The Standing Commission on Health

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MEMBERSHIP

The Rt. Rev. William E. Swing, *Chair,* Diocese of California
The Rt. Rev. Robert W. Estill, Diocese of North Carolina
The Rev. Mwalimu Imara, Diocese of Atlanta
The Very Rev. George L. W. Werner, Diocese of Pittsburgh
Dr. A. Dale Brandt, Diocese of Eastern Oregon
Dr. Carolyn Gerster, Diocese of Arizona
Dr. Lillian Robinson, Diocese of Louisiana
Ronald L. Stockham, Esq., Diocese of New Jersey
Dr. Charity Waymouth, Diocese of Maine

In addition, the Rev. Dr. Sjoerd Bonting of the Diocese of El Camino Real attended most of our meetings; Mrs. Harold Nicrosi, Diocese of Alabama, was our Executive Council Liaison; and the Rev. Tally Jarrett, Diocese of San Diego, was in charge of all arrangements.

SUMMARY OF THE COMMISSION'S WORK

The Commission met four times, once in Florida (Duncan Center), once in Pittsburgh (Trinity Cathedral), and twice in California (Mercy Center, Burlingame).

FINANCIAL REPORT

Income	*1989*	*1990*	*1991*
Appropriated	$10,667	$10,667	$10,667
Expenses	10,667	9,912	

Please Note:

At the 70th General Convention, the Very Rev. George Werner will accept non-substantive changes from the House of Deputies. The Rt. Rev. William Swing will do the same in the House of Bishops.

REPORT OF THE STANDING COMMISSION ON HEALTH (1989-1991)

I. Introduction

At this time the Church's attitude toward health concerns is directed toward a few issues but avoids a comprehensive approach. While the Church may make statements on abortion and on substance abuse, it is quiet on many other health problems, such as a national health care policy, medical ethics, nutrition, exercise, stress control, healing services, and environmental pollution. The Standing Commission on Health feels that our nation is at a critical moment regarding issues related to health. Therefore, we want to encourage each diocese to establish a Health Concerns Committee to address these issues, establish goals or guidelines for healthy Christian living, raise up leaders, and assist the Church in voicing ethical insights in national debates on health matters. It is hoped that a dialogue will develop between the Diocesan Health Concerns Committees and the Standing Commission on Health during the next triennium.

A. The problem

Everyone is aware of the crisis in obtaining affordable health insurance, but that is just the tip of the iceberg. Why should having health insurance ever be a question? What about the high incidence of disease that should never happen in the first place? What about cardiovascular disease that springs from smoking, wrong diet, insufficient exercise, undetected hypertension? What about the excessive stress that contributes to 80% of our serious illness (T.H. Holmes and R.H. Rake, Journal of Psychosomatic Research, II: 213-219, 1967)? What about the relation between our diet and cancer? What about the rapid scientific advances in the fields of genetic manipulation and transplantation?

Our nation pours billions of dollars into a health care system that largely manages pathology of people who are approaching death or are victims of trauma. As Dr. Gruenberg, of the Johns Hopkins University School of Hygiene and Public Health, stated: "Now that we recognize that our lifestyle technology of the past four decades has outstripped our health-preserving technology, the net effect has been to worsen health. We must begin to search for prevention of chronic illnesses."

B. The solution

Obviously, the Church is not going to solve the health care problems that confront this nation. Nevertheless, our commission feels a moral resolve to call upon each diocese to address these problems in an aggressive way. We can and must be responsible for health promotion and disease prevention. It would be immoral to remain quiet and uninvolved in the present health crisis. Furthermore, we have resources of the Spirit that need to come into action. Our Lord came "preaching, teaching and healing." If we are to be faithful, we who so honor his preaching and teaching must also honor his healing.

II. Theological Considerations

A. Humans as created beings in a created world

Our belief about Creation is summed up in the opening lines of the Nicene Creed: *We believe in one God, the Father, the Almighty, maker of heaven and earth, of all that is, seen and unseen.* . . . The Creator does not come forth from the primeval matter, is not dependent on matter, is absolute and timeless. Through his autonomous and all-powerful Word, creation takes place. His creation evolves, but he does not. He continues his creative work and brings his creation to completion. Creation is a continuous activity

of God, including origin and evolution, laws of nature and chance, biological and technological evolution, time and eternity.

Humankind is created in the image of God, in the likeness of God, who blesses these humans and tells them to rule over all the earth and its creatures. "And God saw that it was very good" (Gen. 1:26-31). Humans receive the earth as a loan, to make it habitable, to populate it and to cultivate it with the help of God, whose possession it is. This Creation faith has a number of consequences:

1. Humans and nature have their deepest ground of existence not in themselves but in God, their Creator. This means that humans and nature are not divine but finite and limited. Yet our finiteness is neither sinful nor shameful but a normal condition of our creatureliness. We must be content to be mere humans in a mere world.
2. The creation is good because God has wanted it and has made it. Thus nothing in creation is wrong or imperfect of itself; it only become so through our wrong use of it.
3. Being in the image of God implies that humans must use their God-given talent of creativity to cultivate the earth, thus fulfilling God's charge to them. So science and technology, whether primitive or advanced, are in principle necessary and good.

B. Human ambivalence

The story of human origins in the first three chapters of Genesis tells us that human beings are ambivalent creatures. On the one hand: 1. Humans are created in the likeness of God (Gen. 1:26-31), i.e., only humans can communicate with God, think about themselves, their surroundings, and their Creator. 2. Humans are given to rule over all the earth and its creatures. 3. In naming all the animals (Gen. 2:19-20), humans interpret and order God's creation, pursue science and technology. On the other hand: 1. Humans are earth-bound creatures, not divine, dependent on God's life-giving spirit. 2. They are to live in community with God in a created world in obedient service to their Creator.

The symbol of this obedient service to the Creator is the tree of the knowledge of good and evil in the garden of Eden (Gen. 2:8-17), where God placed Adam and Eve, telling them to cultivate the garden and to feel free to eat from any of the trees, except from that one tree. The knowledge of good and evil is a Hebrew expression for the kind of full and comprehensive knowledge that brings to its possessor the power and independence that rightfully belong only to the Creator. Humans are continually tempted to acquire that power and independence. In pursuing scientific and technological advances they must constantly reach beyond themselves in mastering new knowledge and skills, so that even without any conscious evil intent they come close to grasping for "the knowledge of good and evil," for equality with God. Every application of new scientific knowledge brings with it its own problems and potential for evil. When Adam and Eve succumb to the temptation to eat from the fruit of the tree of knowledge (Gen. 3:1-24), they suddenly see their nakedness, they see themselves as they really are, in their spiritual and moral nakedness, their brokenness: as God's creatures who are not satisfied with being in his likeness, but who also want to be equal to God. Thereby they cut themselves off from their nearness to him in the paradise he gave them, and they become wanderers in the desert of this earthly life, of the high-technology society in this present era.

Human ambivalence thus consists of the presence of two opposing traits in one creature: grandeur and brokenness. The grandeur of humans is being God's image bearers, who may rule over the entire Creation in their God-given creativity, in the pursuit of science and technology for the well-being of humankind and for the glory of God their Creator. The brokenness of humans makes them restless aspirers, who again and again

are grasping for equality with God, misusing their God-given creativity, their science and technology, for their own glory, power, and wealth. Human ambivalence thus also taints our medical science and technology. To this we address ourselves in this report of the Standing Commission on Health. We may do this in the joyful knowledge that the Incarnation of God's Spirit in the man Jesus has in principle resolved our human ambivalence once and for all. In the words of St. Paul, "As sin and death enter the world through the disobedience of Adam, so through the obedience of the man Jesus Christ righteousness and life return to the world and mankind" (Rom. 5:12-19).

In considering the vital issues of health care and biomedical ethics we have been aware of four cardinal truths in our faith:

—The sacredness of all human life, affirmed by the 69th General Convention in 1988, which has been the basis for all our discussions, but particularly those on the prolongation of life, infertility and reproductive technology, and abortion;

—Our Lord's injunction to feed the hungry and thirsty (Mt. 25:31-46), which to us implies the solemn obligation to provide adequate medical care to all his children, regardless of ability to pay. This has been in our thoughts in speaking about genetic manipulation, transplantation, and allocation and access in health care;

—The responsibility for the care of our bodies, as implied in the words of Paul: "You are God's temple and God's spirit dwells in you" (1 Cor. 3:16). This is the basis for our speaking on alcohol and drug abuse and holistic health care.

—The fact of the limitation of our earthly life: "Man that is born of a woman is of few days" (Job 14:1). While we live in the promise of the life to come, this limitation has permeated our discussions about the prolongation of life.

III. Genetic Manipulation

A. Definition and description

Important advances have been and are being made in the field of biotechnology, which is the production by means of genetically manipulated cells of (a) medicinal materials or (b) therapeutic effects (gene therapy).

Examples of (a) are human growth hormone, human insulin, erythropoietin (cures anemia associated with kidney disease), tissue plasmin activator (dissolves blood clots after heart attacks), which are on the market. Many other promising materials are in the process of development and testing. A multitude of useful diagnostic aids (monoclonal antibodies) are produced in this way.

Gene therapy of hereditary disease (b) is the subject of a clinical study, and may well be ready for use in one or two diseases in another five or ten years. The currently studied application is based on the insertion of a missing gene in lymphocytes from a patient, multiplication of the altered cells in vitro, followed by reinsertion of the cells in the patient. This approach is only possible when the genetic defect is in cells that continue to multiply in the patient, so that the altered cells can "overgrow" the patient's faulty cells. This is true for a small minority of hereditary diseases. For the others, where the defect is in cells that do not multiply in adults, the genetic manipulation would have to take place in a germ cell, e.g., in a fertilized ovum. This has been accomplished in animals but has not yet been attempted for humans. It could not cure persons who have the disease, but it could prevent the disease in their offspring.

B. Risks

Risk of the laboratory work involved in genetic manipulation has been studied extensively, and guidelines have been formulated by the National Institutes of Health. After more than a decade of widespread application of genetic manipulation without a single accident, it is now clear that the risk is very low. The guidelines have therefore been relaxed, and in 1982 they were made voluntary. The medicinal materials, produced by biotechnology, have to be approved by the Food and Drug Administration before they can be administered to patients, as is required for any new drug.

There are two risks involved in gene therapy. First, the inserted gene could become located on a chromosome in a postion where it might interfere with the function of other genes. Although this has not occurred in animal experiments, it calls for prudent planning and checking of the procedure. Second, gene insertion in germ cells implies that the inserted gene will be passed onto the offspring, which may not always be desirable. Gene therapy experiments require approval by an expert committee of the National Institutes of Health and other clinical investigation committees.

C. Ethical aspects

Genetic manipulation in the laboratory does not differ in principle from conventional breeding practices for animals and plants, which also involve gene manipulation. Likewise, the use of medicinal materials, produced by genetic manipulation, for therapeutic, preventive or diagnostic purposes, does not differ in principle from the use of conventional drugs. There can, therefore, be no ethical objection to the production and use of these materials as long as they are aimed at the prevention or alleviation of human suffering. The treatment of persons with human growth hormone for frivolous purposes, like athletic excellence, would not seem to qualify.

Gene therapy, if proved to be effective without undue risk to the patient and if aimed at prevention or alleviation of serious suffering, should likewise be ethically acceptable.

The rapid advances in genetic screening of adults, the newborn and the unborn raises a number of ethical questions that need to be answsered in the near future: Could genetic testing lead to discrimination in jobs and insurance? Could it lead to more abortions? Should someone destined to be stricken with a fatal or crippling hereditary disease be told about this if no cure is yet available?

An entirely different ethical aspect of genetic manipulation is that of availability on the basis of financial worth. With the current state of health care delivery in the United States, the benefits of this new technology are not equally available to all.

IV. Transplantation

When certain body parts fail to perform their specialized functions, or are lost or damaged, the question is, How may these functions be restored? In some cases, this is relatively simple. Diabetics can take insulin rather than receive a new pancreas. In the case of blood, a failure of the blood-forming tissues to function properly, or a severe loss of blood, may be treated with transfusions. In the case of a failing cornea, kidney, heart, lung, or liver, transplantation of a donor organ can replace the failing organ.

There is, however, the problem of rejection of the donor organ by the reaction of the body's immune system against foreign tissue. Early in this century research disclosed that blood from one person may be donated to another, but that the transferred blood cells must "match," i.e., be compatible with those of the recipient. This led to the discovery that human blood falls into four major immunologically distinct groups, named

A, B, AB, and O. Usually the blood of donor and recipient must be of the same group, although group O, whose carriers lack these distinctive antigens, may be safely used for those of other blood groups.

Thus it became evident that tissue and organ transplantations also depend upon immunological matching of donor and recipient. Because full immune potential is not developed before birth, human fetal tissues may sometimes be sought to provide safe material for therapeutic purposes. Some countries, e.g., Great Britain and Germany, have outlawed such use of fetal tissues. Where there is no prohibition, important ethical issues may be raised: Would it be acceptable for a woman to conceive a child for the purpose of aborting the fetus and allowing its tissues—e.g., bone marrow or skin—to be used to treat another person? Would it be acceptable if such "donations" were commercial transactions?

Human fetal tissue transplants have been used experimentally for the alleviation of diabetes, Parkinson's disease and thalassemia, but the United States government will not provide funds for the support of such research, arguing that government approbation of such a practice might provide an incentive for women to have abortions for profit. The American Medical Association has aruged for restoration of funding to allow the benefits of these techniques to be assessed.

Donations of organs are sometimes made from healthy persons who have died in an accident. Such tragedies may thus enable other persons to live by securing them a healthy heart, lung, kidney, cornea or skin. In emergencies, such organs and tissues may be useful, but if the donor tissue does not match immunologically, the continuous use of anti-immune drugs to prevent rejection of the foreign tissue may be needed.

Living persons obviously cannot donate hearts but may be blood donors or may donate pieces of skin (which grows back) for repair of burns, or a kidney (as the donor can survive with only one kidney.)

In seeking donors it is important that financial advantage not be a primary motivation and that coercion not be applied to potential donors. Although pregnancies followed by abortions solely to harvest tissues would be unethical, it is arguable that, where an abortion is required to safeguard the health or life of the mother, the use of such tissues for therapeutic purposes might be acceptable.

One may then ask, should the Church take positions on some of the following ethical questions:

—Support the donation of healthy organs from persons who are the victims of fatal accidents?

—Support the use of fetal tissues from healthy fetuses aborted to save the life of the mother, but not the use of fetal tissues aborted to provide tissues for profit?

—Support widespread typing of tissues, as well as blood, so that organs of accident victims could be immediately used for the benefit of others?

—Reject the practice of pregnancy for the purpose of providing fetal tissues?

V. Holistic Health Care

Modern medicine's biomedical model is based on the idea that the body is a machine and that disease can be understood by analyzing the functioning of the different body parts down to the molecular level. This has brought great advances in diagnosis and treatment of disease. Yet overall health has not improved significantly. We experience an epidemic of chronic diseases (cardiovascular disease, cancer, diabetes, arthritis, chronic

lung disease, cirrhosis of the liver), our medical expenses rise rapidly, and life expectancies have changed little since 1900. New causes of morbidity and mortality have arisen through AIDS, substance abuse, and suicide.

Modern medicine has been most effective in treating acute infectious disease and nutritional deficiencies. It is much less effective in dealing with the chronic diseases, where alleviation and some extension of life is achieved only through costly interventions like coronary bypass surgery, organ transplantation and renal dialysis. We are now becoming aware that lifestyle and environmental factors, like smoking, substance abuse, wrong diet (excess fat, low fiber, additives), lack of exercise, stress and undetected hypertension play a large role in causing this morbidity.

A new approach to health, a holistic approach with emphasis on prevention, is needed to cope with the health crisis. The holistic approach holds that true health is achieved when the self is expressed through the balance of the mind, body and spirit through the exercise of responsibility rather than through the mere delivery of medical care. It recognizes that body and mind are constantly influencing each other. Thoughts, feelings, emotions are expressed biochemically in the body. Emotional stress affects the nervous, endocrine and immune systems.

Helping people to cope with stress is attempted through psychological counseling, relaxation, meditation, hypnosis and biofeedback. Nutritional imbalances are assessed through analysis of diet, blood and urine, and a nutrition prescription is then given to the patient. Environmental health risks can be assessed through analysis of blood, urine and hair, and recommendations aimed at improvment can be based on the results. For improvement of spiritual health, pastoral counseling, prayer, meditation, and laying on of hands for healing is recommended. The goal is spiritual attunement, our ability to be in touch with the meaning and purpose of our lives, a deep understanding of our relationship to ourselves, to nature and to God, which will make us more loving and caring persons dedicated to the art of living.

The holistic approach is seen as an extension of the biomedical approach. Several major studies have shown the need and the effectiveness of this approach for health promotion and disease prevention.

(Based on the paper "Optimum Health and Wellness: A Holistic Approach" by James H. Carter, Jr., M.D., Atlanta, GA, August 1990.)

VI. Allocation and Access in Health Care

A. Access

In Canada, Great Britain, Japan and the Netherlands, everyone has access to basic health care. In our rich and resource-filled United States, 35 million people are without health insurance, Medicare or Medicaid coverage. About 80% of these people are workers (and their family members), whose low-wage jobs do not provide health insurance.

In a land where gleaming hospital towers are the home of state of the art equipment and the latest in advanced research, our infant mortality rate is highest of all industrialized nations (1%), life expectancy is lowest (71.3 years for males at birth). However, our total health expenditure (12% of GNP) is the highest of all advanced nations, although government health expenditure is the lowest (4.5% of GNP).

In a nation that prides itself on its quality of life, emergency rooms are shutting down at a frightening pace, obstetricians and other specialists are leaving practice, claiming impossible malpractice premiums, and we now lead the world in Cesarean Sections (18 per 100 births against only 10 in Western Europe), due in part to an apparent overkill of litigation.

The 1985 Report of the Secretary's Task Force on Black and Minority Health of the United States Department of Health and Human Services clearly documents a wide health status disparity between Blacks, Latinos and Native Americans as contrasted with Whites in our country. Congressman Louis Stokes in "The Health of Black America" *(Health Aims,* 1988) describes a two-tier system with a drastic difference of health service to the poor, underinsured, uninsured and unemployed. There are some new statistics that seem to indicate that life expectancy of Blacks in the United States is shortening rather than lengthening.

A prime example of the impact of these costs came when Chrysler asked Joseph Califano, a former Secretary of Health, Education and Welfare, to become a member of the automaker's Board of Directors with the express purpose of addressing runaway health insurance premiums. Chrysler estimated that $600 of the cost of each new car went to employees' health coverage, about five times more than for their competitors in Japan, West Germany and other countries.

During the 1980s, labor-management contract participants were saying that health insurance had become the second major issue in negotiations and work stoppages. Clearly, both the public and private third-party players have reached their capacity. Unfortunately, the two usual responses to the crisis are redefining the poor and lowering reimbursement.

In an Oregon Senate study, it is pointed out that those people being arbitrarily excluded from health care are working full or part time or are the dependents of workers, with 40% being children.The myth of the lazy welfare recipient needs to give way to the picture of the single parent or the underemployed or those who have insufficient funds to retire completely.

We believe in a Gospel that demands our concern for those in need, including the sick, a Gospel that reminds us that it is a problem of faith if we allow millions of our neighbors to be excluded from even the most basic health care.

B. Cost

Health care expenditure has doubled between 1960 and 1990, about twice as much as general inflation. Reasons cited are: the expanding arsenal of costly diagnostic and therapeutic procedures, escalating drug prices, rising income of physicians and other health care workers, rising administrative costs, aging of the population, need for costly interventions which could be avoided with adequate preventive care (see Section 5, Holistic Health Care).

C. Inequality

The United States is the only industrialized democracy without universal health coverage, hence the 35 million people without health insurance. About 80% of these people are workers (and their family members) whose low-wage jobs do not provide health insurance. The others are unemployed persons and their families. Employer-provided health benefits vary and are on a downward trend, because many employers feel they cannot fully pay the ever-increasing premium rates. Those who are not insured do get health care, but only when they are acutely and severely ill and then in hospital emergency rooms, many of which are shut down because of hospital insolvency. Not surprisingly, there is a wide health status disparity between minority groups and the white majority.

D. Inefficiency

The large number of uninsured persons leads to an underclass of people who get into a vicious cycle of poverty, poor health and unemployment, a disaster for them and

a financial burden to society. This is a moral as well as an economic deficiency. The fee-for-service system, in which physicians and hospitals are paid by the number of operations and tests, leads to many unnecessary tests and treatments. This is exacerbated by fear of malpractice suits, and to some extent by the increasing number of clinical laboratories owned by physicians. Remedies have been sought in the past, but these have been on a partial basis (V.A., Medicare, Medicaid, the repealed Catastrophic Coverage Act), which only increases the inefficiency.

E. Proposed remedies

Several proposals for a National Health Plan, aimed at universal coverage and at controlling costs, have recently been made. Cost control is sought by simplifying the finance and reimbursement system, replacing the fee-for-service system by an HMO plan (which would also stimulate preventive care), restraining fees and drug costs, and by rationing health care based on cost-effectiveness analysis.

F. Task of the Church

Our Lord's call to feed the hungry and give drink to the thirsty implies that we have a duty to help provide adequate health care to all in our nation. At the same time we should expound the Christian vision that physical health is not an end in itself, and that our primary goal in this life is not to postpone death but to prepare for the life to come. In this spirit the Church should support all those who are trying to devise a system of equitable health care delivery for all citizens, with emphasis on preventive care and if necessary a certain form of rationing of health care.

VII. Alcohol and Drug Abuse

Should alcohol and drug abuse be seen as a misuse of freedom or as a disease? The Fall comes as a result of the misuse of our God-given freedom, illustrated by the disobedience of Adam and Eve in eating the forbidden fruit. Stephen Bayne wrote, "Our freedom is potentially both a curse and a blessing. Our daily task and burden is to learn how to accept and use our freedom as the primary, given fact of life on which our very selves are to be built. . . . What lies ahead is the hard road of choice, along which He has gone before, to show us how it may lead to a second and better paradise" *(Christian Living,* Seabury Press, New York, 1957).

For alcohol and drug abuse this means that "the use of the substance can create dependency, robbing the self of its freedom. Both [alcohol and drugs] can be destructive of physical and mental health, [and] . . . one's individual behavior can have tragic consequences for others in one's life: family, friends, co-workers" (Earl Brill, *Christian Moral Vision,* Seabury Press, New York, 1957). There is the deeper moral issue of our casual use of chemicals in order to provide ourselves a short cut to health, beauty, or a good night's sleep. Similarly, young people in poor urban neighborhoods turn to hard drugs as a way of escaping an unbearable environment, however briefly and at whatever cost. Then there are the wider socio-economic realities of today's world. "The drug chain begins in the Third World with impoverished peasants who cannot afford not to grow cocoa or poppies. Faced with undernourished children, disease, and perhaps oppressive taxation, it is difficult for them to make sacrifices so that the U.S. and other affluent nations can have safe streets" (Editorial, *The Living Church,* Oct. 8, 1989).

Others consider alcohol and drug abuse as a disease and not a moral problem. The National Episcopal Coalition on Alcohol and Drugs (NECAD) states that "alcoholism and other drug addiction are primarily physical diseases that affect the individual spiritually, physically and emotionally [and] . . . they affect the whole family, not just the

afflicted." Thus the Church has a role to help people understand the spiritual bankruptcy that addiction causes and the importance of addressing this spiritual dimension in personal recovery and of providing spiritual support and direction to those in recovery. Successful recovery is a life-long process, involving wellness of the whole person and family, and not simply abstinence from chemicals.

There is thus a fine line between the medical characterization of substance abuse as a disease and the theological idea of misuse of freedom. A spiritual solution is the way to healing and wholeness, yet the "healer" who perceives substance abuse as a moral weakness is said to be inadequate.

Notwithstanding some recent statistics supposed to show a decline in drug use, there is a woeful lack of non-profit treatment programs, with existing facilities having waiting lists of four months. Sadly, an addict who cannot get treatment when ready and willing to accept it may not try again.

The commission recommends that General Convention give maximal support to NECAD, that the Church make the attack on substance abuse a priority in the Decade of Evangelism by providing spiritual direction and aid to the addicted, and that this be done by supporting our inner-city churches to become centers for counseling of addicts.

VIII. Prolongation of Life

Resolution #A093

Resolved, the House of _____ concurring, **That this 70th General Convention set forth the following principles and guidelines with regard to the forgoing of life-sustaining treatment in the light of our understanding of the sacredness of human life:**

1. Although human life is sacred, death is part of the earthly cycle of life. There is a "time to be born and a time to die"(Eccl. 3:2). Our Christian faith in the resurrection transforms death into a transition to eternal life: "For as by a man came death, by a man has come also the resurrection of the dead" (I Cor. 15:21).

2. Despite this hope, it is morally wrong and unacceptable to intentionally take a human life in order to relieve the suffering caused by incurable illness. This would include the intentional shortening of another person's life by the use of a lethal dose of medication or poison, the use of lethal weapons, homicidal acts, and other forms of active euthanasia.

3. However, there is no moral obligation to prolong the act of dying by extraordinary means and at all costs if such dying person is hopelessly ill and has no hope of recovery.

4. In those cases involving persons who are in a comatose state from which there is no reasonable expectation of recovery, subject to legal restraints, this Church's members are urged to seek the advice and counsel of members of the church community, and where appropriate, its sacramental life, in contemplating the withholding or removing of life-sustaining systems, including hydration and nutrition.

5. We acknowledge that the withholding or removing of life-sustaining systems has a tragic dimension but that the decision to withhold or withdraw life-sustaining treatment should ultimately rest with the patient, or with the patient's surrogate decision-makers in the case of a mentally incapacitated patient. We therefore express our deep conviction that any proposed legislation on the part of national or state governments regarding the so called "right to die" issues, (a) must take special care to see that the

individual's rights are respected and that the responsibility of individuals to reach informed decisions in this matter is acknowledged and honored, and (b) must also provide expressly for the withholding or withdrawing of life-sustaining systems, where the decision to withhold or withdraw life-sustaining systems has been arrived at with proper safeguards against abuse.

6. We acknowledge that there are circumstances in which health care providers, in good conscience, may decline to act on request to terminate life-sustaining systems if they object on moral or religious grounds. In such cases we endorse the idea of respecting the patient's right to self-determination by permitting such patient to be transferred to another facility or physician willing to honor the patient's request, provided that the patient can readily, comfortably and safely be transferred. We encourage health care providers who make it a policy to decline involvement in the termination of life-sustaining systems to communicate their policy to patients or their surrogates at the earliest opportunity, preferably before the patients or their surrogates have engaged the services of such a health care provider.

7. Advance written directives (so-called "living wills," "declarations concerning medical treatment," and "durable powers of attorney setting forth medical declarations") that make a person's wishes concerning the withholding or removing of life-sustaining systems should be encouraged, and this Church's members are encouraged to execute such advance written directives during good health and competence and that the execution of such advance written directives constitute loving and moral acts.

8. We urge the Council of Seminary Deans, the Christian Education departments of each diocese, and those in charge of programs of continuing education for clergy and all others responsible for education programs in this Church, to consider seriously the inclusion of basic training in issues of prolongation of life and death with dignity in their curricula and programs.

IX. Infertility and Reproductive Technology

Several techniques are now available for overcoming infertility, including ovulation induction, in vitro fertilization (IVF) and embryo transfer, gamete intrafallopian transfer (GIFT), artificial insemination with donor sperm (AID), and surrogacy.

Ethical arguments about these technologies are influenced by attitudes about infertility. Some persons place a high value on having their own biological child. Others insist that infertile couples should adopt a child or accept their childlessness, stressing that in the marriage service the primary emphasis is on the relationship of the husband and wife, with procreation of children only "when it is God's will." On the other hand, some couples believe that obtaining a child through use of some of the newer reproductive technologies can be God's will and point out that if all health problems were left to chance or God's intervention, there would be no need for modern medicine.

Techniques which utilize ova and sperm of a married couple have led to few objections from the Protestant and Anglican Christian communities, but when a third party is the biological or gestational parent there are complex moral and ethical problems.

Ethical issues involved in ovulation induction, IVF and GIFT include high cost and low success rate, often leading to severe disappointment for the would-be parents. The Roman Catholic Church opposes their use because only the conjugal act is considered acceptable for procreation. Our Standing Commission on Human Affairs and Health reported their conclusion in 1973 that external fertilization and embryo transfer is "morally

licit and proper'' for married couples but recommended consideration of adoption as one of the options available to couples with fertility problems.

Another moral issue related to in vitro fertilization is embryo freezing and the fate of surplus embryos. These embryos constitute potential human life and thus should be treated with respect. Freezing them so they can be used if the first attempt at conception fails would seem to be permissible. Using excess frozen embryos for research aimed at improving fertilization technology might be permissible, because it could eventually help other infertile couples. Donation or sale to infertile couples raises ethical questions about surrogacy.

Christian ethicists have seriously questioned the use of sperm or ova from a third party. It is now possible for a child to have as many as five ''parents'': the genetic father, the rearing father, the genetic mother, the gestational mother, and the rearing mother. Using surrogacy or the use of donated sperm or ova creates many ethical and perplexing legal problems concerning individual rights and responsibilities. There are issues of lineage, legitimacy, parenthood, family and identity. These methods have the potential for consequences which could damage the child and/or the parents, including custody battles, marital stress, incest, identity problems and psychological trauma. The Standing Commissions on Human Affairs and Health of the Episcopal Church have expressed grave doubts about these methods of having children, but General Convention has neither approved nor condemned these practices that have potential both for good and evil. Being wary of absolutes and open to change has been an unstated policy of this Church. We value this openness. If we attempt to overcontrol—to prohibit the unfamiliar—we stifle creativity and make it impossible for anyone to give us anything new. It seems inappropriate at this time either to affirm or denounce surrogacy or use of donated sperm, ova or embryos.

Recommendations: When members of this Church consider having children through surrogacy or use of donated sperm, ova or embryos, they should be urged to become thoroughly informed about the ethical issues involved and seek the counsel of a priest of this Church.

X. Abortion

The commission has decided to restrict itself to reaffirming Resolution C047 on this subject, adopted by the General Convention of 1988.

FINAL RESOLUTIONS

Resolution #A094

Resolved, the House of _____ concurring, **That the 70th General Convention recommend that every diocese establish a Committee on Health Concerns for the purpose of reviewing the reports of this Standing Commission and other resources nationally and locally, with the intention of addressing the issues, establishing guidelines for healthy Christian living, informing our members, assisting the Church in voicing ethical insights in national debates on health matters, and sharing our concern and support with those working in the field of health care.**

Resolution #A095

Resolved, the House of _____ concurring, **That the 70th General Convention adopt the following guidelines in the area of genetic engineering:**

1. There is no theological or ethical objection against the production and use of medicinal materials by means of genetic manipulation for therapeutic or diagnostic purposes aimed at the prevention or alleviation of human suffering.

2. There is no theological or ethical objection against gene therapy, if proved to be effective without undue risk to the patient and if aimed at prevention or alleviation of serious suffering.

3. The benefits of this new technology should be equally available to all who need these for the prevention or alleviation of serious suffering, regardless of financial status.

4. The use of results of genetic screening of adults, newborns and the unborn for the purpose of discrimination in employment and insurance is unacceptable.

Resolution #A096

Resolved, the House of _____ concurring, **That the 70th General Convention rejects conception for the purpose of providing fetal tissues for therapeutic or medical research usages;** and be it further

Resolved, **That this 70th General Convention rejects the use of fetal tissues aborted for profit for use in therapy and medical research,** and be it further

Resolved, **That the discussion concerning the use of tissues from healthy fetuses, aborted to save the life of the mother, for therapeutic or medical research purposes, be continued during the next triennium.**

Resolution #A097

Resolved, the House of _____ concurring, **That the 70th General Convention recommend and urge all members of this Church to consider seriously the opportunity to donate organs after death that others may live, and that such decision be clearly stated to family, friends, church and attorney.**

Resolution #A098

Resolved, the House of _____ concurring, **That the 70th General Convention remind all members of this Church that they have a responsibility for the care of their body as the temple of God, which includes a healthy mind and spirit, the utilization of preventive medical care, the maintenance of a healthy diet and regular exercise and the avoidance of all types of substance abuse.**

Resolution #A099

Resolved, the House of _____ concurring, **That the 70th General Convention, decries the inequitable health care delivery system of the United States of America and calls upon the President, the Congress, Governors and other leaders to devise a system of universal access for the people of our country.**

Resolution #A100

Resolved, the House of _____ concurring, **That the 70th General Convention urge the Church to give spiritual direction and care to those addicted to substance abuse and that alcohol and drug abuse be given a prominent place in this Church's program for the Decade of Evangelism.**

Resolution #A101

Resolved, the House of _____ concurring, **That the 70th General Convention reaffirm the recommendation that married couples who are members of this Church and who are considering the use of external fertilization and embryo transfer, seek the advice and assistance of a qualified professional counselor as well as the counsel of a member of the clergy of this Church, and consider adoption as one of the options open to them.**

PROPOSED BUDGET FOR THE TRIENNIUM

Income	*1992*	*1993*	*1994*
	$10,667	$10,667	$10,667

RESOLUTION FOR BUDGET APPROPRIATION

Resolution #A102

Resolved, the House of _____ concurring, **That there be appropriated from the Assessment Budget of General Convention the sum of $32,000 for the triennium for the expenses of the Standing Commission on Health.**