favor of physician assisted suicide
based on examples of Christ and the martyrs. On the other hand, unaided reason calls into question his
assumptions about the nature of death as in some cases a good for the human person. Finally, if Aquinas is right about the relationship of faith and reason, Engelhardt’s sharp contrast between ‘Christian’ and ‘secular’ approaches to physician assisted suicide needs reconsideration, although his conclusions about physician assisted suicide would find support.”


“Roman Catholicism has long opposed suicide. Although Scripture neither condones nor condemns suicide explicitly, cases in the Bible that are purported to be suicides fall into several different categories, and the Roman Catholic tradition can show why some of these should be considered morally wrong and some should not. While Christian martyrdom is praised, it is not correct to argue that this Christian outlook invites suicide, or that it recommends physician assisted suicide for altruistic motives. Church tradition, from its earliest days, has clearly distinguished martyrdom from suicide. The principles of double effect and cooperation, mainstays in Roman Catholic moral theology, enable one to see the moral difference between martyrdom and suicide, and to appreciate why physician assisted suicide is wrong for both patient and physician.”


When and how do inexplicably immoral acts become not only ethically correct but even noble? In this article, the author traces the path to justification of medicalized murder in Germany during Hitler’s reign and compares this to the current physician-assisted suicide movement. He comments, “The language we use to describe moral medicine is not merely a matter of etiquette; it is revelatory of the way we understand the practice of medicine.” When we look at today’s ethical environment, the author writes, “the spectre of euphemistic language applied to assisted homicide is upon us again….By sheer redefinition, lawmakers think they can take the sting out of a practice we would otherwise find unconscionable.” He concludes with a noble call to those committed to Christian and Hippocratic medicine. “We must be willing to verbalize the truth that assisted death is a form of homicide and that those who practise it are guilty of murder or are accomplices to murder. [If] we are unwilling to be forthright and honest about what is happening, we ourselves may become accomplices.”


When the cases State of Washington v. Glucksberg and Vacco v. Quill came up to the Supreme Court to be decided, six philosophers (John Rawls, T. M. Scanlon, Robert Nozick, Thomas Nagel, Judith Jarvis Thomson and Ronald Dworkin) wrote an amicus curiae brief urging the court to affirm that “patients have a constitutionally protected right to secure the help of willing physicians in terminating their own lives.” In this article, the author argues against the points put forth in “the Philosophers’ Brief”.


In this article, the author explains Aquinas’ rule of double effect and differentiates between the intent to do harm versus the undesirable effect of doing good, though the end result of both is the same. “Morality”, he writes, “is not just about consequences …intention is important in medical and nursing ethics because it can not only determine whether an act is right or wrong, but it can define the very nature of the act itself.” As for the legal aspect of the double effect, “while foresight can be evidence of intention, it is never the same as intention.” The author concludes, “[The principle of double effect] informs and guides good palliative care and distinguishes it from ‘euthanasia’- intentional killing of patients. The principle remains an essential aspect of sensible medical ethics, good palliative practice and sound criminal law.”


“The debate about the morality of active versus passive euthanasia is confused in the American context because of definitional problems. In order to create an atmosphere for meaningful debate, redefinition is necessary. Furthermore, one of the chief proponents of removing the distinction between active and passive euthanasia has been James Rachels. Rachels fails to account for moral intuitions in making decisions about the morality of euthanasia. Part 1 of this article argues that Rachel’s thesis is deficient and that both intention and situation are two moral notions on which the debate about euthanasia ought to focus. The debate over the morality and legality of active euthanasia commands new prominence in American society. With the US Supreme Court ruling that the legality of physician-assisted suicide should
be decided by each state, special interest groups are fervently attempting either to pass or block the legalization of active euthanasia. Despite the Court’s ruling, the debate seems as murky and confusing as ever. There are, therefore, very good reasons to look for a new way to examine the issues surrounding euthanasia.”


“In part one of this article, I argued that the ‘active / passive’ terminology and categorization confuses rather than helps the euthanasia debate. In part two, I argue that ‘situation’ and ‘intention’ are necessarily required in any euthanasia discussion and I offer a new categorical structure that incorporates more fully than has traditionally been the case.”


A Catholic theologian analyzes the drift toward acceptance of physician assisted suicide. He believes there at least five converging cultural trends which will regrettably cause society to accept this concept in the foreseeable future: (1) the absolutization of autonomy without considering whether choices are good or bad, and the consequent intolerance of dependence on others, (2) the secularization of medicine which has divorced the profession from its moral tradition and made it into a business, (3) the inadequate management of pain, (4) the nutrition-hydration debate and the distinction between killing and letting die, and (5) the financial pressures of health care. He states [a]ssisted suicide is a flight from compassion, not an expression of it. It should be suspect not because it is too hard, but because it is too easy.


A psychiatrist laments that the debate on physician-assisted suicide has focused on establishing safeguards instead of on the unique opportunities and responsibilities inherent in the role of physician as healer. He believes that rather than assisting in their suicides, physicians should address the needs that prompt patients to request it. In addition to relieving their physical causes of suffering, they can help patients to establish realistic hopes by expanding their possibilities, bear suffering by assuring them that their suffering is understood, and by remaining with them and achieving perspective by reviewing the meaning of their lives. He states that these compelling responsibilities are rooted in the medical traditions of beneficence, virtue, and sharing of power. Physicians inability to meet all of their patients’ needs does not detract from the importance of the psychological, personal, and pastoral aspects of their role.

Miles SH. Physicians and their patients suicides. *JAMA* 1994;271(22):1786-1788

A geriatrician/ethicist offers a profound and personal insight into the effect on the physician’s psyche when a patient commits suicide. He concludes that the societal taboo against physician-assisted suicide is constructive because it may prevent suicides which are improperly based on the physician’s own fear of dying and it enable and point to the necessity of an honest, painful intimacy to better understand and treat suffering patients.

Bernardi, Peter J. "Dr. Death s Dreadful Sermon." *Christianity Today* August 15, 1994; 38:30-32

The author maintains that the campaign to legalize physician-assisted suicide is gaining momentum due both to the depiction of such an act as a right and to current societal conditions. He points out that the right not to have to suffer has its roots in the right to choose and the right to privacy which were extolled in the Roe v. Wade case that legalized abortion. Such a case in effect set the stage for the potential legalization of physician-assisted suicide. Further, society’s increasing ascription to the belief that people have a right not to suffer (because suffering has only negative consequences) and that they have a right to choose, or control their own destiny (even in dying), has resulted in mounting support for physician-assisted suicide. The widespread violence, increasing fragmentation of family, and overall lack of respect for human life which characterize our society also contribute to a climate in which physician-assisted suicide may flourish.

In this discussion of physician-assisted suicide, the author considers the case of Dr. Timothy Quill, who assisted in the suicide of his patient Diane. This patient was diagnosed with leukemia and did not wish to undergo treatment estimated to give her a 25% chance of survival. In his analysis of the case, the author points out that although physician-assisted suicide is often portrayed solely as an act which bestows absolute autonomy on those who wish to die, the conditions and objectives of the physicians involved and of the medical profession as a whole also enter into such decisions to end life. Thus, physician-assisted suicide is most often not completely voluntary and may become, as in The Netherlands, increasingly involuntary.

**Kass, Leon R. "Suicide Made Easy." Commentary 12/91; 92(6):19-24**

In examining the increasing societal trend to favorably regard assisted suicide as a rational, humane, and courageous act, the author contends that the inherent evil of such an act is thereby dangerously disguised. Because assisted suicide is not depicted as overtly evil but is instead characterized as an act which serves humanity by delivering people from their suffering, its power to garner support is especially sinister. In a similar vein, Derek Humphrey, a prominent advocate of assisted suicide and the author of Final Exit (a handbook on how to end one's life), also masquerades as one who, apart from being evil, is exceedingly compassionate. Humphrey is here criticized for failing to honor the professional ethics of medicine which forbids physicians to assist in bringing about the death of their patients. While acknowledging that issues at the end of life are becoming increasingly problematic due to increases in technology, etc., the author nevertheless asserts that the professional ethics of medicine includes an absolute proscription against physician assistance in dying.


Instead of invoking considerations of biblical dictates or current trends in society as factors in the debate over assisted suicide, the author illuminates the issues involved in such a debate via the real life story of a family confronted with making a decision for or against such an act. In doing so, he illustrates how factors such as lack of sufficient health insurance, ineffective pain management, intolerable suffering, and the fear of loss of control can result in the regarding of physician-assisted suicide as a very favorable option. Gospel accounts of Jesus life in which he endured suffering in order to maintain allegiance to God are used as basis for the absolute proscription of physician-assisted suicide.


While asserting that philosophical arguments may be employed to refute the bases for justifying euthanasia and assisted suicide, the author believes that such arguments constitute primarily a negative or defensive response to the case for assisted dying. He points out that both those who favor and those who oppose euthanasia and assisted suicide often cite the same bases for their disparate commitments. That is, both Christians and proponents of assisted dying intend to act in the name of compassion and human freedom and dignity. Because the Christian understanding of these concepts differs markedly from that which is used to support assistance in dying, Christians must introduce the theological meaning and implications of such concepts into the present debate.


After discussing the history of suicide, eugenics and euthanasia, the author outlines the pro and con arguments of the modern physician-assisted suicide/euthanasia debate. He then gives a more detailed history of the Netherlands experience of the last 15 years including data from the 1990 Remmelink Report. He draws a clear distinction between decisions to forgo treatment and physician-assisted death, showing differences of intention, attitude, means, and agency. He concludes that hospice care, the compassionate care of dying patients and their families, is the morally required alternative to physician-assisted death.


The author, a psychiatrist, uses two case descriptions from TV and the popular press to demonstrate that patients may be encouraged or even coerced into a suicidal decision or action. He maintains that the
empowerment which is supposedly directed to the vulnerable patient is really being given to that person's relatives and physician.


In commenting on two recent federal Courts of Appeals decisions, the author, professor of religion at Hope College, points out that the judges are trying to maximize freedom and personal autonomy. However, choosing this path then requires the weak and the sick to justify their continued existence. He acknowledges that Scripture presents life and its flourishing as goods, but not the ultimate good. Thus we need not cling desperately to life; other goods may be more weighty. At the same time, however, we may not kill. Christians must not choose death or intend death by their actions.

Bibliography


This book contains essays from prominent authors such as Daniel Callahan, Edmund Pellegrino and Allen Verhey.


The author argues from different angles against physician assisted suicide.

Pornography is any medium that depicts erotic behavior and is intended to entice sexual imagination. Pornography has no beneficial use but damages human relationships. Mass communication technologies such as the Internet have expanded its reach to an unprecedented degree. Video and virtual reality have intensified its content. The introduction of sex robots that imitate human speech and sexual behaviors and are designed to perform sexual acts with humans are an extreme elaboration of pornography. All of these have dangerous psychological, social, and spiritual consequences.

As of 2016, in the United States, 93% of male and 62% of female university students had viewed internet pornography during adolescence, with 49% of males viewing pornography before age 13.1 64% of young people, ages 13-24 actively pursue viewing pornography weekly or more frequently.1 A study in 2012 showed 93% of boys and 52% of girls aged 16 to 19 had watched a pornographic movie in the 6 months prior to survey.2,3 The world’s most popular pornography website averages 92 million daily visits and ranks #8 among all websites in the world, outranking Wikipedia, Amazon, or Netflix.4,5 One in four internet users view pornography in any given month.1 Pornography is the most common online topic for men, more than any other subject.1 Sexually explicit dialog, dress and actions are increasingly common in regular television programming, even during the purportedly family friendly hours, and the so called “soft” porn or “mommy” porn publishing industry is increasing.

Pornography is also a substantial problem for practicing Christians and clergy in the United States. Among practicing Christians, 2% seek out pornography daily, 5% weekly and 6% once or twice a month. 21% of youth pastors and 14% of senior pastors admitted to using pornography regularly. Among the users of pornography, 56% of the youth pastors and 33% of the senior pastors stated they were addicted.6

In evaluating pornography and counseling those affected by it, the following areas should be considered:

1. Biblical
   A. Scripture is unequivocal about the necessity for human beings to remain sexually pure, and that sexual activity is to be restricted to monogamous marriage between one man and one woman (Ex 20:14; Ex 22:16-17; Deut 22:13-30; 1 Cor 6:9, 13b-20; Gal 5:19; Eph 5:3-5; 1 Thes 4:3-5; Heb 13:4).
   B. God has reserved the most intimate expressions of sexuality, including sexual intercourse, specifically for the marriage relationship. The Bible describes the covenantal relationship of love which God has for His people; the husband-wife relationship reflects the relationship between Christ and the Church and as such is holy. (Song of Songs; Prov 5:15-19; Eph 5:25-31).
   C. Scripture also makes it clear that defiling the mind and heart with lust is sinful and the moral and spiritual equivalent of adultery, and may lead to committing adultery (Ex 20:17; 2 Sam 11:2-5; Ps 66:18; Ezek 23:5-10; Matt 5:28; Rom 1:24-28; Col 3:5; 1 Pet 2:11).
   D. God sees sin that is done in secret (Ezek 8:7-13; Matt 10:26; 1 Tim 5:24).
   E. Christians have a duty to warn when society is faced with moral danger (Ezek 33:1-6).
   F. God through Jesus Christ offers forgiveness, no matter how shameful the sin (Hos 3:1, 1 John 1:9).
2. The Human Cost

Pornography is extremely harmful, and this harm is done at multiple intertwined levels: biological, psychological, medical, social, and spiritual.

A. Pornography is harmful to individual users; it:
   1. Trains them to think that sexual gratification is obtained with images or objects that exist for the user’s pleasure, rather than with an ensouled, thinking and feeling person who bears the image of God.⁷,⁸
   2. Promotes the myth that the purpose of sex is primarily to take rather than give pleasure.⁷
   3. Is not a morally neutral substitute for fornication or adultery. There is no honor or virtue in having sex with a thing.⁹
   4. Defiles their bodies and souls with lust for something illusory and unreal and, in the case of sex robots, further defiles their bodies and souls by physical coupling with an interactive artificial humanoid device.¹⁰
   5. Supports the sexual revolution’s lie that sexuality is all about orgasm and personal gratification.⁸
   6. Is addictive. Like a potent drug, pornography releases dopamine in the brain, providing a transitory escape from stress, disappointment, boredom, and facing one’s responsibilities, while over the long term placing the user who desires more and more pornography at risk of becoming socially crippled and emotionally stunted.⁷,¹¹-¹⁴
   7. May lead to employment termination in the case of workplace viewing.¹⁵
   8. Contributes to loneliness.⁸
   9. May encourage a variety of sexually deviant behaviors.¹⁶-¹⁸
   10. Leads to estrangement from God.¹²

B. Pornography is harmful to marriages; it:
   1. Leads to decline in sexual satisfaction within marital relationships.¹²,²⁰
   2. Leads to destruction of loving relationships.²⁰,²¹
   3. Further separates the goods of love and the potential for generation of life from love and mutual giving.²⁰,²²
   4. Encourages a “throw-away” culture of disposable relationships, leading to more single-parent, divorced, and fractured families.¹⁹,²⁰,²³
   5. Diverts finances from legitimate family needs to narcissistic sexual gratification.²⁴
   6. Denies the legitimacy of sexuality and family as defined by God.¹⁹

C. Pornography is harmful to children:
   1. It diverts parental affection to images or objects.⁸,¹⁹
   2. It subverts the modeling of genuine love.⁸,¹⁹
   3. It fuels the sexual perversion of pedophilia (in the case of child pornography), increasing the risk that children may become victims of molestation.¹⁸,²⁵,²⁶ This risks distorting the child’s understanding of God the Father.
   4. When sex robots are designed to resemble children, it normalizes sexual gratification with the immature and places children at further risk.²⁷

D. Pornography is harmful to those used in the creation of pornography; it:
   1. Reduces them to nameless instruments of unseen strangers who, to gratify their own urges, leer at their nakedness, exploit their vulnerability, and abuse their dignity as people bearing God’s image.
2. Forces sex trafficking victims to engage in unsafe sexual practices of every imaginable form.28
3. Fuels the appetite for and profitability of sex trafficking. Children and many women depicted in pornography frequently have been trafficked into forced prostitution25 (see CMDA statement on Human Trafficking).
4. Spreads sexually transmitted diseases, some of which are potentially deadly, and not all of which are preventable by barrier methods.29,30
5. Suppresses their sense of personal identity and self-worth as they endure the message that their value is nothing more than their bodily appearance.7,8,31
6. Severely shortens the lifespan of those trafficked due to malnutrition, infections, violence, limited access to medical care, and forced drug use (see CMDA statement on Human Trafficking).32,33

E. Pornography is harmful to society; it:
1. Furthers the pernicious tendency in our society of commodifying and denigrating others, particularly women and children.7,26
2. Incentivizes withdrawal from authentic human relationship and community, which contributes to emotional and relational disability.20,23
3. Is toxic to marriages, contributing to the destruction of stable families.9,20,23
4. Decreases tolerance and acceptance of others.19,20
5. Corrupts and debases the ideal of beauty, which is reduced to only that which is sexual.8,10,20,33
6. Generates inhuman expectations for others, who may feel that they must imitate pornography to be attractive and, through immodest dress or augmentative surgery, become hypersexualized to be loved.31,34
7. Perpetuates or worsens misogyny.22
8. May increase the incidence of rape as it teaches individuals that they are entitled to have their sexual gratification anytime they want it.22
9. Disseminates exposure to all sorts of sexual deviancies, such as sexting, hookup apps, virtual impersonation, sexual violence, bestiality, and “deepfake” pornographic video manipulations intended to humiliate, manipulate and ruin the reputations of other people.22,25
10. Confuses lust with genuine love, leading to a society that no longer seeks truth and the good, sacrifices for others, or retains its will to survive.
11. Signifies the seeking after a vacuous substitute for being in relationship with God.7
12. Contributes to cyber-crime, malware and malicious Internet activity.24,26

3. Medical Considerations
Use of pornography has been claimed to have potential beneficial effects, such as diffusing sexual aggression. These claims are, or potentially are, without merit as follows:

A. Pornography, including interactive sexual images and devices, has no therapeutic value. Patients who have difficulty interacting with other people would not be trained to deal with real people in a healthy way by interacting with artificial and controllable sex robots.35

B. Interactive sexual technologies do not have potential to treat pedophilia or rehabilitate sex offenders. Retrospective studies have strongly correlated pornography with increased incidence of rape, prostitution, normalization of sexual deviancy, and addiction to sexual activity.35,36
C. If the use of interactive sexual devices leads to increased desire for “real” sexual activity, the individual may become inclined to engage in risky behavior.\textsuperscript{35,36}
D. Sex robots will likely not promote safer sex. If used in a brothel the potential for sexually transmitted infection between serial users may persist.\textsuperscript{35}

4. Responding to Pornography
   A. Christians should promote the beauty and benefits of sexual purity.
   B. Christians should acknowledge the pervasive and addictive nature of pornography and recognize that its root is ultimately spiritual.
   C. Christians who are involved with pornography should confess their sins and demonstrate repentance, and this necessitates a plan of action and accountability to prevent recurrence.
   D. Christians should have early and ongoing discussions with their children about the dangers of pornography and consider using filtering technologies to decrease the risk of accidental exposure to Internet pornography.
   E. Christian healthcare professionals, because of their duty to respect and protect the dignity of every patient as a bearer of God’s image, have an even higher obligation to abstain from sexual impurity, including pornography.
   F. Internet search engines, advertisers, and other custodians of information technology should be required to filter pornographic content so that it is not presented to users who do not request it. At a minimum, the default policy should be filtering of pornographic content.
   G. Christians should become aware of the content used in sex education curricula and oppose the use and promotion of sexually explicit material in schools at all levels.
   H. Christians should testify that God is just, merciful, loving, and faithful, and that He will, if we ask Him and repent, forgive sexual sins and bring us into a relationship with Him that is far more fulfilling and intimate than the fleeting and false pleasures of pornography. God rejoices when sinners repent (Luke 15:7; John 3:16-17; Jer 2:13).
   I. Christians are obligated to welcome with compassion those who are caught up in pornography, which is not to condone the use of pornography (Gal 6:1).
   J. Christians should pray for those trapped in this perverse industry: the performers, the users, the victims, and the perpetrators, that they would be released from bondage, and that the industry would fail.

5. Conclusion
   A. CMDA affirms, with gratitude to God, the beauty of our nature as sexual beings.
   B. CMDA acknowledges that while God creates us as sexual beings, our created human nature and flourishing are far more than sexual.
   C. CMDA rejects the notion of pornography as a harmless or victimless activity.
   D. CMDA condemns the creation, distribution and use of pornography, including extreme forms of pornography such as sex robots. Pornography is an imminent threat to public health, a clear and present danger to all people and to their relationships with others and with God.
   E. CMDA affirms that Jesus Christ, with open arms, offers the possibility of repentance, spiritual renewal, healing, and hope for all who are afflicted by pornography (1 John 1:9).

References

Additional Sources and Position Papers

Helpful Websites

• Conquer Series  
  [https://conquerseries.com](https://conquerseries.com)

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*Unanimously approved by the House of Representatives  
April 21, 2020  
Bristol, Tennessee (and virtual locations)*
Principles of Christian Excellence in Medical & Dental Practice

As Christian care-givers in the dental and medical professions, we commit ourselves to the following principles:

• We will do no harm to our patients by acts of either omission or commission.
• We are dedicated to the prevention and relief of human pain and suffering.
• We hold all human life to be sacred as created in God's image.
• We respect the confidentiality of all communications exchanged with our patients.
• We affirm the standard of honesty in all circumstances.
• We believe that our patients have the right to be carefully taught about all aspects of their disease and treatment so that they may give consent that is properly informed.
• We pursue excellence in dentistry and medicine through advancement of research and education.

Because we follow the example of our Lord and Savior Jesus Christ who came to earth "not to be ministered unto, but to minister and to give His life," we are dedicated to the service of all persons regardless of the state of their economic resources or the nature of their illness. In circumstances where their care is beyond our own resources, we will intervene on their behalf as advocates of adequate care.

We desire to maintain a quality of relationship with our patients which will bespeak our availability for counsel as well as care.

Approved by the House of Delegates
Passed unanimously

Explanation

Medicine is necessarily a moral enterprise. Practicing medicine involves making decisions, and many of those decisions must be made between good and bad; between right and wrong. It thus seems intuitive that a clinician's moral understanding and ultimate world view will influence how he or she makes those decisions.

Some maintain that the profession of medicine has its own internal morality which can provide guidance to clinicians as we wrestle with these moral questions. Such an internal morality, they claim, can be found in historical oaths and codes, and in the teachings of one generation of clinicians to the next. Others maintain that the morality of medicine is external to the profession; i.e., the medical profession is amoral, and each clinician brings to the practice his or her own morality. The idea here, in effect, is that medicine is more of a technique than a profession per se. Still others maintain that the profession of medicine used
to be more monolithic in its foundational beliefs, but modern pluralism has made those foundations obsolete so that individual clinicians must now grapple with moral issues without professional assistance.

Many Christians believe that medicine does, in fact, have an internal morality. Historically, however, it is clear that such an ethical foundation of modern medicine arose within the polytheistic culture and belief system of ancient Greece, and was probably first articulated in the Hippocratic Oath (c 500 BC). At its inception, this Hippocratic ethos of medicine was a minority perspective. It was a call to reform a profession that had up to that point no firm moral base. The Hippocratic ethic clearly affirmed several enduring principles such as using appropriate means to benefit the sick, limiting the means and ends of medicine to exclude killing patients, protection of the vulnerable patient (confidentiality, proscription of sexual impropriety), etc. But perhaps the most important aspect of that ethic is the concept that the clinician is responsible both to a divine power and to the patient. The practice of medicine involves a vertical (transcendent) as well as a horizontal relationship. This Hippocratic ethic gradually became the dominant ethic of the practice of medicine because its because it precepts are essentially consistent with the Christian ethic.

Members of the Christian Medical and Dental Society believe being a Christian should have a profound influence on how we approach the practice of medicine, how we view the individual patient, and how we make decisions. Whether that morality is internal to the profession of medicine and just happens to be consistent with the teachings of Jesus, or whether it comes purely from within the individual, it is vitally important to recognize the inherent moral dimension of the practice of medicine and to articulate the necessary guiding principles. It was with this concept in mind that the Ethics Commission proposed the statement on Principles of Christian Excellence in Dental and Medical Practice in 1990 which was subsequently passed by the House of Delegates in 1991.

**Bibliography**


Christian physicians are called to a ministry in medicine which integrates the roles of competent scientist and authentic Christian healer. They must guard against the increasing tendency to dichotomize the spheres of medicine and Christian faith. In doing so, they must take caution against both esteeming too highly the achievements of medicine over against the role of faith and against demoting the role of medicine to the level of suspicion or mistrust. Christian physicians must seek to actively harmonize their faith and their medicine; for them, the two must remain inextricably linked.


Physicians are fundamentally servants of God as they bring about healing and wholeness, protect the weak, and regard death as being within the context of the Resurrection of Jesus Christ. Healing and the restoration of wholeness in patients are manifestations of God’s great mercy and love which he freely extends to fallen humanity. Further, in providing their services indiscriminately, physicians model the compassion exemplified by Christ and obey his commands to care for even the least of these (Matt. 25:40). Finally, by interpreting death from the perspective of Christ’s resurrection, physicians may provide hope to their suffering patients as well as sustain their own.


The editor of this CMDS publication begins the book by contrasting secular and Christian world views and their logically deduced principles. He then applies these two perspectives to scientific discoveries, medical ethics and public policy.


Christian physicians must commit themselves to resisting the temptation to idolize the practice and power of medicine. They must recognize the pervasive idolatry of life and health as absolute goods and seek, instead, to both understand and convey a theological understanding of life, health, and death. They must proclaim God, and a trust in Him, to be the absolute good—one which transforms the way in which we
view life, health, and death. Thus, it is essential that Christian physicians commitment to Christ permeate their practice of medicine.


The authors, both Roman Catholics, have written a series of books in a project of developing a coherent moral philosophy of medicine. Earlier works include: A Philosophical Basis of Medical Practice, For the Patient's Good, and The Virtues in Medical Practice. In the current work, the authors examine virtue-based ethics and propose a theological view of medical ethics which helps the Christian physician reconcile faith, reason, and professional duty. They attempt to balance theological ethics, based on the virtues of faith, hope, and charity, with contemporary medical ethics, based on the principles of beneficence, justice, and autonomy. The result is a clinical ethic which centers on the virtue of charity and is manifest in practical moral decisions.
Professionalism

Medical professionals avow publicly that they are competent and willing to care for the sick and that they will make this endeavor their way of life. All independent healthcare professionals (henceforth referred to inclusively as "doctors," and with appreciation that the ethos of professionalism extends to the entire healthcare team) affirm a commitment to moral goodness and to subordinating their self-interest to the patient's good. Professionalism in healthcare consists of inseparable technical and ethical aspects. For the Christian there is also a third imperative, which reinforces and enriches the meaning of the first two.

The Technical Aspect

The medical professional diagnoses health and sickness objectively, according to scientific criteria based, to the extent possible, on rational analysis of empirical data and provides care that is supported by valid and reliable evidence. The application of knowledge, experience, and clinical judgment to an individual patient is the discretionary skill or art of medicine.

Gaining competence in the science and art of medicine requires years of intensive, systematic, and intellectually rigorous study under the personal mentorship of experienced physicians or dentists in a broad range of specialties. Following entry into medical or dental practice, the pursuit of scholarly learning continues throughout the professional's lifetime as the doctor seeks continually to acquire new knowledge and improve upon the skills of application with ever-advancing technical competence.

The credentialed doctor serves under the aegis of a medical or dental community that trains and provides support throughout his or her professional career. This community gives medicine and dentistry their exclusive practice privileges and fiduciary identities in society by establishing binding standards of care and by maintaining vigilant self-assessment and self-correction. The subsidiary goals of medicine and dentistry include serving society through education and scientific knowledge advancement, and providing a living for their practitioners.

The Ethical Aspect

The doctor's decisions should arise from virtuous character in conformity with prudence in the principles of beneficence, non-maleficence, respect for persons, and justice. Medical and dental practice requires a life of discipline, integrity, self-giving, and self-effacement. Excellent care must always be given, even if there is personal cost or physical danger.

The doctor has the moral responsibility to respect the worth and dignity of patients, who at all times are his or her equals as persons. Moral equality mandates mutual respect; there must be trust and integrity of communication combined with cooperation in giving and receiving care. In medical practice, interventions and recommendations are chosen to accommodate the patient’s perspective, as health is integrally related to the patient’s life goals, needs, and personal values. All medical and dental care must respect the patient’s personal needs and preferences without compromising sound medical judgment or violating the doctor's conscience (see statements on Healthcare Right of Conscience and Patient Refusal of Therapy).

The doctor cares for the individual patient from a position of expertise that must always be exercised for the patient’s good. The primary goals of the doctor are to preserve and restore health, to comfort or relieve suffering, and always to care.
The doctor must be vigilant to avoid harm, whether that be adverse outcomes or the use of immoral means to desired ends. In diagnosing, counseling, prescribing, performing procedures, communicating, documenting, managing resources, and in all other matters, the doctor should act with caution and forethought, protecting the patient's health, safety and confidentiality.

The doctor should treat patients without favoritism or discrimination and endeavor to make healthcare available to the poor. The doctor has a stewardship responsibility to foster affordability and availability of care by applying medical or dental resources prudently (see statements on Healthcare Delivery and Allocating Resources).

The doctor should communicate respectfully with colleagues and team members, acknowledging the contributions of all.

The doctor's attitude must not be limited to the reductionist tendencies of science or economics but should strive for ever-increasing moral discernment and knowledge of life's higher meanings and obligations.

**The Christian Aspect**
In addition to the previous two aspects, which apply to all healthcare professionals, the Christian physician or dentist recognizes a third and transcendent aspect. The Christian doctor knows that the patient's dignity derives from having been created in the image of God. The Christian doctor appreciates and encourages a deeper meaning of health and illness in the context of the special value and eternal destiny of human life. Sickness and facing the inevitability of death may be used by God as avenues toward greater meaning and purpose in life. The Christian doctor knows that true wholeness consists not only of physical health and emotional well-being but ultimately in being in a right relationship with God through faith in Jesus Christ.

The Christian doctor learns this spiritual perspective on reality through an intimate and personal relationship with Jesus Christ, the study of God's self-revelation in the Scriptures and creation, fellowship within a Christian community, and prayerful reflection.

The Christian doctor knows that he or she is accountable to God for the care provided fellow human beings. The Christian doctor also recognizes that, despite one's best efforts and intentions, medical and dental care is sometimes imperfect or inadequate. Faith in Christ provides the doctor with humility, encouragement, and the inspiration to improve and persevere (see statement on A Christian Response to Adverse Outcomes Arising from Medical Error).

The Christian called to the practice of medicine or dentistry is given a ministry: humble service of others in a spirit of self-sacrificial love for all, including the neediest and the lowliest. The Christian's response to the calling to medicine or dentistry proves the doctor a faithful professional (see statement on Principles of Christian Excellence in Medical & Dental Practice).

*Approved by the House of Representative*
*Passed unanimously*
*April 24, 2014, Green Lakes, WI*
Sharing Faith in Practice

As Christians we should share the good news of Jesus Christ. Christ has explicitly called us to make disciples.

As Christian physicians and dentists we seek the well-being of our patients in our covenantal relationship with them. Clinical studies have demonstrated the importance of spiritual health in physical well-being. It is concern for the well-being of our patients that leads us to take a spiritual history from and share our faith with our patients.

As Christians we acknowledge the central role of the Holy Spirit in the process of evangelism. We rely on the discernment provided by the Holy Spirit to know when and how it is appropriate to share our faith. We recognize conversion is the Spirit’s work, not ours.

Our faith should be implicit in our actions. We should be prepared to share our faith with patients and colleagues when our actions and the Holy Spirit prompt them to ask us questions. We should readily accept invitations from our patients to pray with them. We should offer to pray with our patients when they have indicated a belief in God and a practice of prayer. Some physicians and dentists choose to make their faith manifest through their statements, attire, or their office environment. Such indicators are not inherently disrespectful of patients and have the beneficial effect of making them aware of their doctor’s faith perspective.

At times we may be prompted to initiate sharing our faith with our patients. In these situations, recognizing their vulnerability, it is appropriate to receive their permission for such an interaction. We should remain sensitive to patients’ wishes in such interactions, especially when communicating with those who are of another culture or when caring for patients with diminished decision-making capacity.

Just as we respect our patients and their beliefs, our faith should be respected by the institutions in which we work. Policies that prohibit physicians and dentists from sharing their faith with others as described above restrict the freedoms of speech and religion of all involved and should be opposed.

Approved by the Board of Trustees

Approved unanimously as amended by the House of Delegates
May 9, 1997. Mesa, Arizona

Explanation

Background

The United States was founded by people fleeing religious persecution. The freedom to practice one’s own religion has been one of the basic and cherished freedoms of this country. Because everyone enjoys that same freedom, there has been both considerable freedom to talk about one’s own beliefs and considerable caution about where and when that activity is allowed to take place. Witness the frequent and emphatic discussion of the "separation of church and state" which is often invoked inappropriately. That original concept was articulated to ensure that the state did not endorse any one form of religion. But
the precept is often brought up in discussion as if it meant that the state must pretend that religious belief does not exist and enforce that agnosticism.

**Secular Perspective**

The relationship between healthcare professionals and their patients may be construed in many ways: as profession, as mission, as covenant, as contract, as duty, etc. But one of the most commonly invoked constructions is that it is a "fiduciary" relationship, i.e. an unequal relationship in which one party (physician, dentist, nurse, etc.) has more knowledge and skill than the other (patient), and therefore the former has an obligation to always act in the best interests of the latter. This same fiduciary relationship exists between an attorney and client, banker and customer, etc.

Prior to the current generation, physicians and dentists often acted in a paternalistic manner toward their patients. Assuming they knew what was best for each patient, they often made decisions and gave orders without discussing other options with the patient. Even though this was almost always done in a beneficent way, clinicians came under justifiable criticism for this seemingly arrogant attitude.

In the social upheaval of the 1960's, individual rights became first a focus of activism, and later became the preeminent social value. This was manifest as activism for minority rights, women's rights, consumer rights, and also patients' rights. In this generation, the individual patient’s right to self-determination has become the dominant force in medical ethics. Patients now have the right to refuse unwanted treatment, and sometimes even assume that they have the right of entitlement to demand any treatment they want.

In this atmosphere, healthcare professionals who "share their faith" with patients have become suspect of taking advantage of the fiduciary relationship by forcing on the vulnerable patient a belief which they may not share or want to hear about. Physicians or dentists who actively witness to their patients have often been criticized. But there have been few if any sanctions against the self-employed individual practitioner; it is assumed that patients may leave and go to another professional if they are offended. However, clinicians who work for someone else, whether another individual practitioner, a clinic, or a large secular institution, have occasionally been forced to curtail their witnessing or risk losing their position.

**Christian Perspective**

Unfortunately, this negative perception of witnessing sometimes conjures up the image of a high-pressure used car salesman. However, the task of evangelism is not to force a conversion, but simply to proclaim the good news of Jesus Christ and allow the Holy Spirit to work in that individual's life. Thoughtful Christians realize that high-pressure tactics represent an invasion of privacy and can be counterproductive.

Christian physicians and dentists have a broader obligation than merely caring for the physical needs of their patients. Jesus demonstrated through his healing ministry a concern for both the physical and spiritual aspects of human illness. Jesus also gave us a mandate to "go and make disciples of all nations" (Matthew 28:19). To assist with the carrying out of this mandate, we have been promised the power of the Holy Spirit to make this possible (Acts 1:8).

The Christian Medical and Dental Society has been aware of the tension between this gospel mandate and the above-mentioned societal mandate to respect others by not forcing religious beliefs on them. CMDS has given support to some individual practitioners who have been sanctioned for their witnessing. Many individual CMDS members have developed their own styles and methods of witnessing. And CMDS members have developed methods which can be adopted and adapted, e.g. the METS (Medical Evangelism Training & Strategies) Program and the Saline Solution.

In preparing this statement on Sharing Faith in Practice, the CMDS Ethics Commission and House of Delegates have been conscious of both the importance of individual witness and the potential vulnerability of the individual patient.
Abstracts

The authors believe that the relationship between spirituality and health is a new frontier in medicine. The study is a preliminary investigation into the relationship between a patient's experience of overall health, physical pain, and intrinsic spirituality. The study found significant correlation between patient health and spirituality. Significant differences were also found in both overall health and physical pain, based on the study's three levels of spirituality. The study suggest an association between intrinsic spirituality and a patient's experience of health and pain. Assessment of spirituality may be important for family physicians to consider as a supplement to patient interviews.


The article reminds physicians of the importance that prayer plays in the lives of a majority of Americans. With this in mind, the authors suggest that once the religious preferences of the patient and physician are accounted for, it is appropriate for the physician to privately pray for the patient, and pray with the patient. The authors believe that physicians can play a crucial role in validating the faith of their patients in a time of crisis, and can harness the positive effect that faith and prayer have on physical and mental health.


The authors attempted to determine the type and frequency of religious interactions that occur between devout physicians and their patients. Physicians identified by their peers as having religious or spiritual beliefs that were an important part of their lives were surveyed. Forty physicians responded (response rate 77%). In general, these physicians agreed that their religious beliefs have an important influence on their practice of medicine. Thirty-two percent reported having shared their beliefs with patients. Praying aloud with patients occurred with only 13% of patients, but 67% of respondents reported having done this on at least one occasion. Multivariate analysis showed the physician's religious group to be the most important determinant of sharing beliefs with patients, occurring most commonly with Protestant physicians. In this small sample of devout physicians, physician religious beliefs appear to influence the interactions between physicians and their patients.


Physicians rarely question patients about their religious beliefs. This lack of inquiry may be contrary to patients’ wishes and detrimental to patient care. This study examined whether patients want physicians to discuss religious beliefs with them. Two hundred three family practice adult inpatients at two hospitals were interviewed regarding their views on the relationship between religion and health. Many patients expressed positive attitudes toward physician involvement in spiritual issues. Seventy-seven percent said physicians should consider patients’ spiritual needs, 37% wanted their physicians to discuss religious beliefs with them more frequently, and 48% wanted their physicians to pray with them. However, 68% said their physician had never discussed religious beliefs with them. This study supports the hypothesis that although many patients desire more frequent and more in-depth discussions about religious issues with their physicians, physicians generally do not discuss these issues with their patients.


Most physicians do not address spiritual and religious issues with patients, although there are data documenting the relationship between religious variables and disease, health, and well-being. The purpose of this study was to examine patient attitudes regarding physician-directed inquiry about issues related to spiritual matters and faith; and to identify screening variables that would identify patients who would be receptive to such a discussion. This study supports the use of frequency of religious service attendance as a screening variable for patients receptive to physician-directed inquiry into religious and spiritual issues. It also confirms that patients are accepting of physicians’ referring patients to pastoral professionals (ie, clergy) for spiritual problems.

Spirituality is an important aspect of health care that is not often addressed in modern day primary medical practice. Controversy surrounds the role of spiritual issues in medical practice. Some of this stems from confusing spirituality with religion. This paper distinguishes between spiritual and religious issues and reviews the history of these issues in medicine, the growing medical literature in this area, and some practical guidelines for the practicing physician. The authors conclude that, when appropriate, spiritual issues should be addressed in patient care since they may have a positive impact on patient health and behavior, and recommend that the medical model be expanded to a biopsychosocial-spiritual one. The guidelines developed by the American Psychiatric Association provide a useful model for the practicing physician to follow. More research is needed in this area, but the authors conclude that enough is already known to support the inclusion of spiritual issues in medical education.


The author calls physicians to recognize the importance that religion plays in the lives of patients. Only then, she argues, can positive effect of spirituality on mental and physical health be effectively harnessed.


The study of 160 family physicians and general practitioners found that the majority of physicians believed that religion has a positive effect on the mental health of older patients, and many believed that religion has a positive effect on physical health. While more than one half reported that patients only rarely, if ever, mentioned religious issues during a medical visit, a significant proportion of the physicians felt they should address religious issues when an older person indicates religion's importance and that religious issues should not be reserved completely for the clergy. Nearly two thirds of the physicians felt that prayer with patients was appropriate under certain circumstances, and over one third reported having prayed with older patients during extreme physical or emotional distress. The strongest predictors of physicians' belief in the appropriateness of addressing religious concerns were an understanding of the importance of religion in the lives of older adults and an awareness that patients might desire to engage in prayer with them. The authors found that the beliefs and attitudes of the physician appear to be important factors in determining their receptivity to discussion of religious issues, which in turn may influence whether patients mention such issues in the context of the medical visit.


Recognizing the importance of spirituality in the relationship of patient and physician, the author remarks "Christian health care professionals are also people of genuine hospitality, who welcome patients into the space of Christian healing and invite them to share their stories of faith, hope, and love."

Chen Y. Doctor on the front lines. Physician; March/April 1990:8-10; and Wright R. Faith and practice. Physician; September/October 1998:20-22

The first article is an interview with the president of, and the second a description of, the Medical Strategic Network. This organization (1) holds seminars (METS Conferences; Medical Evangelism Training & Strategies) to train physicians in how to share their faith; (2) develops mentoring relationships between younger and more experienced Christian physicians; and (3) cultivates a biblical and culturally relevant medical mission mind-set.

Bibliography


In an effort to find an appropriate method for physicians to discuss faith with patients, the author describes the inception and basic methods of a program designed to facilitate spiritual discussion in the clinic. The program calls physicians to use simple remarks in discussion to help patients identify them as persons of faith.

Recognizing the difficult challenges that many patients face, both in illness and life, and the important role that faith plays in the lives of many, the author asks physicians to allow the holy spirit to guide them in the arena of prayer, spirituality, and physician-patient relations.

**Short D. Total patient care.** British Journal of Hospital Medicine. 1994;51(4):189-91

The author argues that the true role of a physician goes beyond the physical and psychological needs, and includes both the social and spiritual. He finds that ignoring the spiritual element is to practice merely as a technician.

**Shuler J.E. Earning the right to intrude.** CMDS Journal. Spring 1993;24(1):30-1

The author argues that through a long term commitment to the patient's general welfare, we can develop a relationship to discuss issues of faith.
Suffering

Suffering occurs when we perceive or actually experience a threat to or loss of our wholeness. Wholeness includes an individual's cognitive, emotional, spiritual, and physical conditions, which are inherently interrelated.

While pain is an important component of suffering, it may sometimes protect us. Suffering may even provide an opportunity to experience God's grace.

Suffering has a variety of causes and effects. Suffering may be the result of personal choices, or other's choices, or may come without obvious reason or explanation. Everyone suffers; particular instances of suffering are not necessarily the result of spiritual or moral failure. Suffering may compel us to confront the meaning and purpose of our existence and to question the goodness and justice or even the existence of God.

CMDA endorses the historic commitment of the healing professions to the relief of suffering. Our model is the Lord Jesus Christ. Luke 7:11-17 depicts Christ as responding to a grieving woman by recognizing her suffering, feeling compassion for her, comforting her, and then alleviating her suffering. We are motivated to follow this model as we experience God's love.

It is essential for us to recognize both declared and non-declared suffering. This recognition involves sensitivity to the patient's cognitive, emotional, spiritual, and physical condition. This requires individual discernment and may be enhanced by the leading of the Holy Spirit. We should be cautious not to judge the validity or meaning of another's suffering.

Compassion/ Comfort

Comforting includes listening and being present even as God listens to our prayers and is always with us. Listening and being present cannot be replaced by other attempts to alleviate suffering. While we recognize that God can and does bring good out of suffering, telling this to one who is suffering often does not bring comfort.

As Christian physicians and dentists, we use our technical and interpersonal skills to alleviate suffering. Since we acknowledge that physical conditions are not the only causes of suffering, physicians and dentists should cooperate with the patient's family and friends as well as other members of the health care team and pastoral care team to address all aspects of suffering.

In this life, our efforts to relieve suffering will be only partially effective, and complete victory over suffering will only be realized in God's new kingdom. Treatment to relieve suffering does not include euthanasia. (Please see statement on euthanasia.)

Approved by the House of Delegates
Passed unanimously
Pain and suffering—the words seem inextricably entwined in our thoughts and in our speech. But they are not synonymous, neither are they necessarily connected. It is possible, even common, to suffer without having pain. Conversely, it is possible to be in pain but not to suffer, e.g. when the pain is temporary, understood, and accepted.

Pain is a physical symptom, one which physicians and dentists confront daily and attempt to alleviate with varying degrees of success. [See Statement on Pain Management.] Suffering is a broader concept which may include physical pain and many other types of unpleasant sensations and emotions. Dame Cicely Saunders, founder of the hospice movement in Britain, in teaching about caring for patients who are dying, discusses the concept of total pain which she says includes physical pain, emotional pain, social pain, spiritual pain, financial pain, and perhaps other components.

One of the several goals of the professions of medicine and dentistry is to relieve suffering. Most often this refers to a direct or indirect assault on physical pain and/or its causes. Most clinicians, however, subscribe to the 15th century French proverb, To cure---sometimes; to heal---often; to comfort---always. And bringing comfort involves attempting to relieve as many of the components of suffering as possible. This is generally accepted by healthcare professionals, whether coming from a secular or a theological perspective.

Christian Perspective

Since the Fall, humans have been subject to both pain and suffering. We can rejoice that in Heaven He will wipe every tear from their eyes. There will be no more death or mourning or crying or pain, for the old order of things has passed away. (Rev 21:4 NIV). But we are still living in the fallen world and must cope with both pain and suffering. Pain and suffering are part of life, and they are bad.

But, just to make things more complicated, scripture tells that sometimes God uses pain for correction (Hosea 10:13), or to encourage development (I Peter 5:10), or to glorify himself (John 9:3). Unfortunately, the reason or explanation for specific instances of pain or suffering, in scripture or in our own lives, is not always clear; The secret things belong to the Lord our God, but the things revealed belong to us. (Deut. 29:29)

In the past, perhaps because of greater familiarity with scripture, pain and suffering were accepted as part of life; not glorified, but accepted. Today’s attitude is more frequently that pain and suffering must be eliminated. When we focus on the tremendous advances in the provision of healthcare, this goal almost seems achievable. We can fix it! However, this arrogant assertion is part of the humanistic (vs theistic) perspective Paul described in the first chapter of Romans. This attitude is not confined to the secular world, it is unfortunately frequently seen among Christians as well.

Still, Christians must follow the model of Jesus, and must attempt to bring healing and relief from suffering. This is expected of all believers. But it is especially true for Christian healthcare professionals. We must try to relieve physical pain, emotional pain, social pain, financial pain, and spiritual pain. And when we are unable to be fully effective, we are not to give up and abandon the sufferer, we are to continue to be present; we are to continue to have compassion. Compassion means to suffer with. We are to continue to suffer with those who suffer.

Abstracts


The question of suffering and its relation to organic illness has rarely been addressed in the medical literature. This article offers a description of the nature and causes of suffering in patients undergoing medical treatment. A distinction based on clinical observations is made between suffering and physical distress. Suffering is experienced by persons, not merely by bodies, and has its source in challenges that threaten the intactness of the person as a complex social and psychological entity. Suffering can include physical pain, but is by no means limited to it. The relief of suffering and the cure of disease must be seen as twin obligations of a medical professional that is truly dedicated to the care of the sick. Physicians failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.
Attempting to define the concept of suffering, the author concludes that all suffering is characterized by a disruption in the coherence and order that [one] perceives in the world. Nevertheless, he notes that because people's experiences of suffering may differ according to individual experiences and perspectives, physicians must be able to distinguish between suffering in general and that which is experienced by a particular patient. Lamenting the fact that Christian theodicies tend primarily to be concerned with evil and the need for redemption from sin, he proposes a theology of suffering in which those who suffer may gain comfort by identifying with Christ as the paradigmatic and quintessential sufferer Who suffers with us.


The author, professor of theological ethics, is suspicious of attempts to explain why God allows pain and suffering. Instead, in this book he tries to understand why that question is so important to us. The book focuses primarily on illness and death, especially that of children. He tries to show how God can give a voice to pain in a manner that at least gives us a way to go on. He says "I cannot promise readers consolation, but only as honest an account as I can give of why we cannot afford to give ourselves explanations for evil when what is required is a community capable of absorbing our grief."


In this analysis of the concepts of "care" and "cure," the author asserts that there has been a noticeable shift in the treatment of the dying, such that the goal of curing has become paramount to the aim of caring. The common failure of physicians to continue caring for patients for whom there is no hope for cure is lamented. He urges a return to a commitment to caring which is manifest in "an attitude of the heart which listens, loves and places the cross as the only theodicy necessary in an economy of suffering and death."


Although medicine, theology, and bioethics have developed substantially over the years, clinicians, theologians, and bioethicists alike have failed to address the deeper question of suffering which underlies these developments. Asserting that "suffering is the central question of medicine, of practical theology, and of our lives," the author contends that we have wrongly tried to answer this question by applying medical, theological, and ethical solutions. She maintains that we should not seek to master, solve, or avoid the problem of suffering, but should instead seek to be present with those who suffer, thereby binding the suffering and the nonsuffering together.


Concerned by recent court decisions and individual cases in which physician-assisted suicide has been considered the standard of care for patients experiencing intractable suffering, the author analyzes two paradigmatic cases which are commonly invoked in support of physician-assisted suicide. He decries the "radical individualism" upon which such support is based as inefficient to address the moral issues posed by suffering. As an alternative, he offers a decision-making model based on Old Testament Wisdom literature as adequate to answer questions about the nature of suffering, the moral value of upholding the dignity of sufferers, the influence of suffering on a patient's ability to make decisions, and the role of the caregiver when there is no hope for cure.

Bibliography

The atheist-turned-apologist takes an intellectual look at why there is pain in this world created by a God who is both good and omnipotent. His logic and clarity have made this 1940 book a classic.


The author addresses the "Why?" questions about pain. She explores some of the sources of human suffering, and some of the reasons. She brings light from biblical truths, and she discusses the ways of God with his people.


The author begins with several chapters looking at the what and why questions of human pain. He then enters the world of the sufferer by telling their stories in order to find out what difference it makes to be a Christian. He concludes with several practical chapters on coping.


A thorough examination of the "scandal of suffering in a God-made and God-ruled universe." In his quest to make sense out of suffering, Kreeft finds clues in the philosophers, artists, and prophets, and then shows how the clues converge in "Jesus, the Tears, of God."


The author shares four lessons on suffering presented by Paul in II Corinthians: (1) the importance of receiving comfort from others (II Cor. 1:3-4); (2) those who receive such comfort are specially equipped and therefore called to comfort other sufferers (II Cor. 1:3-11); (3) Christians who suffer share in the sufferings of Christ (II Cor. 11:23-29); suffering is a medium for the revelation of God’s power (II Cor. 12:9).


The author, who has suffered from the death of one son and the disability of another, skips the platitudes and well-meaning advice, and instead offers the truth. He writes "Pain has two faces, human and divine. The human face is haggard, drawn, contorted and streaked with tears. The divine is calm, assuring, kind, and loving—but likewise streaked with tears."


This book underscores the change that is taking place in medicine from a basic concern with disease to a greater focus on the sick person. The author centers his discussion on the problem of suffering because, he says, its recognition and relief are a test of the adequacy of any system of medicine.


In a series of moving studies, the author explores the ways patients and their families have faced their dilemmas and found ways to cope with their crises. He talks about the burned, the retarded, the gestated and sold, the battered, the molested, the aged, and others.

Cook J. Confessions of a secondary sufferer. The Church Herald October 1995:22-26

From the perspective of a grieving father, this theology professor addresses poignant thoughts about prayer, healing, life, death, family, and the church—thoughts directed toward "secondary sufferers”, i.e. those who suffer along with the individual.

Rice R. The meaning of pain and suffering. (Loma Linda University’s) Update 1999;15(1):3-6

A theologian looks at the story of Jesus and gleans applications for us today. He concludes "Suffering has no meaning. But we can find meaning in, through, and in spite of suffering, and religious faith is our greatest resource for doing so."
The author contends that we cannot be confident that we know the reason why we suffer, but this not knowing is very different from claiming that suffering is inconsistent with God's existence. He goes on to discuss the intellectual and the emotional issues in theodicy.
Suicide

We, as Christian physicians and dentists, believe that human life is a gift from God and is sacred because it bears God's image. One of the ramifications of societal acceptance of suicide is further devaluation of the biblical view of human life.

The role of the physician is to affirm life, to relieve suffering and pain, and to give compassionate, competent care as long as the patient lives. The physician as well as the patient will be held accountable by God, the giver and taker of life.

Suicide is an intentional act with the express purpose of ending one's own life, often occurring in the context of isolation, pain, or mental illness that may alter the victim's perceptions, thinking, and judgment. We believe it is only for God to judge the ultimate moral culpability of those who take their own lives.

Suicide is in opposition to the sovereignty of a loving God, the Creator of all life, and it is an inappropriate exercise of the control that God has given us over our own lives as created beings.

Release from suffering is thought by some to justify suicide. However, suffering is a part of the current state of God's redemptive plan. Relief of family or societal burden is thought by some to justify suicide. However, the biblical view of family and community includes an obligation to attempt to meet the needs of the individual.

For those family members who feel stigmatized by a sense of shock and shame when a relative commits suicide, our task is to be agents of grace and healing in the midst of their loneliness, their isolation, their grief, and anger.

We do not oppose withdrawal or withholding of artificial means of life support in patients who are clearly and irreversibly deteriorating, in whom death appears imminent, and who are beyond reasonable hope of recovery.

The Christian Medical & Dental Associations advocate appropriate use of treatment for clinical depression and physical pain as well as support for depressed or suffering individuals by family, church, and community.

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Explanation

Secular Perspective

Suicide has been unacceptable in most western societies for centuries. The social upheaval of the 1960's in our own society has resulted in an increased emphasis on individual rights, and an accompanying de-emphasis on responsibilities. This focus on individualism has also caused many secularists (and some Christians) to re-think the issue of suicide. Many see it as the ultimate expression of personal autonomy, therefore socially acceptable, and even honorable in some circumstances.
Increasing societal acceptance of the person's right to exert control over his or her own death has led to the publication of numerous articles and books supporting the idea, and others offering instruction on successful suicide measures. In addition, several organizations have been formed with the express purpose of disseminating this philosophy and literature, as well as with the intention of encouraging individuals to assist their loved ones in this "self-deliverance".

The act of suicide is most often an act of desperation, a presumed solution for an insoluble situation. The reasons behind and the motivation for self-destruction are usually complex, often the end result of depression or other mental illness. It sometimes appears to be the "only answer" for the person who feels hopeless because he or she does not know God or has rejected God's love. Sadly, it sometimes also occurs in the godly person who feels unable to cope with the burdens of life.

**Theological Perspective**

Jews and Christians have long subscribed to the idea that "we are not our own" but are stewards of a life given to us by the Creator God, a life even made in His image (Genesis 1:28). This concept has resulted in a longstanding Judeo-Christian belief that suicide is wrong. However, there is no clear scriptural prohibition against self-destruction. Many interpret the commandment against killing (Exodus 20:13) as applying to the self as well as to others.

**Christian Perspective**

In the early church when persecution was common, there was some uncertainty about the dividing line between suicide (taking one's life) and martyrdom (laying down one's life). Some of the teachings of the early church fathers may have been initiated to help clarify this dilemma. Augustine and Aquinas are primarily responsible for the formulation of the current Christian position against suicide.

Problems with suicide include the attitudes it implies toward oneself, the community, and God. First, it manifests an unwillingness to bear, in love, with the weaknesses of the person for whom one has a unique and special responsibility: oneself. Second, it also has the effect of discouraging others in their own struggles. Even a suicide committed out of a motivation to relieve caregivers from suffering cuts a tie that binds all of us together and supports us all in our task of living. Third, suicide is a statement that there is no hope for an acceptable future, that such a future is not within God's ability and will. It constitutes an attempt on the part of people to determine the end of their lives, as if they know fully the goal for which God has sustained them to this point. However, it is God's prerogative to determine when there is no purpose for a life to continue. To assume ultimate responsibility for one's life is to reject God, no matter when in the course of life one elects to do so.

The Bible does indeed record various examples of suicide that it neither commends nor condemns explicitly. Since the Bible communicates its message through both the failures and triumphs of people, this silence says nothing about the moral legitimacy of suicide. A broader analysis of other relevant biblical concepts is necessary to determine the moral status of suicide.

Christian motivation has undergirded a significant portion of the modern hospice movement in Europe and North America. Many Christians (and others) believe it is insufficient to say to people who are dying, You should not take your own life. Instead they should offer to help them and their families with their physical, psychological, and spiritual needs during this exceedingly difficult time.

**Modern Dilemmas**

While martyrdom is rarely a cause for uncertainty in modern society, we are not free of dilemmas in relation to suicide. The issue of voluntarily foregoing medical treatment in order to escape a painful illness or other suffering keeps the definitional issue fresh. Because human life as we know it is finite, many Christians are comfortable with the idea of limiting treatment in situations of inevitable and imminent death either to avoid further suffering, or to preserve resources for others. Others place a greater emphasis on the sanctity of human life and would feel an obligation to continue medical efforts for themselves or their loved ones in spite of imminent death. In addition to the basic disagreement, the ambiguity of "inevitable" and "imminent" assures the continuation of this debate. These matters are discussed further in the "Explanation of the Statement on Patient Refusal of Therapy."

**Position Statement**
The CMDS position statement on Suicide attempts to clarify the definition of suicide and take a stand consistent with traditional Christian teaching on the issue. It recognizes those situations where there is disagreement among believers. It should be read and understood in conjunction with other position statements in part 4 of this resource book on Patient Refusal of Therapy, Advance Directives, Withholding or Withdrawing Nutrition and Hydration, Physician-Assisted Suicide, and Euthanasia, as well as with the statements on Medical Futility, Suffering, and Pain Management. In addition, the statement calls us as believers in Jesus, and followers of His example of compassion, to come to the assistance of those survivors who are in pain and turmoil as the result of the suicide of a loved one.

Abstracts


This Bible study addresses the question "What does the Bible say about taking my own life?" After briefly looking at the six instances of suicide recorded in scripture, the author looks more closely at the final action of Samson, and contrasts martyrdom with intentional suicide. He then addresses the question of human suffering, compassionate medical treatment, and the sometimes understandable thoughts of self-destruction when a patient's suffering cannot be adequately relieved. Attention is drawn to God's sovereignty, the image of God in each individual, the sanctity of human life, our call to compassion for those who are suffering, and God's redemption and forgiveness.

He concludes by drawing a distinction between refusal of treatment which might postpone death for a while and intentional suicide---a distinction which is most often quite clear but other times falls in the gray area of moral uncertainty where we should defer judgment.


The authors studied 44 terminally ill patients to determine whether they desire that death should come early. Of these, 34 never had such a wish. Of the 10 who did, 3 had been suicidal and 7 had desired death to come early; however, all 10 were found to be clinically depressed. [It is of interest to note that the subjects were recruited from a hospice program, so likely represent a population whose multiple needs were being addressed.]


After noting the growing trend in society to frame an individual's "right to die" as absolute based on the principle of autonomy, the author examines the biblical doctrine of creation to determine if human beings are granted authority to choose the time and nature of death. He concludes that God alone possesses absolute autonomy and that human beings are created primarily to be dependent on Him and interdependent on other humans. Therefore, autonomy cannot be claimed as an absolute in the defense of human beings' right to die.

O'Mathuna, Donal P. "Does Paul Condone Assisted Suicide in Philippians 1: 21-26?" Audio tape available from The Center for Bioethics and Human Dignity; Bannockburn, Illinois; 1995.

In focusing on this passage in Philippians as a context for the debate over assisted suicide and euthanasia, the author notes that there is a lack of consensus even among Christians as to whether euthanasia is consistent with biblical precedents. He asserts that the book A Noble Death by Arthur Droge and James Tabor and the book What Does the Bible Say About Suicide? by James Clemons incorrectly argue that the Philippians passage supports the view that the immorality of suicide is founded in politics and not in Christian theology. The author argues that this passage instead demonstrates that Paul, in contemplating his own death, maintained that to be in accordance with God's will (which forbids the active taking of life as a means to end suffering) is of paramount importance.
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Ackerman TF. Why doctors should intervene. Hastings Center Report 1982;12:14-17

A philosopher argues that illness has a transforming effect on a person such that his or her autonomy is constrained. Thus physicians should be somewhat paternalistic in over-riding decisions made by a patient who is not acting in his or her own best interests.

Sakinofsky I, Swart GT. Suicidal patients and the ethics of medicine. Canadian Journal of Psychiatry 1986; ??:91-96

This paper discusses the social and religious roots of the medical dilemma surrounding suicidal patients and tries to help health professionals avoid the pitfalls of simplistic solutions which do not take account of clinical experience. They argue for a "policy of postponement", i.e. paternalistic intervention over the objection of a suicidal patient in an effort to assess his or her covert needs which have not been met.

Best EB. Suicide: ethical and moral issues from a theological perspective. Canadian Journal of Psychiatry 1986; ??:97-100

This is a historical review of Jewish, Christian, Islamic, Hindu, and Buddhist attitudes toward suicide. Contributions to current Christian thought are recognized from Aristotle, Augustine, Aquinas, and Donne.


A Christian professor of ethics discusses the issue of "rational suicide" and concludes that "[t]he Christian prohibition of suicide is clearly based in our assumption that our lives are not ours to do with as we please. But that prohibition is but a reminder of the kind of commitments that make suicide which appears from certain perspectives and at particular times in our lives so rational, so wrong."


A professor of philosophy (and Presbyterian minister) gives an in-depth discussion of these issues from a biblical perspective. In addition to the historical information contained in chapter one, chapters two (Suicide: What Is It?) and three (The Morality of Suicide) offer one of the most penetrating and insightful discussions available.


Two theologians clearly present the Catholic position that "...suicide is intrinsically and always wrong, since in all circumstances it constitutes an abdication of one’s responsibility to life our life in community with other persons and with God."


While attempting to take a middle road between patient autonomy and physician paternalism, the authors conclude that "...it is better to err on the side of preserving life than on the side of letting it be lost." (p 263)


This Protestant theologian and philosopher emphasizes the abdication of moral responsibility in a decision for suicide. He goes on to state that "[w]hen an individual rejects medical treatment with the intention of bringing about death, the action is morally similar to suicide and immoral for many of the same reasons..." However, "...not every decision to withhold or withdraw medical treatment is rooted in an intention to bring about death of the patient, and in such cases, analogies with suicide...are not applicable."
Three Parent Human Embryos

CMDA affirms that all children—including those who are biologically flawed—are gifts from God, a heritage of their mother and father to be cherished, nurtured, and guided. Parents’ obligation to protect their children’s health extends also to healthcare professionals.

Reproductive biotechnologies have introduced novel methods for correcting certain harmful genotypes by intervening near the time of conception. One of these methods involves starting with maternal egg and paternal sperm and transferring to the developing embryo genetic or cellular components from a third progenitorial donor with the aim of producing a healthy child. Depending on the specific technology, the added genetic component might be derived from chromosomal or mitochondrial DNA, or it might be an egg or enucleated embryo derived from a third contributor. Reproductive scenarios involving more than three parental genetic or cellular contributions are also foreseeable.

Whereas preventing genetic disease is a laudable goal, the means by which that goal is achieved and the far-reaching consequences of developing such technology are also relevant to the ethical evaluation. Novel biotechnologies that create human embryos having more than two biological parents raise a number of ethical concerns, which fall into three broad categories:

1. *The threshold of germline intervention would be violated.* These biotechnologies could introduce permanent changes into the human germline that, if passed on, would affect countless future generations. Whereas the simple editing out of the germline a single harmful gene causing a disease would itself be ethically praiseworthy, current technology cannot do this without causing a cascade of inadvertent consequences, which could be disproportionately greater. The genetic basis of most diseases is complex, and the repercussions of germline interventions, both beneficial and adverse, could be irreversible for succeeding generations. Once the ethical threshold of human germline editing were crossed, ethical limits on further and more far-reaching germline editing might be unsustainable as an initial attitude of caution gives way to a progressive technological imperative, whereby what is no longer impossible is viewed as irresistible, and what has become possible is viewed as necessary. Abuses would be difficult to detect or prevent. Further enabling of the development of germline intervention biotechnology would open the door to the threat of eugenics, potentially with more dreadful exercise of power over others than has heretofore been seen in history.

2. *Nascent life is destroyed.* Some of these reproductive technologies entail a process whereby more than one human embryo must be created in order to combine components to produce one healthy embryo, resulting in the destruction of the other human embryos.

3. *Biological parentage may be redefined.* These biotechnologies expand the gametal contributions to the child’s conception beyond the natural two, to include three or more biologic progenitors. They also raise dilemmas for parents, offspring, and society to consider:
   a) Disagreements are likely to occur over deciding what type or quantity of biological contribution is sufficient to define parentage in regard to moral, social, and legal responsibility or proprietary rights.
   b) Knowledge of additional parental contributions may confuse the offspring’s sense of identity and relatedness.
   c) Further development of these and related biotechnologies and their normalization could make it possible for male-male and female-female couples to conceive children. This fundamental alteration of the biological definition of the human family would have unforeseeable consequences. It could be seen as a positive development ensuring equality of fertility, or it could be seen as disrupting the natural order of the family to the detriment of offspring and society.

In response, CMDA affirms the obligation of Christian healthcare professionals to care competently and compassionately for parents and children, including those with, or concerned about, inherited mitochondrial and other genetic disease. However, CMDA also believes that, whereas parental responsibility includes the right to make a wide range of decisions on behalf of their children, this
authority is not absolute and does not extend to proprietary control of their children’s genetic make-up. CMDA’s position is based on the following considerations:

A. Biblical

1. Every person is created by God and bears His image (Genesis 1:26-27; Psalm 139:13-16).
2. God has instituted the unique marital bond between one husband and one wife joined together as one flesh (Genesis 2:21-25; Ephesians 5:22-33).
3. Children are a gift from God, a blessing and the fruit of marriage (Psalm 127:3-5; Psalm 128). Human procreation is a mystery only partly explained by biological science.
4. Marriage is an exclusive covenant ordained by God (Mark 10:6-9), affirmed (Matthew 19:4-6) and blessed (John 2:1-11) by Jesus, and for Christians a symbol of Christ’s special union with His bride, the church (Ephesians 5:21-33; Revelation 19:7-8; Revelation 21:9-10).
5. The incorporation of a third person in the marital relationship in an attempt to conceive children historically has produced strife and fractured relationships (Genesis 16; Genesis 21:1-21; Genesis 29:30-30:24).

B. Biological

1. Human beings are sexually dimorphic, and nature requires contributions from both female (mother) and male (father) for procreation.
2. Producing human embryos through novel combinations of three or more parents does not occur in nature but requires technological manipulation beyond in vitro fertilization (see CMDA statement on Assisted Reproductive Technology).
3. The long-term consequences of germline manipulation are unknown.

C. Social

1. Children have a need to know and understand their identity and ancestry, including their direct progenitors. Children also have a need to know their siblings, both relationally and as a means to avoid consanguinity later as adults. Considering that gamete donor-conceived offspring tend to view the donor as a whole person rather than just a source of genetic material, children conceived through three-parent biotechnologies would bear a potentially burdensome sense of self identity, whether or not they know the identity of the third parent.
2. These children might also be perceived by other children, including their siblings conceived naturally, as different and suffer discrimination.
3. The psychological effects on children who are conceived utilizing an additional parent outside of the marriage bond have been insufficiently studied to conclude that these children are not harmed by depriving them of natural relatedness to their parents and siblings.

D. Medical

1. Hormonal manipulation and egg retrieval procedures provide no direct medical benefit to egg donors, but do subject them to medical risks, such as ovarian hyperstimulation syndrome.
2. Micromanipulations of gametes may not have the intended results. They may introduce birth defects as well as genetic diseases that become evident during childhood or that may not become manifest until later in adulthood or even generations later. The degree of risk for novel interventions cannot be known prior to experimenting with them, although the risk is known to be increased for technologies such as intracytoplasmic sperm injection of eggs to accomplish fertilization.
3. Some genetic manipulations of gametes may potentially introduce new unforeseen harmful mutations. The use of assisted reproductive technology is associated with a disproportionate number of infants with low-birth-weight, as well as a variety of chromosomal alterations, genetic and epigenetic defects.

E. Ethical

1. Producing children through the genetic manipulation of mitochondrial or nuclear DNA, such as “three-parent embryo” biotechnologies, are inherently experimental on a vulnerable human population—nascent human beings—who lack the capacity to consent to such experimentation.
Furthermore, truly informed consent by the parents is impossible because the enduring outcome of germline manipulations cannot be known.

2. Three-parent embryo technology is ethically distinct from treatment. Genetic manipulation to determine the genotype of children not yet born is not equivalent to the treatment of persons with illness. The genetic manipulation of mitochondrial or nuclear DNA in a human embryo potentially alters innumerable succeeding generations of human progeny. Developing the ability to alter the human germline at will opens the door to eugenic manipulations, such as “designer babies” in whom desired traits are enhanced or selected out. Eugenic manipulations commodify human beings and, as history teaches, dangerously set the stage for genetic discrimination, societal divisions, and persecution (see CMDA statement on Eugenics).

3. Perfection and implementation of three-parent biotechnologies are very likely to result in unintended genetic or developmental errors along the way, creating the additional ethical dilemma of whether to raise and care for the resulting genetically impaired disabled children or to terminate their lives at some point during development.

4. Three-parent reproductive technologies entail unacceptable harm to nascent human life. Destruction of extra human embryos created during the process of three-parent embryo procedures causes their deaths. Human beings at all sizes of life and stages of development are much more than assemblages of molecules. To deny moral value to the human embryo, who is fully alive, has a unique genome, and possesses the intrinsic capacity to develop into a fully conscious human, would be to believe incorrectly that not all human lives count as members of the human community (see CMDA statement on the Beginning of Human Life).

Conclusion
1. Because human procreation is a mystery only partly explained by biological science, CMDA believes that caution and great humility are needed in regard to proposals to intervene in this special natural order. Human beings, not the novel biotechnologies used to assist with their conception, are sacred.

2. CMDA affirms human procreation as the fruit of marriage between one male and one female. CMDA opposes the use of technologies that would create children having more (or less) than two biological parents.

3. CMDA believes that the stewardship mandate to subdue the earth (Genesis 1:28) entails moral responsibility that does not extend to absolute control over human procreation. Altering the conditions of human procreation to incorporate more than two biological genetic contributors to edit the germline would exceed the boundaries of moral prudence.

4. CMDA opposes the creation of human embryos destined for destruction as raw material for reproductive or research programs. Even if we are not answerable directly to those lives who are not allowed to develop the capacity to protest their destruction, we are still answerable to God, who created us all and knew us all as persons when we were but embryos (Psalm 139).

5. CMDA affirms that children are not products to be manufactured, commodified, or controlled, but are blessings to be cared for and cherished.

6. Recognizing that children may come to be born through three-parent procreative biotechnologies, CMDA affirms that such children, whether healthy or genetically impaired, nonetheless bear the image of God and deserve full inclusion in the human community.

7. CMDA affirms that biotechnology and medical care directed toward treating children and adults living with mitochondrial and other genetic diseases are ethically praiseworthy.

8. Even if the biological, medical, and social difficulties were to be resolved, CMDA nevertheless has grave reservations on theological grounds concerning the procreation of human lives through biotechnologies involving genetic contributions substantial enough to constitute triple parentage, because these disrupt the biblical ideal of human procreation through the uniting of one mother and one father, which for the created order is normative and for Christians holds special value as the visible representation of Christ and His church.

Unanimously approved by the House of Representatives
May 4, 2017
Ridgecrest, North Carolina
References
2. Anonymous Us project at https://anonymousus.org
3. Donor Sibling Registry at https://www.donorsiblingregistry.com
Transgender Identification

CMDA affirms the historic and enduring Christian understanding of humankind as having been created male and female. CMDA has concerns about recent usage of the term “gender” to emphasize an identity other than one’s biological sex, that is, a sense of self based on subjective feelings or desires of identifying more strongly with the opposite sex or with some combination of male and female.\(^1,2,3,4,5\)

CMDA affirms the obligation of Christian healthcare professionals to care for patients struggling with gender identity with sensitivity and compassion. CMDA holds that attempts to alter gender surgically or hormonally for psychological indications, however, are medically inappropriate, as they repudiate nature, are unsupported by the witness of Scripture, and are inconsistent with Christian thinking on gender in every prior age. Accordingly, CMDA opposes medical assistance with gender transition on the following grounds.

A. Biblical

1. God created humanity as male and female (Genesis 1:27, 5:2; Matthew 19:4; Mark 10:6). God’s directives – to have dominion over the earth and to fulfill his goals of procreation, union, fellowship, and worship – are given to men and women together (Genesis 1:26-28, 2:18-24).
2. Men and women are morally and spiritually equal (Galatians 3:28) and are created to have roles that are in some respects alike and in other respects wonderfully complementary (Ephesians 5). (See CMDA statement on Human Sexuality)
3. All people are loved by God (John 3:16-17). All struggle with moral failure and fall short of God’s standards (Romans 3:10-12) and, therefore, need the forgiveness that God provides through Christ alone (John 3:36; Romans 3:22-24; Colossians 1:15-22; 1 Timothy 2:5-6).
4. We live in a fallen world (Genesis 3), and we are all fallen creatures with a sinful nature (Romans 3:9-12). The fall is expressed in nature and in humanity in many ways, including sexuality. Confusion of gender identity is but one example of the fall, as are also marital breakdown and sexual immorality (Romans 1:24-32; Ephesians 5:3).
5. A lifestyle that is directed by pursuing sexual desires or governed by personal sexual fulfillment\(^6,7,8\) misses the divinely ordained purpose of sex, which is for procreation and for facilitating unity in the lifelong commitment of marriage between one man and one woman, which fosters a secure and nurturing environment for children and which reflects the unity of Christ and the church (Exodus 20:1-18; Leviticus 20:10-21; Romans 1; Ephesians 5:23-33).

B. Biological

1. Sex is an objective biological fact that is determined genetically at conception by the allocation of X and Y chromosomes to one’s genome, immutable throughout one’s lifetime, and not a social construct arbitrarily assigned at birth or changed at will.
2. Human beings are sexually dimorphic. Male and female phenotypes are the outworking of sex gene expression, which shapes sex anatomy, determines patterns of sex hormone secretion, and influences sex differences in the development of the central nervous system and other organs.
3. Procreation requires genetic contributions from both one man and one woman.
4. Anomalies of human biological sex are an outcome of the fall and do not invalidate God’s design in creation.

C. Social

1. CMDA recognizes that gender identity issues are complex, and inclination to identify with the opposite gender may have biological, familial, and social origins that are not of the making of particular individuals.\(^9\)
2. In our current social context there is a prevailing view that removing traditional definitions and boundaries is a requirement for self-actualization. Thus, Christian healthcare professionals find themselves in the position of being at variance with evolving views of gender identity in which patients seek validation by the medical community of transsexual desires and choices that may be socially approved but which are contrary to a Christian worldview.
3. In contrast to the current culture, CMDA believes that finding one’s identity within God’s design will result in a more healthy and fulfilled life. CMDA believes, moreover, that social movements which contend that gender is decided by choice are mistaken in defining gender, not by nature, but according to desire. Authentic personal identity consists in social gender expression that is congruent with one’s natural biological sex. CMDA recognizes that this traditional view has become counter-cultural; however, CMDA affirms that God’s design transcends culture.
4. CMDA is concerned that efforts to impose transgender ideology on all society by excluding, suppressing,
marginalizing, intimidating, or portraying as hateful those individuals and organizations which, on scientific, moral, or religious grounds, reasonably disagree, are contrary to the freedoms of speech and religious liberty that lie at the very foundation of a just and democratic society.10,11

5. CMDA is concerned that efforts to compel healthcare professionals to affirm transgender ideology, provide medical legitimization for transgender psychology, or cooperate with requests for medical or surgical sex reassignment threaten professional integrity.

D. Medical
1. Among individuals who identify as transgender, use cross-sex hormones, and undergo sex reassignment surgery, there is well-documented increased incidence of depression, anxiety, suicidal ideation, substance abuse, and risky sexual behaviors.12,13,14,15,16,17,18,19,20,21 Patients’ gender-altering and sexual encounter choices are among the factors relevant to these health disparities in transgender patients as compared to the general population.22,23,24
2. Hormones prescribed to a previously biologically healthy child for the purpose of blocking puberty inhibit normal growth and fertility.25 Continuation of cross-sex hormones, such as estrogen and testosterone, during adolescence is associated with increased health risks including, but not limited to, high blood pressure, blood clots, stroke, and some types of cancer.26,27,28,29
3. Although current medical evidence is incomplete and open to various interpretations, some studies suggest that surgical alteration of sex characteristics has uncertain and potentially harmful psychological effects and can mask or exacerbate deeper psychological problems.30,31,32
4. Transient gender questioning can occur during childhood. There is evidence that gender identity has some degree of malleability and is influenced by psychosocial experiences, including therapeutic interventions.33,34,35,36,37,38
5. CMDA recognizes that exceedingly rare abnormalities exist in which chromosomal and phenotypic sex characteristics are in discord. These disorders of sex development include congenital adrenal hyperplasia, ambiguous genitalia, and androgen insensitivity syndrome. Treatment of these disorders differs categorically from transgender interventions, which are performed on persons whose sex phenotype is in agreement with their chromosomal sex designation.

E. Ethical
1. Medicine rests on science and should not be held captive to desires or demands that contradict biological reality. Sex reassignment operations are physically harmful because they disregard normal human anatomy and function. Normal anatomy is not a disease; dissatisfaction with natural anatomical and genetic sexual makeup is not a condition that can be successfully remedied medically or surgically.
2. The medical status of gender identity disorder as a mental or psychosocial disorder should not be discarded on the basis of social activism.
3. For Christians struggling with transgender inclinations, spiritual, psychological, and social support are needed, as attempts to change gender through hormonal or surgical interventions only lead to further spiritual turmoil and distress.
4. CMDA is especially concerned about the increasing phenomenon of parents of children who question their gender intervening hormonally to inhibit normal adolescent development.22,23,24,25 Children lack the developmental cognitive capacity to assent or request such interventions, which have lifelong physical, psychological, and social consequences.44
5. The purpose of medicine is to heal the sick, not to collaborate with psychosocial disorders. Whereas treatment of anatomically anomalous sexual phenotypes is restorative, interventions to alter normal sexual anatomy to conform to transgender desires are disruptive to health.45
6. The inability of men, including men who identify as women, to bear children is not an illness to be remedied by medical or surgical means, such as uterus transplantation.
7. Many diseases affect men and women differently, according to biological sex phenotype. Transgender designations may conceal biological sex differences relevant to medical risk factors, recognition of which is important for effective healthcare and disease prevention. As accurate documentation is necessary for good patient care, healthcare professionals should document patients’ biological sex and any alterations of gender characteristics factually in the medical record.

CMDA Recommendations for the Christian Community
1. A person struggling with gender identity should evoke neither scorn nor enmity, but rather our concern, compassion, help, and understanding. Christians must respond to the complex issues surrounding gender identity with grace, civility, and love.
2. The Christian community must help society understand that gender complementarity and fixity are both good and a part of the natural order. CMDA is concerned that attempting to reconstruct gender as something that is fluid and changeable through technical means would have grave spiritual, emotional, cultural, and
medical repercussions.

3. The Christian community and especially the family must resist stereotyping or rejecting individuals who do not fit the popular norms of masculinity and femininity. Parents should guide their children in appropriate gender identity development. For children who are experiencing gender identity confusion, the Christian community should provide appropriate role models and informed guidance.

4. The Christian community must condemn hatred and violence directed against those struggling with gender identity. Love for the person does not equate with support of the decision to change sex anatomy or gender identity.

5. For the sake of the common good, Christians should welcome inclusion of transgender individuals but oppose claims to grant special rights based solely on transgender identification.

6. The Christian community is to be a refuge of love for all who are broken – including sexually broken – not to affirm their sin, nor to condemn or castigate, but to shepherd them to Jesus, who alone can forgive, heal, restore, and redirect to a Godly, honorable, and virtuous way of life. God provides the remedy for all moral failure through faith in Jesus Christ and the life-changing power of the Holy Spirit.

CMDA Recommendations for Christian Healthcare Professionals

1. CMDA advocates culturally competent medical care of patients who identify as transgender. Such care requires our compassion, an open and trusting dialogue, a genuine effort to understand and respond to the patient’s psychological distress, and acceptance of the person without necessarily agreeing with the person’s ideology or providing a requested sex-altering intervention.

2. CMDA believes that the appropriate medical response to patients with gender confusion should be to support and encourage them in areas we can affirm and to help them understand themselves as people God loves and who are made in his image, even when we cannot validate their choices. We should validate their right as individuals in a free society to make decisions for themselves, while explaining that their right does not extend to obligating the healthcare professional to prescribe medication or perform surgical procedures that we believe to be harmful, such as interventions that deface, disfigure, or mutilate the patient’s biological sex.

3. CMDA believes that Christian physicians should not engage in hormonal and surgical interventions that alter natural sex phenotypes, as this contradicts the basic principles of Christian medical ethics, which regards medical treatment as intended to heal and not to harm.

4. CMDA believes that prescribing hormonal treatments to children or adolescents to disrupt normal sexual development for the purpose of gender reassignment is ethically impermissible, whether requested by the child or the parent. (See CMDA statement on Limits to Parental Authority in Medical Decision-Making, and Abuse of Human Life)

CMDA Recommendations Regarding Nondiscrimination

1. Mutual respect and civil discourse are cornerstones of a free society. The Christian healthcare professional should respect how a patient wishes to be addressed.

2. Christian healthcare professionals, in particular, must care for their patients with gender identity disorders in a non-judgmental and compassionate manner, consistent with the humility Jesus modeled and the love Jesus commanded us to show all people.

3. Those who hold to a biblical or traditional view of human sexuality should be permitted to question transgender dogma free from exclusion, oppression, or unjust discrimination. Healthcare professionals who hold the position that transgender identification is harmful and inconsistent with the will of God should not be stigmatized or accused of being bigoted, phobic, unprofessional, or discriminatory because of this sincerely held and widely shared belief.

4. To decline to provide a requested gender-altering treatment that is harmful or is not medically indicated does not constitute unjust discrimination against persons. CMDA affirms that healthcare professionals should not be coerced or mandated to provide or refer for services that they believe to be morally wrong or harmful to patients. (See CMDA statement on Healthcare Right of Conscience)

5. Healthcare professionals must not be prevented from providing counseling and support to patients who are experiencing confusion in regard to gender orientation and who request assistance with accepting and maintaining their biologic sex and gender identity.

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April 21, 2016
Ridgecrest, North Carolina


33 Zucker KJ. Gender identity development and issues. Child Adolesc Psychiatr Clin N Am 2004; 13(3): 551-568. "... because GID seems to desist in most children, it seems that gender identity has some degree of malleability that likely is influenced by psychosocial experiences, including therapeutic interventions."


Unionization

The Patient – Doctor relationship today is subjected to unprecedented pressures. These include economic strategies by third-party payers and employers, increasing regulation by governmental agencies, and the bureaucratization of medicine itself.

Unions are proposed by some as a mechanism to provide doctors with a unified voice for expression of concerns and grievances, with a more powerful vehicle for self-representation, and for increased leverage in negotiations to improve patient care.

However, unionization of medical professionals is an ethically dubious strategy for addressing these issues because some strategies of unionization conflict* with the needs of patients, and erode medicine’s foundational principles.

- The traditional mechanisms by which unions ultimately protest – work stoppage or slowdown – jeopardize patient care.

- Historically, the effects of unionization have conflicted with and diminished the spirit of self-sacrifice characteristic of medicine as a calling.

- Action taken by doctors in protest or strike – especially to negotiate monetary reward for the practice of medicine and dentistry – could be perceived by the public as self-serving, and could violate the covenant relationship inherent in our calling.

- Christians are called to emulate the self-sacrificing life of Christ; to obey legitimately governing authorities; and to serve God, not money. Unions tend to re-direct even Christian doctors’ professional priorities away from these values.

While there are legitimate concerns which drive the unionization movement, we urge that doctors use means other than unionization to resolve those concerns.

*See Conflict of Interest Statement passed by House of Delegates in 1994.

Passed by the House of Delegates
52 approvals, 2 abstentions.
June 13, 2001 San Antonio, Texas.
Valid Consent in Shared Decision-Making

Good communication is a necessary part of the practice of medicine and dentistry. The honesty and integrity that independent healthcare professionals (IHP) exemplify in their daily practice is, for Christians, an expression of the command that we love God and that we love our neighbor as ourselves (Matt 22:37-40).

Truthfulness in the presentation (Eph 4:25) and representation (Eph 4:15) of medical information is an integral part of medical and dental care. When engaging in the medical or dental decision-making process, the doctor is obligated to disclose accurately, and in a manner that the patient can comprehend, the information needed for the patient to make an autonomous decision. The Christian IHP seeks not only to abide by legal standards for informed consent but also, respecting that our patients are persons made in the image of God, to invite them to share actively in medical decision-making and setting goals of care. This requires our commitment to the process of consent and also to our patients’ care, relieving their suffering and avoiding harm. Our purpose is to communicate this commitment effectively and foster patients’ trust throughout the shared decision-making process.

Valid consent should include presenting the information to the patient appropriately, assessing the decision-making capacity of the patient, and ensuring a voluntary decision. Shared decision-making also includes a discussion and understanding of the values and goals of the patient. The IHP of record is responsible for ensuring adequate discussion of the risks and benefits of, as well as alternatives to, the planned medical or surgical intervention. The IHP is not obligated to a course of action that is unsupported by scientific evidence or that is contrary to his or her conscience or professional judgment (see CMDA statement on Healthcare Right of Conscience).

There are certain situations in which the IHP may not be able to obtain consent directly from the patient. Typically, this occurs when the patient does not have decision-making capacity or when such has been delegated to another person. In these situations, the IHP communicates with the patient’s healthcare agent to discern the best course of action (see CMDA document on Healthcare Agent). Additionally, in clinical practice urgent situations may arise when no healthcare agent or family member is available, in which case implied consent and patient’s best interest standards apply.

The Bible instructs the people of God to act justly, love mercy, and walk humbly with God (Micah 6:8). CMDA believes that these virtues are honored in patient care by listening to the patient and engaging in shared decision-making in the process of obtaining valid consent.

Approved by the House of Representative
Passed unanimously
April 24, 2014, Green Lakes, WI

9 Throughout the document “patient” also includes surrogates for decision making.
10 The patient does not comprehend the information or has an unrealistic understanding of the situation.
Vegetative State

I. Rationale for the Opinion
As Christian physicians, we seek to practice our profession in accordance with the Word of God, and the leading of the Holy Spirit. Medical science and technology have made it possible to keep patients alive when they are in a vegetative state. Even among Christians there is considerable controversy over the status and treatment of these patients. Biblical teaching does not provide explicit guidance to patients, their surrogates, and their physicians for making treatment decisions in these challenging situations. We issue this opinion to help Christian physicians care for such patients.

II. General Principles
A. God is the Creator and is sovereign in all circumstances and conditions.

B. God created all humans in His image, and therefore all human life has inestimable worth.

C. God has entrusted us with our lives and resources. We are responsible to Him for our healthcare decisions. We desire to be wise and trustworthy stewards of what God had given us to use.

D. When humans die, their eternal destiny rests with a just and loving God. For a Christian, to be absent from the body is to be at home with the Lord; therefore, death need not be resisted at all costs. (See the opinion on Patient Refusal of Therapy).

E. All patients, regardless of their diagnosis or condition, must be treated with dignity, and we should continue to pray for their healing.

F. As physicians, we are never to kill patients or assist in their suicide (See Opinions on Physician-Assisted Suicide and Euthanasia).

III. Definitions
A. While much of the medical literature refers to individuals who suffer severe cortical dysfunction as "vegetative," we must be careful not to dehumanize our patients through our language, attitudes, or actions. Patients said to be in a vegetative state are neither dead nor less than human ("vegetables").

B. A person is said to be in a vegetative state when he or she exhibits no evidence of cortical brain function, but exhibits some brain stem function. This is a descriptive term. A person is said to be in a persistent vegetative state when repeated careful clinical examinations confirm that the condition has continued for some length of time. This is a diagnostic term. A patient is said to be in a permanent vegetative state when sufficient time has passed that the professionals involved believe there is no reasonable probability that the condition will improve. This is a prognostic term. Patients in a vegetative state are unaware of themselves and their environment and are unable to interact with others. They may breathe on their own and retain some brainstem reflexes, possibly including the ability to swallow.
IV. Recommendations

A. To respect the sanctity of human life and to be good stewards of it, Christian physicians ought to ensure that the diagnosis and prognosis of the permanent vegetative state are correct. Once the prognosis is established, and recognizing that God is not dependent on our technology to effect His perfect plan, the use of medical technology to prolong these patients’ earthly existence may not be morally required in all cases.

B. The decision regarding the use of technology should have been made by the patient (by use of an advance directive prior to cortical injury) or be made by the patient’s surrogate attempting to decide as the patient would have decided. Patients and surrogates may decide to refuse procedures and/or artificial supports to life or to have them discontinued. While artificially administered nutrition and hydration may be considered an artificial support to life, food and water by mouth should be offered to all patients. Sincere Christians differ about the morality of withholding or withdrawing artificially administered nutrition and hydration from patients in a permanent vegetative state. There are compelling arguments on both sides. Since we hold that withdrawal of nutrition or hydration for the specific purpose of taking a patient's life is impermissible, we suggest that anyone (either patients and surrogates or physicians) faced with such a decision weigh both sides of the issue prayerfully and seek God's will in reaching a decision.

C. Remembering that God is sovereign, we suggest that each Christian physician seek His guidance prayerfully, and solicit the wise counsel of others in the management of these patients. If a physician, because of moral convictions, is unable to comply with the patient's or surrogate's wishes to withhold or withdraw artificially administered nutrition and hydration, it is appropriate for the physician to withdraw from the care of the patient as soon as another physician assumes that care.

D. As Christian physicians we desire to share the love of Christ with others. We will treat the families of patients who are in a vegetative state with compassion, kindness, humility, gentleness, and patience, as we assist them in making these decisions.

Approved by the House of Delegates
Passed with 61 approvals, 2 opposed, 4 abstentions
May 2, 1998, Cincinnati, Ohio.

Explanation

The vegetative state was first described in 1972. It is now a commonly recognized clinical entity which results primarily from failed technology. Before the medical profession was able to resuscitate patients and maintain physiologic support, almost all patients with such severe brain damage succumbed to their acute illness or injury. Using current technology, thousands of patients have been successfully resuscitated only to find at a later time that they were able to recover homeostatic stability, but not cognition. After several days or weeks of intensive support, most of these survivors in the permanent vegetative state can continue to live for long periods of time if they receive good nursing care plus artificially administered fluids and nutrition. With such care, there have been reports of 30-year survival.
The potential for prolonged survival of these severely brain-damaged individuals raises questions about the definition of life vs death, the appropriate goals of medicine, the cost of medical care for severely disabled individuals, and the degree of certainty needed for decision-making in such cases.

Secular Perspective

The secular debate about care for PVS patients has been dominated by discussions of data. Are there clear boundaries for the clinical diagnosis of the PVS? What are the chances for survival of a particular patient? How early after a devastating brain injury can we have a high degree of certainty of the long-term outcome?

Some of the secular debate has gone beyond the data to look at personal, professional and societal values. Since most people surveyed consider life in the PVS to be "as good as dead" or "worse than death", some have suggested that a patient with no cortical brain function (including those in the PVS, infants born with anencephaly, etc.) should be considered dead, so-called "neocortical death." This would not only save financial resources and caregiver burden, but would introduce another large source for transplantable organs. Most are hesitant to make this major move because of the significant conceptual problem with seeing a "dead" person who is still breathing.

In spite of this current reluctance to redefine death to include PVS patients, there is not societal consensus on how to treat PVS patients. There is a wide variability of recommendations about the use of life-sustaining treatment in such patients. Since most people would opt to forego life-sustaining treatment for themselves if they should be in the PVS, some have argued that the default management option for PVS patients should be non-treatment, shifting the burden from those who want to discontinue treatment to those who want to continue it.

Christian Perspective

There is not a unanimous Christian voice or perspective on this issue. When the Ethics Commission of the CMDS wrote an opinion statement on the Withholding and Withdrawing of Nutrition and Hydration in 1989, it could not reach consensus on the use of this modality in PVS patients. Discussion has continued, and differences of opinion remain.

There are some Christians who maintain that, because patients in the PVS can survive for a long time, the sanctity of that individual human life is the most important consideration, and we are therefore obligated to provide the needed sustenance, even if we decide to withhold other more invasive treatments. They would argue that artificially administered fluids and nutrition are not treatment, but are a sign of continued loving care.

There are others who maintain that, because patients in the PVS are exceedingly unlikely to recover cognizance and they cannot take nourishment without mechanical assistance, they are terminally ill, and we therefore have no moral obligation to artificially postpone their deaths. They would maintain that artificially administered fluids and nutrition are treatment, and are therefore optional when a decision has been made to no longer attempt to forestall death.

This statement on The Vegetative State is an attempt to articulate pertinent principles, clarify definitions, and to give some guidance to Christian healthcare professionals, pastors and laypersons as they deal with the realities of this clinical entity.

Abstracts


The author discusses the PVS in the light of Christian beliefs. He explores the possible suffering of the PVS patient, Christian arguments for the withholding of food and liquids and raises the issue of the Biblical concept that man is made in the image of God. He concludes, "Our God is in the business of protecting and nourishing broken, discarded lives which seem to have little meaning. He can use these tragedies to let his glory shine into a dark and painful world. His images should respond likewise."

"We were a group of Christian friends searching for affirmations that lay at the heart of our faith and reached to the limits of our existence and moral authority. As we have reflected on our role in deciding whether and to what extent we could assist in allowing our terminally ill friend, seventy-nine-year-old Norman to die, we were deeply troubled by the moral ambiguity of our involvement. Through a careful process of authority through communal discernment, our responsibility for Norman became clear: we were to assist him in living the life he embraced in baptism – a life which included a destiny that was conformed to the crucified and risen one. That was not the destiny we chose for Norman; it was the destiny he owned. We recognized with Norman that our lives are not our own to be guided by autonomy and liberty, but rather to be lived for the glory of Jesus the Christ."


"Medical decisions regarding end-of-life care have undergone significant changes in recent decades, driven by changes in both medicine and society. Catholic tradition in medical ethics offers clear guidance in many issues, and a moral framework accessible to those who do not share the same faith as well as to members of its faith community. In some areas, a Catholic perspective can be seen clearly and confidently, such as in teachings on the permissibility of suicide and euthanasia. In others, such as withdrawal of nutrition and hydration, the Church does not yet speak with one voice and has not closed out the discussion. Yet, it is not in the teaching in individual issues that a Catholic moral tradition offers the most help and comfort, but in its account of what it means to lead a life in Christ, and to prepare for a Christian death. As in the problem of pain and suffering, it is the spiritual support more than the ethical guidance that helps both patients and physicians bear the unbearable and fathom the unfathomable."


"'Best interests' is widely accepted as the appropriate foundation principle for medico-legal decisions concerning treatment withdrawal from patients in persistent vegetative state (PVS). Its application appears to progress logically from earlier use regarding legally incompetent patients. This author argues, however, that such confidence in the relevance of the principle of best interest to PVS is misplaced and that current construction in this context is questionable on four specific grounds. Furthermore, it is argued that the resulting legal inconsistency is distorting both the principle itself and, more particularly, individual patient interests."


In this article, 2 members of the CMDA Ethics Commission take opposing viewpoints about the moral requirement for continued use of tube feedings in a case study involving a family whose son has been in a persistent vegetative state with no improvement for 7 years.


This consensus statement was developed by experts from the American Academy of Neurology, the Child Neurology Society, the American Neurological Association, the American Association of Neurological Surgeons, and the American Academy of Pediatrics. Part 1 addresses definition and clinical aspects, related terms and conditions, epidemiology, pathologic features, and ancillary diagnostic studies. Part 2 covers prognosis for recovery, survival, pain & suffering, treatment, and future directions.

The 2-part article includes several useful tables and graphs as well as 152 references. The data presented point out the significant differences in prognosis between PVS from traumatic (better) and non-traumatic (worse) causes, as well as the differences between children (better) and adults (worse).


The author recognizes that the ethical and legal ramifications of the MSTF consensus statement are enormous. After carefully analyzing the statement, he concludes "...first, that the conception of (un)consciousness invoked ... is conceptually incoherent; second, that even if one were to invoke a coherent, widely accepted conception of (phenomenal) consciousness, the MSTF has failed to provide
good reason for believing that all PVS patients lack consciousness so conceived; and, third, that [it] does more than simply summarize medical facts about this unfortunate psychophysical disability; rather it attempts, under the guise of medical science, to advance its own inchoate, idiosyncratic ethical and more broadly philosophical ideologies."


Of 40 patients admitted to a rehabilitation facility, 17 (43%) were misdiagnosed. All of the 17 were severely disabled, but nearly all were able to communicate their preferences in quality of life issues. The author concludes "The vegetative state needs considerable skill to diagnose, requiring assessment over a period of time; diagnosis cannot be made, even by the most experienced clinician, from a bedside assessment. Accurate diagnosis is possible but requires the skills of a multidisciplinary team experienced in the management of people with complex disabilities. Recognition of awareness is essential if an optimal quality of life is to be achieved and to avoid inappropriate approaches to the courts for a declaration for withdrawal of tube feeding."

Andrews K. Recovery of patients after four months or more in the persistent vegetative state. BMJ 1993;306:1597-1600

Eleven of 43 patients in this study regained some awareness after 4 months or more in a clearly diagnosed vegetative state. Although only 2 regained full independence, all but one regained the ability to communicate. The recovery period was prolonged. The author concludes that "even patients with profound brain damage should be offered the opportunity of a specialist rehabilitation programme."

Bibliography


This was the first and one of the more authoritative empiric studies (of 210 patients) which attempted to predict long-term outcomes based on early examination after hypoxic brain damage.


This more recent study based on data from the SUPPORT Study concludes that 5 readily available clinical variables present on the third day after the onset of nontraumatic coma can identify a large subgroup of patients at high risk for poor outcomes. The 12 authors propose that the risk identification
approach offers physicians, patients, and patients' families information that may prove useful in patient care decisions and resource allocation.


This survey of members of the CNS deals with the unique challenges in the diagnosis and management of this condition in infants and children.

Christensen DW, Jansen P, Perkin RM. Outcome and acute care hospital costs after warm water near drowning in children. Pediatrics 1997;99:715-21

This retrospective chart study of 274 children admitted after near-drowning concludes that no combination of variables could accurately separate all intact survivors from the vegetative and dead patients. The authors encourage initial aggressive treatment before any consideration of limitation of treatment.