



CMDA *Position* STATEMENTS

Based on scientific, moral
and biblical principles

**Christian
Medical & Dental
Associations[®]**
Changing Hearts in Healthcare

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Abortion

The active termination of pregnancy has existed since 1550 BCE, with the first documented abortion occurring in Egypt.ⁱ The School of Hippocrates included the following prohibition against abortion in the oath named for him in approximately 400 BCE: “I will not give to a woman a pessary to cause abortion.”ⁱⁱⁱ The attitude toward abortion throughout its 3500-year history has varied from general acceptance to criminalization of the act, including the death penalty in certain circumstances.¹ That range of perspective, except for the death penalty, remains today with the overall trend worldwide toward increasing cultural acceptance of abortion. The Christian Church from its earliest recorded Patristic writings outside of the New Testament condemned abortion as murder.^{iii,iv} CMDA affirms the historical prohibition against abortion, as supported by the following:

A. Biblical

- a. After God released the ancient Israelites from slavery in Egypt, one of the rules He instituted acknowledged the ability to cause harm to an unborn child. Harm to an unborn child resulted in a significant additional penalty above the harm to the mother (Exodus 21:22-25).
- b. God knew each of us as persons before conception (Jeremiah 1:5, Ephesians 1:4).
- c. God begins formation of us *in utero* (Isaiah 44:2, 24).
- d. King David’s record of his *in utero* development recognizes that God “wonderfully” created him (Psalm 139:13-16).
- e. The Lord’s calling and naming of Isaiah began *in utero* (Isaiah 49:1, 5).
- f. God acknowledged and set apart the prophet Jeremiah while he was still *in utero*, treating him as a person (Jerimiah 1:5).
- g. John the Baptist *in utero* leapt for joy when he heard Mary’s greeting, revealing his ability to perceive and respond (Luke 1:41-45).
- h. Scripture prohibits murder (Genesis 9:6, Exodus 20:13).

B. Biological

1. When a sperm fertilizes an ovum, two haploid sets of chromosomes are combined, resulting in a unique compilation of chromosomes.
2. Except in the phenomenon of identical twinning, no other individual will possess this unique collection of chromosomes.
3. The genetic encoding contained within these chromosomes determines and regulates the ongoing development of the embryo.
4. After fertilization, this ongoing development and growth consist solely of cell division and specialization. Normally, no further alteration of the chromosomal composition occurs.
5. Therefore, at fertilization there is the creation of a unique collection of chromosomes capable of directing growth and development represents the event in which the life of a new individual begins.
6. Science defines the creation at fertilization of a new human being.^{v,vi,vii}
7. The concept of a pre-embryo (fertilization to the formation of primitive streak about day 14) is an illegitimate attempt to lessen the moral status of the earliest forms of a human being.^{viii}

8. Any effort to stop the normal growth and development of this unique individual after fertilization is equivalent to taking the life of this human being.
9. The active effort to end a pregnancy is known as “elective abortion” to differentiate it from spontaneous abortion or miscarriage. Throughout the remainder of this document, the word abortion will refer to elective termination of a pregnancy.

C. Social

1. Statistics

- a. In the US alone, an estimated 63 million abortions^{ix} have been performed since the nationwide legalization of abortion in 1973 following the Supreme Court’s *Roe v. Wade* ruling. The total estimates of elective abortions worldwide is over 1.5 billion since 1980.^x
- b. In the US, abortion advocates emphasize that the number of reported abortions per 1,000 women 15 to 44 years old has declined in recent years. However, states are not required to report abortion data to the Centers for Disease Control and Prevention (CDC)^{xi} and accurate data are not available.

2. *Roe v. Wade*

- a. While science makes clear that a developing baby is a human being, the law has not always followed science. Abortion in the US hinges on the flawed legal rationale developed by the Supreme Court in the 1973 *Roe v. Wade* and *Doe v. Bolton* decisions, ruling abortion a Constitutional right, without legitimate Constitutional justification.^{xii}
- b. The Supreme Court ruling also tore governance and decision-making power away from the citizens and their duly elected representatives in the states, and opened the door to nationwide abortion on demand.
- c. In analyzing medical ethics, Supreme Court Justice Blackmun acknowledged the later confluence of the Hippocratic oath with Christian biblical principles. Yet, he chose to cast his lot with non-Hippocratic ancient Greeks who rationalized killing.

3. Abortion as a business

- a. To abortion providers such as Planned Parenthood, terminating the lives of developing babies is not only an ideology; it is also a lucrative business. As a “nonprofit” enterprise, Planned Parenthood in one year made well over a billion dollars with a profit approaching one-quarter of a billion dollars. Taxpayer money provided a third of funding to Planned Parenthood for many years.^{xiii} Planned Parenthood performs roughly a million abortions every three years.^{xiv}

4. Abortion clinic conditions and regulations

- a. Since *Roe v. Wade*, the regulation of abortion clinics has repeatedly been removed by the court system, such that now abortion clinics are not required to meet routine standards required of health care facilities. Without regulation and standards, there is no ability to audit or prevent the “back-alley” abortion.
- b. Without proper oversight, the risk of harm to women increases dramatically (e.g. Gosnell)^{xv}

5. Pro-abortion advocacy

- a. The American College of Obstetricians and Gynecologists (ACOG) aggressively promotes abortions and access to abortions.^{xvi} Other leading medical specialty

organizations cannot be relied upon to provide objective scientific evidence supporting a pro-life position.

- b. A prominent pro-abortion argument is that abortion allows a woman to control the most intimate aspect of her life.^{xvii} This argument ignores that the majority of unwanted pregnancies occurs as a result of poor sexual choices by both men and women. Women and their unborn children bear the disproportionate consequences of those choices.
6. Pro-life advocacy provides alternatives to the perceived need for abortion
- a. Thanks to the compassionate work of thousands of pregnancy centers around the country, women who face financial and personal challenges during pregnancy and after giving birth are receiving financial, medical, and practical help plus emotional and spiritual support. Young fathers are learning, through pregnancy centers' education, counseling, and mentoring, to share in the responsibility and fulfillment of bringing a new life into the world.
 - b. Multiple national organizations help shepherd thousands of community-based pregnancy centers offering counseling, testing, education, and provisions to pregnant women.
 - c. Pro-life clinics often provide services such as childbirth classes, parenting classes, ongoing pregnancy support, as well as maternity and baby clothing at no cost to the client.
 - d. Many organizations continue supportive services after the birth of the child. There are organizations that will help with adoptions, if needed. For the protection of the child, baby safe haven laws exist in all states.

D. Medical (see Appendix)

1. Abortion can be induced through medications or performed through surgical methods.
2. The option of FDA-approved medication abortion began in 2000 using mifepristone with the prostaglandin misoprostol for termination of a pregnancy less than 49 days duration.^{xviii} These chemical agents are hazardous and have resulted in significant morbidity and the loss of many lives.^{xix}
3. If after taking mifepristone (progesterone blocker), the woman changes her mind, then reversal of the effects of mifepristone with progesterone has been evaluated with small anecdotal reports and one large case series. Successful reversal rates between 64 and 68% have been achieved.^{xx}
4. Short-term complications of surgical abortion include infection, perforation, hemorrhage, incomplete abortion, anesthesia-related complications, and death of the mother.^{xxi,xxii}
5. Long-term complications may surface several years after the abortion and include pre-term birth, infertility, breast cancer, and increased long term mortality.^{xxiii, xxiv}
6. Mental health complications are not being systematically reported, and we recognize that there are many anecdotal reports of mental health harm, but overall these harms are difficult to assess.²³ Documentaries such as *Silent No More* have recorded the personal testimonies of women who were traumatized by having an abortion.^{xxv}

E. Ethical

1. Two ethical questions usually form the basis for the arguments for or against abortion:¹⁷
 - a. The moral status of the embryo/fetus.

- b. The woman's right to control her body to the exclusion of any interests from the embryonic/fetal human being, her child.
- 2. The status of the embryo/fetus
 - a. Some pro-abortion advocates argue that the embryo/fetus, because of their absolute dependence upon the mother for survival, does not constitute a separate being worthy of the status of personhood.
 - i. Some who hold this view will argue that the fetus does not become a separate being of worth until birth.
 - ii. Others will go further to include the requirement that the baby must be wanted and valued even after birth. This view justifies infanticide for babies born alive during an abortion.
 - iii. Some will argue that the fetus becomes a person with dignity only when the threshold for viability outside the uterus is achieved. The proponents of this view will support early abortion but will oppose late-term abortion.
 - b. CMDA holds that fertilization creates at least one new individual with inherent dignity worthy of all the protections, rights, and respect granted to any human being. Therefore, the embryo/fetus has the moral status of a human being from the time of conception.
- 3. The right of the woman to control her body
 - a. Some pro-abortion advocates emphasize the autonomy of the woman over her pregnancy, and may characterize the pregnancy as an invasion of her body.
 - i. This position invalidates the independent moral status of the embryo/fetus and relegates it to the will of the woman.
 - ii. In this view, if the woman decides to terminate her pregnancy, she is within her rights, independent of the status of the embryo/fetus.
 - b. CMDA respects, honors, and cherishes the unique abilities of a woman to bear children. CMDA respects the autonomy of women. CMDA holds that the embryo/fetus has inherent value as a unique human being. The mother has responsibility for her child that is not lessened by her autonomy. She should not end the life of her unborn child, regardless of her non-life threatening medical circumstances.
 - c. In the rare instance that the continuation of a pregnancy threatens a woman's life, decision-making should proceed on the basis that two lives are at stake, that of the mother and the baby. CMDA recognizes these situations are rare, complex, and difficult. In extremely rare circumstances with a medical condition that will result in the death of both the mother and the fetus, therapeutic abortion may be indicated. (See CMDA Statement on Double Effect)

CMDA Recommendations for the Christian Community

1. CMDA recommends that Christian communities develop and support local organizations providing loving care and resources in the name of Christ to assist women with unwanted pregnancies.
2. CMDA recommends the Christian community minister to the couple's physical, spiritual, emotional, and psychological needs.
3. CMDA recommends the local Christian community give those struggling with an unwanted pregnancy love, understanding, and compassion. In providing support to these

persons, we must be careful not to be self-righteous, but to act with humility. We are all capable of sin and all are dependent on the mercy of God (Rom 3:23).

4. CMDA holds that the Christian community should advocate against laws and regulations promoting abortion at the local, state, and federal levels.
5. CMDA condemns any violence perpetrated against abortion centers and abortionists. Prayer vigils and demonstrations at abortion centers need to follow local regulations.
6. CMDA recognizes the struggle over abortion is an issue of spiritual warfare. Prayer is the primary weapon against the spiritual evil of culture of death and the lie that unborn lives don't matter.

CMDA Recommendations for Christian Health Care Professionals

1. CMDA recommends that HCPs counsel patients with unwanted pregnancy against abortion, while helping them access resources that are available. HCPs should be a voice of healing without condemning, shaming, or being judgmental.
2. CMDA believes that HCPs caring for women with a history of abortion should maintain a loving and compassionate attitude, especially if she is suffering from a complication.
3. CMDA believes that if the HCP refers for a medication or surgical abortion, the HCP is complicit in the act of abortion. (See CMDA Statement on Moral Complicity with Evil)
4. CMDA recommends that Christian HCP's consider offering their expertise and support to local crisis pregnancy centers on a complimentary basis.

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Passed with 41 approvals, 2 opposed, 0 abstention
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Abuse of Human Life

Abuse of human life assaults 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, repairable, or only partially repairable. 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.

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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:

F. 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).

G. Biological

Aging, illness, and death are inevitable.

H. Social

7. 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.
8. 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.
9. 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.

I. Medical

7. 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.
8. 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.
9. 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.
10. 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.
11. Using a patient's advance directive to limit interventions at the end of life can relieve moral distress of the surrogate decision-maker.
12. 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.
13. 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.

J. Ethical

Implementing Advance Directives

4. 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.
5. 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.
6. The patient who has an advance directive has the obligation to communicate it to the potential surrogate and to medical caregivers.
7. The surrogate who is chosen must be willing and able to speak on behalf of the patient and to make difficult decisions when necessary.
8. 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

9. 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.
10. When natural death approaches, the option of withholding or withdrawing treatment should always be considered.
11. Patients have the right to refuse any medical treatment. Honoring a patient’s advance directive for nontreatment does not equate to euthanasia.
12. 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.
13. 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.
14. A DNR status does not mean “do not treat.”
15. Medical technology is inherently expensive, but treatment decisions should not be based primarily on economic considerations.
16. 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.
17. 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.
18. 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.
19. 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)

20. Patients have the right to refuse oral eating or drinking and to change their mind.
21. 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.

22. 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)

23. 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.
24. 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.
25. 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.
26. 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.
27. 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.
28. 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*

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.*

Alternative/Complimentary Therapy

Alternative / complimentary 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.

*** For more information and a comprehensive look at various therapies, reference Alternative Medicine: The Christian Handbook, Donal O’Mathuna, Ph.D., and Walt Larimore, M.D., (Zondervan, Grand Rapids, Michigan, 2001)

*Passed by the House of Delegates
Passed unanimously.
June 13,2001. San Antonio, Texas*

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
May 3, 1991. Chicago, Illinois.*

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 as informed a 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*

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.¹ 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:
 - Artificial insemination by donor (AID)
 - The use of donor egg or donor sperm for:
 - In-vitro fertilization
 - Gamete Intrafallopian Transfer
 - Zygote Intrafallopian Transfer
 - Gestational Surrogacy (third party carries child produced by wife's egg and husband's sperm)²
- Cryopreservation of Embryos³

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*

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.*

The Beginning of Human Life

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

Definition of human life

1. A living human being is a self-directed, integrated organism that possesses the genetic endowment of the species *Homo sapiens* who has the inherent active biological disposition (active capacity and potency) for ordered growth and development 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.

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). "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, 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 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.

Biblical basis for the beginning of human life

1. Procreation is acknowledged in the Bible to be the gift of God.
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 (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. 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 II: 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.*

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 variously (re)defined in the current scientific, medical, and bioethics literature. Christian’s 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. *Euangelium 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; Cf. also John 8:41; 9:34 and the translation in BGD: “you were altogether conceived in sin”) or sullamba,nw (“syllambano” 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”). 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.” 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,pmiW “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.”

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.

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
May 3, 1991. Chicago, Illinois.*

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
May 3, 1991. Chicago, Illinois.

Amended by the House of Delegates
June 11, 2003. Schroon Lake, New York.

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*
June 10, 2005. Denver, Colorado.

*Approved by the House of Delegates
Passed with 63 approvals, 3 opposed, 1 abstention*
May 3, 1991. Chicago, Illinois.

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.

Upon discovering an error, we must distinguish our level of responsibility and culpability before God. 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 action or attitude 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 culpable
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. In addition, we must take necessary steps to prevent recurrence of the error.
3. Errors for which we are both responsible and morally culpable
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.
 - b. Confession: Scripture requires that we confess our sins to God. It is wise for Christian physicians to have a small group of fellow believers to whom they are accountable.
 - c. Restitution: There is biblical precedent for restitution. 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.

Approved by the House of Representatives

Passed unanimously

April 28, 2011. Mount Hermon, California

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
April 29, 1994. Dallas, Texas.*

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
June 11, 2004 . San Antonio, Texas.*

*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.

*Approved by the House of Delegates
Passed with 52 approvals, 7 opposed, 1 abstention
April 30, 1993. Danvers, Massachusetts.*

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. 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. Many academic medical institutions and the US Government 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.

Biblical Foundation

A Christian's response must consider several Biblical principles:

- The two great commandments are to love God and neighbor.
 - Jesus warns of the danger of being motivated by a love of money or other things of this world.
 - Jesus directs that our motives be pure and undivided.
 - Christians must "guard their hearts" against undue influence.
- The behavior of a Christian must be "above reproach."
 - Christians should avoid any form of inappropriate behavior.
 - A reputation for doing what is right is of value.
- Solomon warned that receiving gifts could place people under the influence of others. Even with our best intentions, we may be inappropriately biased toward those who give us gifts.

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 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. 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.
 - 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

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
June 10, 2005. Denver, Colorado.*

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.

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
April 29, 1988. Seattle, Washington.

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*
May 5, 1989. Minneapolis, Minnesota.

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.
May 2, 1998. Cincinnati, Ohio.*

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.

* See statements entitled "Principles of Christian Excellence in Dental and Medical Practice," "Christian Physician's Oath," "Christian Dentist's Oath," "Biblical Model for Medical Ethics," and "Sharing Faith in Practice."

*Approved by the House of Delegates
Passed with 56 approvals, 6 opposed, and 3 abstentions
May 1, 1999. Toronto, Canada.*

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.
June 11, 2004. San Antonio, Texas.*

Homosexuality

CMDA affirms that all human beings are created in the image of, and beloved by, God. All human beings are our neighbors and are to be loved by us as we love ourselves. As such, every human being possesses intrinsic dignity and is worthy of equal respect and concern from healthcare professionals.

CMDA affirms the biblical teaching that the appropriate context for sexual relations is within marriage, defined as a consensual, exclusive and lifelong commitment between one man and one woman. This teaching exists for the benefit of individuals, of families, and of all society. This teaching is about more than just what one does with one's own body because sexuality has moral and spiritual dimensions in addition to the physical dimensions.

CMDA also recognizes that many individuals struggle with or accept same-sex attraction and that there are voices in our culture that celebrate this and seek to make it conventional and to force participation in educational programs promoting it. Thus, Christian healthcare professionals find themselves in the position where some sexual choices and behaviors that have broad social approval are contrary to an orthodox Christian worldview. Christianity teaches human equality, not behavioral equality.

CMDA affirms the obligation of Christian healthcare professionals caring for patients who identify as gay or lesbian to do so with sensitivity and compassion, even when we cannot validate their choices. CMDA views homosexuality within the following frameworks:

A. Biblical

1. All people are loved by God (John 3:16-17).
2. We are to love our neighbors as ourselves (Matt 22:39).
3. God, in his holiness and wisdom, is the creator of the world and the definer of moral reality. Christians are called to obey God and his commandments. When we engage in any sexual sin, we are failing to love God with our whole heart and soul and mind and strength. When we condone another person's embrace of sexual sin, we are not truly loving our neighbor (1 Cor 6:18-20).
4. Everyone struggles with moral failure and falls short of God's standards (Rom 12) and, therefore, needs the forgiveness that God provides through Christ alone (John 3:36; Rom 3:22-24; Col 1:15-21; 1 Tim 2:5-6).
5. The moral authority of the Bible in matters of sexuality rests in God, who inspired and reliably guided its human authors (Josh 1:8; Matt 5:18, 24:35; Luke 16:17; 1 Thes 2:13; 2 Tim 3:16; Heb 4:12; 2 Pet 1:21). The moral teachings of the Scriptures are trustworthy (Psa 119:86; John 17:17b), beneficial (Deu 30:19; Psa 119:105, 133; Luke 11:28), and true for all times (Psa 119:89; Isa 40:8; Heb 13:8).
6. We live in a fallen world (Gen 3), and we are all fallen creatures with a sinful nature (Rom 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 our fallenness, as are marital breakdown and fornication (Rom 1:24-32; Eph 5:3).
7. To experience temptation alone is not to sin. Jesus was tempted yet did not sin (Matt 4:1-11, Mark 1:12-13, Luke 4:1-13). We are commanded to pray for relief from and

- to flee temptation (Matt 6:13, 1 Cor 6:18, 1 Thess 4:3, James 1:13-15). Scripture clearly teaches that yielding to the temptation to engage in homosexual behavior, or even to indulge in homosexual fantasy, is sinful (Matt 5:28).
8. A lifestyle that is directed by sexual desires or personal sexual fulfillment misses the divinely ordained purpose of sex, which is for procreation, mutual marital enjoyment, and for facilitating unity in the lifelong commitment of marriage between one man and one woman. This unity fosters a secure and nurturing environment for children, reflects the unity that exists between Christ and the church (Exod 20:1-18; Lev 20:10-21; Rom 1; Eph 5:23-33), and is the human image of God (Gen. 1:26-28).
 9. The Scriptures promise God's blessing on lifelong heterosexual union in marriage, and they prescribe chastity in all other circumstances.
 10. The Scriptures consistently forbid the practice of homosexuality, calling it sin (Lev 18:22, 20:13; 1 Kings 14:24; Rom 1:24-27; 1 Cor 6:9; Jude 1:7). Same-sex attraction cannot be consummated within God's design for human sexuality and procreation (Gen 2:24; Mark 10:6-8; Eph 5:1-17). The Scriptures affirm, however, the value of same-sex friendships that are not erotic in nature.
 11. It is possible by God's grace for those with same-sex attraction to live a chaste life (Psa 51:10, 119:9-10; Rom 6:11-14, 12:1-2; 1 Cor 6:18, 10:13; 2 Cor 7:1; 1 Thes 4:3-5, 5:23-24; Gal 2:20, 5:16, 22-25; Col 3:5).
 12. Homosexual behavior is not a victimless activity even among consenting adults. Modeling homosexual behavior to young children contributes to normalizing same-sex attraction, that may also entice them to imitate that behavior, and is a grievous sin (Mark 9:42).

B. Social

1. God has designed us for, and with a desire for, intimacy. Most everyone has a sex drive and is responsible for managing it. This is true regardless of one's type of sexual attractions or desires. Intimacy is distorted by sin. Ultimate intimacy is to be found in a relationship with God.
2. 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 cross those boundaries. One outcome of this trend is a view that same-sex relationships should be regarded as equivalent to opposite-sex relationships.¹ In our current culture there is also a view that to embrace diversity means to enforce acceptance and affirmation of same-sex relationships, while suppressing other viewpoints.²
3. CMDA believes that, in contrast to the current culture, living out one's biological sexuality (as standardly defined by X and Y chromosomes and observed in genital anatomy) within God's design will result in a healthy and fulfilled life. CMDA recognizes that this traditionally affirmed view has become counter-cultural; however, CMDA affirms that God's design transcends culture.
4. 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.³ However, deciding on a same-sex lifestyle and pursuing same-sex fantasies and encounters are voluntary and therefore involve moral responsibility.

5. CMDA recognizes that, for individuals who struggle with same-sex attraction, choosing not to act on their same-sex erotic desires may be difficult. Similarly, many individuals who are sexually attracted to the opposite sex also struggle with erotic desires that are contrary to the teachings of Scripture.
6. Endorsement of same-sex marriage harms the stability of society, the raising of children, the institution of marriage,⁴ the revelation of Christ's relationship to His Church, and the revelation of God through those who bear His image. If the only criterion for marriage were love, mutual consent, or commitment, then there would be no logical grounds to prohibit polygamy, polyamory, incestuous unions, adultery, or pedophilia.⁵⁻¹⁰
7. Adoption into homosexual environments puts children at risk.^{10,11} Children need both primary male and female attachments in their social development and the modeling of a male-female relationship. Children should not be exposed to the promiscuity that the gay culture often promotes (nor to heterosexual promiscuity). Children raised by same-sex couples are at increased risk of later engaging in homosexual activity.^{12,13,14}

C. Medical

1. Among individuals who engage in homosexual acts, there is an increased incidence of drug¹⁵ or alcohol¹⁶ dependence, compulsive sexual behavior,¹⁷ anxiety,¹⁸ depression,¹⁹ and suicide.²⁰ These are harmful to the health of same-sex patients^{21,22} and are associated with increased medical costs to society.²³
2. Some sexual acts, common to, but not unique among, homosexuals, are physically harmful because they disregard normal human anatomy and function. These acts are associated with increased risks of tissue injuries, anal cancers, HPV-induced head and neck cancers, and transmission of infectious diseases, including HIV/AIDS, Hepatitis C, parasitic infections, and bacterial infections due to exposure to, or ingestion of, fecal material.²⁴
3. Data demonstrate that life expectancy is significantly shortened in male homosexuals compared to their heterosexual peers.^{25,26}
4. Individuals who act on their same-sex attractions can change their behavior even when desire persists. There is valid evidence that many individuals who chose to abstain from homosexual acts have been able to continue to abstain.²⁷⁻³² Such change often will be difficult, and individuals seeking assistance to change their behavior need an empathetic, loving, and mutually consenting approach.

CMDA Recommendations for the Christian Community

1. A person struggling with same-sex attraction should evoke neither scorn nor enmity, but rather a Christian's loving 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 gay- and lesbian-identified individuals into friendship and community, affirming them as equal with all other human beings before God, yet without condoning sexual choices and behaviors that are contrary to Scriptural teaching.
3. The Christian community, beginning with the Christian family, must resist labeling and rejecting individuals who do not fit the stereotypes of masculinity and femininity.

At the same time, parents should guide their young children and adolescents in appropriate gender identity development. For children and adolescents who are experiencing gender identity confusion, the Christian community should provide appropriate role models and, if needed, counseling.

4. The Christian community, in its biblical calling to be salt and light to the world, has a key role to help society understand that traditional marriage is good and is a part of the natural order. CMDA believes that redefining marriage, so as to include same-sex relationships, for the aforementioned reasons, would have detrimental spiritual, emotional, cultural, and medical repercussions. Even if the legal definition of marriage within a society changes, the Christian's definition remains the same *see A. Biblical, point #8 above*).
5. The Christian community must condemn hatred and violence directed against homosexuals. 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. Chastity should be encouraged for those with same-sex attraction and for those not in a marriage between a man and a woman.
8. The Christian community should strenuously oppose pornography, which is a source of temptation to sexual sin of all types, including homosexual behavior (See CMDA Statement on Pornography).
9. The Christian community should oppose the adoption of children into homosexual households.
10. Sexual education for children should be determined by their parents. Curricula that promote or normalize sexual behaviors outside of God's design should be avoided.
11. The Christian community is one body with Christ as the head. As such, Christians should support those who suffer for upholding biblical values and truth regarding sexuality.
12. The Christian community is to be a refuge of love for all who are broken, including the sexually broken. We should not affirm their sin, or condemn them, but should shepherd them to Jesus, who alone can forgive, heal, restore, and redirect them 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 competent and compassionate medical care of patients who identify as gay or lesbian. Such care requires our love, an open and trusting dialogue, and acceptance of the person without agreeing with the person's sexual ideology. When responding to a patient's psychological distress over sexual matters, Christian healthcare professionals should make a genuine effort to understand and respond to the patient's perspective.
2. CMDA believes that the appropriate medical response to patients who identify as gay or lesbian should be to affirm their value as human beings and their longing for meaning and worth in life, even when their lifestyle choices or sexual behaviors cannot be condoned.

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

CMDA Recommendations Regarding Nondiscrimination

1. Christian healthcare professionals, in particular, must care for their gay- and lesbian-identified patients in a non-judgmental and compassionate manner, consistent with the love Jesus has commanded us to show all people.
2. Christian healthcare professionals who hold to a biblical 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 discrimination. Healthcare professionals who hold the position that homosexual behaviors are 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 belief. The label "homophobic" implies a prejudice against and overwhelming fear of homosexual persons; such prejudice does not apply to the vast majority of healthcare professionals, including Christian healthcare professionals. CMDA rejects the homophobic label as inaccurate and a prejudicial attempt to disparage individuals without a willingness to engage in respectful discussion or to seek mutual understanding. Healthcare professionals are not afraid of individuals practicing homosexual acts, but rather are concerned about the physical, psychological, and spiritual health risks inherent in homosexual behavior. Bigotry in any form from any party is unacceptable.
3. Healthcare professionals should not be prevented from providing support and counseling to patients or to parents of children who request assistance with abstaining from homosexual behavior (change-allowing therapy).

*Revised from 2016 CMDA Statement Approved by Board on January 30, 2021
Approved by the House of Representatives
Passed with 42 approvals, 0 opposed, 0 abstention
May 2, 2021, virtual*

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.

*Approved by the House of Delegates
Passed with 63 approvals, 3 abstentions
May 2, 1998. Cincinnati, Ohio.*

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 questions 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 ennoble, 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?
 - Does it demean, debase, or degrade individuals?
 - 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?
 - Does it appeal to our pride?
 - Does it encourage materialism?
 - Does it promote narcissistic self-absorption?
 - Does it appeal to lust or promote sexual commodification?
 - Does it promote servitude or enslavement to fickle whims of fashion?
 - 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.

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.¹ 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.²
 - Humankind alone has the unique capacity to enter into a personal relationship with God through Jesus Christ his Son.³ 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.*⁴
 - 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.⁵ 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.

*Approved by the House of Representatives
Passed with 52 approvals and 2 abstentions
June 20, 2008, Chicago, IL*

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*¹ 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.² 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."³

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 ontological⁴ 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.

Approved by the House of Representatives
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 4:2)

- 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

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

- 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.

- 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.

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

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.

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*

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.

Proposals are undergoing evaluation in the U.S. and already are implemented in some other countries to increase the supply of potentially transplantable organs by procuring organs from patients who are imminently dying. 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. 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. 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.
 - 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.
 - 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. 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. 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. 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."
 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. 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; 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."
 - 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. 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.
 - 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.
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. 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.

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
 - 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.
 - 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
Ridgecrest, North Carolina*

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
June 13, 2001. San Antonio, Texas*

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*

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
April 29, 1994. Dallas, Texas.*

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
May 2, 1998. Cincinnati, Ohio.*

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.
4. Proximity. A greater degree of association with an evil act increases culpability.
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.

Approved by the House of Representatives

Passed unanimously.
June 11, 2004. San Antonio, Texas.

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.
June 11, 2004. San Antonio, Texas.*

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.

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.” 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.

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. 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.

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.
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.

2. Pain is sometimes a necessary condition of medical or surgical treatment in the pursuit of healing.
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.
4. Opioids are rarely indicated for the treatment of chronic nonmalignant pain.
5. Many effective options other than opioids are available for the treatment of specific types of pain. 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 $\alpha_2\delta$ subunit inhibitors, for example, gabapentin or pregabalin
 - g. Tricyclic antidepressants, for example, amitriptyline, nortriptyline
 - h. Select SSRIs and SNRIs, 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. (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. 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.
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. 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.
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)

13. Opioids should not be stopped abruptly for patients with long term use, but rather tapered.
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”).

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.

*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*

Organ Transplantation after Assisted Suicide or State Execution¹

CMDA affirms the sanctity of every human life, recognizing that life is a gift from God². 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 illicit³. 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 evil⁴. 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 execution⁵.

*Approved by the House of Representatives
Passed with 43 approvals, 3 abstentions
April 26, 2012
Ridgecrest, North Carolina*

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 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, 2011. Mount Hermon, California*

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*

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
June 12, 2002. Chicago, Illinois.*

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.
 - 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*

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
April 29, 1994. Dallas, Texas.*

Persons with Acquired Cognitive Impairment

CMDA affirms the value of all persons with cognitive impairment and recognizes their inherent dignity. Within a Christian worldview, all people have worth and meaning regardless of their cognitive abilities and deserve our utmost respect.

Principles to consider:

A. Biblical

1. All deterioration, disease, and death are the result of the fall (Gen 3:16-22).
2. God is sovereign over all things including cognitive impairment (Ps 115:3). His ways are perfect and just (Deut 32:4, Job 37:23).
3. His ultimate purpose, in all things, is His own glory (Rom 11:36).
4. Cognitive impairment is not meaningless, as God's ways are often beyond our comprehension (Rom 11:33, Is 55:8-9, Deut 29:29) yet wonderful (Job 42:3).
5. He exists in eternity (Ps 90:2) and His purposes may not be understood during our earthly lives (Heb 11:35-40).
6. All humans are made in God's image (Gen 1:26-27) and receive life from God himself (Gen 2:7), thus imparting inherent dignity to all persons independent of their functional or intellectual capacities. Whereas humans tend to attribute their worth to their capacities, God loves every person, independent of their abilities, because love is his nature (Rom 5:8, 1 John 4:16) (See CMDA Ethics Statement Human Life: Its Moral Worth).
7. Serving the needy and disabled is part of serving Christ (Matt 25:40).
8. Human beings are living mysteries, fearfully and wonderfully made (Ps 139:14), whole persons, and embodied souls; we are not merely minds (Matt 10:28-29). A person's fundamental identity is grounded in God's relationship to him or her (Acts 17:28).
9. God is with us, even when our minds are dysfunctional. We can trust that the Holy Spirit is active on behalf of those who are cognitively impaired (Rom 8:20-27), and we give thanks that no impairment can separate us from the love of Christ (Rom 8:35-39).
10. God may use cognitive impairment to instruct us as to the true foundation of human value (Jer. 9:23-24).
11. Jesus showed care and compassion to those with cognitive impairment (Luke 4:33-35, 8:27-33, 38-39 and 9:37-43^a).

B. Medical

1. Cognitive impairment encompasses a spectrum of clinical conditions ranging from mild memory impairment to dementia; these may occur transiently or permanently, and they may be static or progressive. Its causes include birth anoxia, encephalitis, head trauma, stroke, epilepsy, malnutrition, alcohol and other toxins, prescription drug adverse effects, illicit drug effects, and neurodegenerative disorders such as Alzheimer disease, among others.
2. All potentially correctable causes of cognitive impairment should be diligently sought before the patient is labeled as having an untreatable condition.¹

3. Whereas the medical profession currently has no curative means to treat most of the causes of cognitive impairment, we should show respect for the patients' dignity through loving interactions that engage them to the greatest degree possible.¹⁻⁶
4. There is currently no cure for degenerative dementias. There are pharmacologic interventions, such as memantine, that may slow the progression of cognitive deterioration in a subset of patients with dementia.^{2,4-6} There are also some non-FDA-approved interventions and nutritional supplements that are claimed to improve declining memory, but such claims are not supported by valid scientific evidence.
5. It is imperative for the medical profession to attempt to relieve distress experienced by the cognitively impaired even when they are unable to express them verbally. CMDA cannot support physician-assisted death as a means to relieve this distress. (see CMDA statements on Physician-Assisted Suicide and Euthanasia).
6. Life-prolonging interventions may not be indicated in patients with profound dementia and may need to be carefully assessed by a shared decision-making model (see CMDA Statement on Artificially Administered Nutrition and Hydration).

C. Ethical

1. A person's inherent value is not diminished by physical or mental disability.
2. The person with cognitive impairment who displays inappropriate and/or abusive behavior may or may not be ethically culpable. HCPs should take appropriate precautions and protections in cases of violent or aggressive patients.
3. Despite the stress of caring for a person with cognitive impairment, it is always wrong to respond with any form of abuse.

D. Social

1. Caring for a person with dementia is demanding. The HCP should recognize the toll exacted on caregivers, particularly in the later stages of the disease, when the patient often becomes increasingly dependent, agitated, aggressive, or confused.
2. Caregiver strain is felt physically, emotionally, mentally, financially, and spiritually.
3. Caregivers should be encouraged to seek and utilize available resources to help in areas of need. The HCP should be familiar with locally available resources, including people who can be of assistance (e.g. social workers).⁷
4. The local church and its members may be of assistance to patients and their caregivers. Caregivers should be encouraged to reach out to their faith communities.

E. Clinical Implications

1. Persons with cognitive impairment may have no sense of time or memory. They may still be able to engage socially and may enjoy spending time in the presence of others. Time spent with loved ones, even if soon forgotten, is nevertheless of value.^{1,8-11}

2. Individuals with cognitive impairment should be involved in decision-making to the extent of their current capacity. They may have preferences regarding items such as food or clothing, and these should be solicited and respected. Their current ability to make decisions will determine the appropriateness of involving the person in making choices.^{1,12}
3. Patients with cognitive impairment should be encouraged to engage in activities meaningful to them.⁴⁻⁶
4. Patients with cognitive impairment may enjoy being reminded of memories and participating in activities enjoyed in the past.¹
5. Persons with cognitive impairment may have delusions. Depending upon their medical condition or status of their disease, it may or may not be appropriate to address the delusions. At all times, it is important to respect the person and guard their dignity regardless of the delusions.¹³
6. Correction or criticism can be devastating to the dignity of one with dementia. Redirection or distraction may be more effective in addressing inappropriate behavior.^{8,9}
7. Caregivers and HCPs should avoid referring to the patient in the third person, but rather to engage the patient the conversation as much as possible. Ideally, the person with dementia should be spoken to directly, maintaining eye contact.^{1,4-6}
8. Emotional memories are more resilient than other memories. Persons with impaired cognition may not remember what they did, but may remember how they felt.
9. HCPs are encouraged to recommend only FDA-approved interventions that may slow the progression of cognitive deterioration.
10. Followers of Jesus should be reminded of the basic tenets and practices of their faith. Engaging patients in familiar activities such as prayers, liturgy, reading of Scripture, hymns, or worship music may encourage them powerfully in the exercise of their faith.¹⁴

Conclusion

All people with cognitive impairment have God-given worth and can lead meaningful lives. Their caregivers, too, deserve our help, support, and prayers.

*Approved by the House of Representatives
Passed with 40 approvals, 0 opposed, 0 abstention
May 2, 2021, virtual*

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.

Pornography and Interactive Sexual Devices

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. 64% of young people, ages 13-24 actively pursue viewing pornography weekly or more frequently. 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. 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. One in four internet users view pornography in any given month. Pornography is the most common online topic for men, more than any other subject. 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.

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.
 2. Promotes the myth that the purpose of sex is primarily to take rather than give pleasure.
 3. Is not a morally neutral substitute for fornication or adultery. There is no honor or virtue in having sex with a thing.
 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.
 5. Supports the sexual revolution's lie that sexuality is all about orgasm and personal gratification.
 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. May lead to employment termination in the case of workplace viewing.
 8. Contributes to loneliness.
 9. May encourage a variety of sexually deviant behaviors.
 10. Leads to estrangement from God.
- B. Pornography is harmful to marriages; it:
1. Leads to decline in sexual satisfaction within marital relationships.
 2. Leads to destruction of loving relationships.
 3. Further separates the goods of love and the potential for generation of life from love and mutual giving.
 4. Encourages a "throw-away" culture of disposable relationships, leading to more single-parent, divorced, and fractured families.
 5. Diverts finances from legitimate family needs to narcissistic sexual gratification.
 6. Denies the legitimacy of sexuality and family as defined by God.
- C. Pornography is harmful to children:
1. It diverts parental affection to images or objects.
 2. It subverts the modeling of genuine love.
 3. It fuels the sexual perversion of pedophilia (in the case of child pornography), increasing the risk that children may become victims of molestation. 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.

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.
3. Fuels the appetite for and profitability of sex trafficking. Children and many women depicted in pornography frequently have been trafficked into forced prostitution (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.
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.
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).

E. Pornography is harmful to society; it:

1. Furthers the pernicious tendency in our society of commodifying and denigrating others, particularly women and children.
2. Incentivizes withdrawal from authentic human relationship and community, which contributes to emotional and relational disability.
3. Is toxic to marriages, contributing to the destruction of stable families.
4. Decreases tolerance and acceptance of others.
5. Corrupts and debases the ideal of beauty, which is reduced to only that which is sexual.
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.
7. Perpetuates or worsens misogyny.
8. May increase the incidence of rape as it teaches individuals that they are entitled to have their sexual gratification anytime they want it.
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.
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.
12. Contributes to cyber-crime, malware and malicious Internet activity.

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.
- 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.
- 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.
- 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.

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).

*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
May 3, 1991. Chicago, Illinois.*

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
January, 1997. San Antonio, Texas

Approved unanimously as amended by the House of Delegates
May 9, 1997. Mesa, Arizona

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 dentist, 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*
April 30, 1993. Danvers, Massachusetts.

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.

*Approved by the House of Delegates
Passed unanimously
May 1, 1992. St. Louis, Missouri*

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,¹ 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

- 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.
- 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.
- 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.
- 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).
- CMDA affirms that children are not products to be manufactured, commodified, or controlled, but are blessings to be cared for and cherished.

- 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.
- CMDA affirms that biotechnology and medical care directed toward treating children and adults living with mitochondrial and other genetic diseases are ethically praiseworthy.
- 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*

Transgender Identification

Preamble

A novel way of thinking about one's body has entered into popular culture. "Transgender" individuals refer to their "gender" as a sexual identity that may be male or female, something in between, or neither. This self-identification differs from, and takes priority over, their biological sex as recognized in their chromosomal DNA and innate physical sexual characteristics. The naming of gender as a category set apart from sex is an idea foreign to the holistic view of the person as understood within Christianity. Christians affirm the biblical understanding of humankind as having been created male and female, with the two sexes having equal dignity and a complementary relationship to each other.

At the heart of disagreement over transgenderism is a difference in worldviews. If the human body is nothing more than the product of mindless, random, purposeless physical forces, then one may do with it what one wishes, even to demand medical and surgical cooperation in projects to alter, amputate, or reconstruct normal tissue to conform to the patient's revised psychological sense of identity. If, on the other hand, our bodies are an inseparable aspect of our true selves and are a good gift from God, who has designed the sexes to be wonderfully paired, and who has a purpose for humanity, then respecting the gift of given sexual identity and the ensuing moral obligations to our neighbors is the surest path to human flourishing.

Both worldviews share the recognition that humanity is broken and in need of renewal, but they look to different answers for healing. Christians seek not a reconfiguring of the body, but a spiritual transformation of the mind to become more like Christ; not rejecting the gifts of God, but welcoming God's purposes and demonstrating God's love by loving our neighbors. This love of neighbors includes loving our transgender neighbors as persons who, like all people, are created in God's image. However, loving them and validating them as people does not mean agreeing with their ideologies or use of language.

The Christian Medical & Dental Associations (CMDA) believes that healthcare professionals should not be forced to violate their conscientious commitment to their patients' health and welfare by being required to accept and participate in harmful gender-transition interventions, especially on the young and vulnerable. CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion, consistent with the humility and love that Jesus modeled and commanded us to show all people.

Introduction

CMDA affirms that all human beings are created in the image of, and beloved by, God. All human beings are our "neighbors", and are to be loved by us as we love ourselves. All human beings possess intrinsic dignity and are worthy of equal respect and concern from Health Care Professionals.

CMDA considers "sex" (i.e., male or female) to be an objective biological fact (see section B.1. below). CMDA affirms the historic understanding of gender as referring to biological sex and the enduring biblical understanding of humankind as having been created male and female and that

this is good. CMDA acknowledges the current cultural use of the word “gender” to refer to one’s sense of identity as male or female. CMDA cannot support the recent usage of the term "gender" to emphasize an identity other than one's biological sex, that is, a subjective sense of self based on feelings or desires leading to identifying somewhere on a fluid continuum of gender identity.^{xxvi,xxvii,xxviii,xxix} (See Glossary at the end of this document)

CMDA cannot support the prevailing culture’s acceptance of an ideology of unrestrained sexual self-definition that, in celebrating gender fluidity and gender transition efforts, is indifferent to biological reality and opposed to the biblical understanding of human sexuality. Further, CMDA is alarmed that some proponents of transgender ideology, through activism and intimidation, are insisting that healthcare professionals cooperate with and affirm their beliefs in gender fluidity, even if the healthcare professionals believe that such cooperation and affirmation would be doing harm to their patients. This violates the most fundamental core value of medicine since Hippocrates, that of caring only for the good and benefit of the patient while abstaining from all unnecessary harm. The evolving scientific and medical facts demonstrate that the mutilation of normal tissue and profound disruption of normal physiology that occur during gender transition procedures are very difficult to justify, as this constitutes deliberate harm.

CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion. CMDA holds that attempts to radically reconstruct one’s body surgically or hormonally for psychological indications, however, are medically, ethically, and psychologically inappropriate. These measures alter healthy tissue and increasingly are not supported by scientific research evaluating behavioral, medical, and surgical outcomes.^{xxx,xxxi,xxxii,xxxiii,xxxiv,xxxv,xxxvi}

Accordingly, CMDA opposes medical assistance with gender transition on the following grounds:

A. Biblical

1. God created humanity as male and female (Gen 1:27, 5:2; Matt 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 (Gen 1:26-28, 2:18-24).
2. Men and women are morally and spiritually equal (Gal 3:28) and are created to have roles that are in some respects alike and in other respects wonderfully complementary (Eph 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 (Rom 3:10-12) and, therefore, need the forgiveness that God provides through Christ alone (John 3:36; Rom 3:22-24; Col 1:15-22; 1 Tim 2:5-6).
4. For the Christian, all of ethics, grounded in God’s moral law, is based upon the first and second greatest commandments: to love God with all our heart, soul, and mind, and to love our neighbors as ourselves (Matt 22: 37-40). If we encourage others to sin sexually, just as if we sin sexually ourselves, we are violating these two commandments. We violate the first greatest commandment by failing to love God in his holiness, wisdom, and rightful place as our Creator, and we violate the second greatest commandment as we fail to respect ourselves and each other by abetting lives of disobedience, deception and unholiness (1 Cor 6: 13b-20). Love may include a corrective component that should be

applied in an appropriate and timely manner; affirmation can be enablement.

5. We live in a fallen world (Gen 3), and we all come into this world as fallen creatures with a sinful nature. (Rom 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 (Rom 1:24-32; Eph 5:3).
6. A lifestyle that is directed by pursuing sexual desires, or driven by personal sexual fulfillment, misses the divinely ordained purpose of sex, which is for procreation, bond creation, and re-creation^{xxxvii} and for facilitating unity in the lifelong commitment of marriage, which is defined as being between one man and one woman. Heterosexual marriage fosters a secure and nurturing environment for children and it reflects the unity of Christ and the Church (Exod 20:1-18; Lev 20:10-21; Rom 1; Eph 5:23-33) (see also CMDA Statement on Homosexuality).
7. Believers in Christ, though having inherited the sinful nature common to all humanity, also receive a new nature in Christ. As the old nature, being crucified with Christ, dies, our new redeemed nature, sealed by Christ's bodily resurrection, is actively transforming our minds and hearts to be more and more like Christ. This transformation is spiritual, not sexual, and is God's work, not something of our own design (Psalm 100:3; Rom 12:2; Col 1:27).

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, is observable at birth, is found in every nucleated cell, and is immutable throughout one's lifetime. Sex is not a social construct arbitrarily assigned at birth and cannot be changed at will.^{2,3,xxxviii}
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.^{2,3,xxxix}
3. Procreation requires genetic contributions from both one man and one woman.^{xl,xli}
4. CMDA recognizes that exceedingly rare congenital abnormalities exist in which phenotypic sex characteristics are not what is expected from the genotype.^{1,2} These disorders of sex development are of a diverse nature, but usually impair fertility.³ Treatment (including non-intervention) of these disorders differs categorically from transgender interventions, which are performed on persons with no inherent defect in sex organ development, function, or fertility. Anomalies of human biological sex are conditions rather than identities, something one has rather than who one is.⁴ Disorders of sex development are not the fault of the patient, do not invalidate God's design in creation, and do not constitute a third sex.^{xlii,xliii,xliv,xlv}
5. Gender dysphoria^{xlvi}, the condition of experiencing discomfort or distress at one's sex and preferring a different "gender" identity, has not to date been linked to a genetic cause and is a psychological disorder of unclear and complex origin.^{xlvii,xlviii,xlix} Gender dysphoria may cause profound distress. It should not be confused with transient gender-questioning that can occur in early childhood.^{l,li,lii,liii,liv,lv}

C. Social

1. CMDA recognizes that gender identity issues are complex. The inclination to identify

with the opposite sex or as some other gender identity along a spectrum may have non-genetic biological,^{lvi} familial,^{lvii,lviii} and social^{27,28,lix} causes that are not personally generated by particular individuals.²¹⁻³⁰

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 or their subcultures seek validation by medical professionals of their transgender desires and choices through medical or surgical solutions to gender dysphoria. Although such desires may be approved by society at large, they are contrary to a biblical worldview and to biological reality and thus are disordered.
3. In contrast to the current culture, CMDA believes that finding one's identity within God's design will result in genuine human flourishing. CMDA believes, moreover, that social movements which assert that gender is a choice are mistaken in defining gender as something independent of sex. Authentic personal identity consists in social gender expression that is congruent with one's natural biological sex but not limited to stereotypes. CMDA recognizes that this traditional view has become counter-cultural; however, CMDA affirms that God's design transcends culture.
4. CMDA opposes efforts to impose transgender ideology on all society by excluding, suppressing, marginalizing, intimidating, or portraying as hateful those individuals and organizations that disagree on scientific, medical, moral, or religious grounds. Such attacks are contrary to the freedoms of speech and religious liberty that lie at the very foundation of a just and democratic society.
5. There is a social contagion phenomenon luring young people into the transgender culture.^{32,33}
6. CMDA opposes efforts to compel healthcare professionals to grant medical legitimacy to transgender ideologies.^{lx,lxi,lxii,lxiii,lxiv,lxv} Cooperation with requests for medical or surgical gender reassignment threatens professional integrity by undermining our respect for biological reality, evidence-based medical science, and our commitment to non-maleficence (see CMDA Statement on Healthcare Right of Conscience).
7. Promotion of transgender ideology by educational institutions and teachers to children as young as 5 years of age is a danger to the health and safety of minor children (for medical reasons elaborated in the next section).^{lxvi,lxvii,lxviii,lxix,lxx,lxxi,lxxii} Education should respect the value of every human being; in supporting and affirming the student, it need not affirm every desire.
8. No educational institution or teacher should ever block parents from supervising their child's education or withhold from them knowledge of the educational content.

D. Medical

1. Transient gender questioning can occur during childhood. Most children and adolescents who express transgender tendencies eventually come to identify with their biological sex during adolescence or early childhood.^{lxxiii,lxxiv,lxxv,lxxvi,lxxvii,lxxviii} There is evidence that gender dysphoria is influenced by psychosocial experiences and can be exacerbated by promoters of transgender ideology.^{21,27,33} Early counseling for children expressing gender dysphoria is critical to treat any underlying psychological disorders, including depression, anxiety, or suicidal tendencies, and should be done without promoting attempts for gender

transitioning.

2. Hormones prescribed to a previously biologically healthy child for the purpose of blocking puberty inhibit normal growth and fertility, cause sexual dysfunction, and may aggravate mental health issues. Continuation of cross-sex hormones, such as estrogen and testosterone, during adolescence and into adulthood, is associated with increased health risks including, but not limited to, high blood pressure, blood clots, stroke, heart attack, infertility, and some types of cancer.^{51,lxxix,lxxx,lxxxi,lxxxii,lxxxiii,lxxxiv,lxxxv}
3. Although some individuals report a sense of relief as they initiate the transitioning process, this is not always sustained or consistent over time. Some patients regret having undergone the transitioning attempt process and choose to detransition, which involves additional medical risk and cost.^{56,lxxxvi,lxxxvii,lxxxviii,lxxxix}
4. Among individuals who identify as transgender, use cross-sex hormones, and undergo attempted gender reassignment surgery, there are well-documented increased incidences of depression, anxiety, suicidal ideation, substance abuse, and risky sexual behaviors in comparison to the general population.^{21,22,23,61,65,66,67} These health disparities are not prima facie evidence of healthcare system prejudice. These mental health co-morbidities have been shown to predate transgender identification.^{24,25,26,27,28,34,68} Patients' own gender-altering attempts and sexual encounter choices (or, in the case of children, their parents' choices on their behalf) are among the factors relevant to adverse outcomes in transgender-identified patients.
5. 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.^{7,8,9,69} Evidence increasingly demonstrates that there is no reduction in depression, anxiety, suicidal ideation, or actual suicide attempts in patients who do undergo surgical transitioning compared to those who do not.^{7,70} The claim that sex-reassignment surgery leads to a reduction in suicide and severe psychological problems is not scientifically supported.^{64,71,72,73}
6. A patient has died because the medical records conveyed only the individual's gender preference, and not their biological sex, leading to misdiagnosis and medical catastrophe.⁷⁴

E. Ethical

1. Restoring and preserving physical and mental health are goals of medicine, but assisting with or perpetuating psychosocial disorders are not. Accordingly, treatment of anomalous sexual anatomy is restorative.⁷⁵ Interventions to alter normal sexual anatomy and physiology to conform to identities arising from gender dysphoria are disruptive to health.^{9,76}
2. 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.
3. The medical status of gender identity disorder (currently termed gender dysphoria) as a mental or psychosocial disorder should not be discarded.
4. 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 uterine transplantation.⁷⁷ Uterine transplantation into biological men cannot be justified medically (See CMDA Statement on Enhancement and CMDA Statement on Transplantation).

5. Fundamentally, it is unrealistic to remove or mutilate normal organs and tissue and to disrupt normal physiology, and then to expect normal function. This illustrates the reality that complete gender transitioning is not medically possible.
6. Christian patients struggling with transgender inclinations face not only the psychological distress of a desire for a gender identity different from their biological sex, but may also face the spiritual distress that comes to anyone who follows a path in life that departs from God's design for humanity. Hormonal or surgical interventions cannot resolve spiritual distress but may lead to further spiritual turmoil. These, our neighbors, need and deserve the spiritual, psychological, and social support of the Christian community.
7. CMDA is especially concerned about the increasing phenomenon of parents enabling their gender-questioning children or adolescent minors to receive hormones to inhibit normal adolescent development. Children and adolescents lack the developmental cognitive capacity to assent or request such interventions, which have lifelong physical, psychological, and social consequences.⁵⁶ Facilitating hormonal or surgical transitioning interventions for those who have not reached the age of majority is a form of child endangerment and abuse.⁶⁴ Highly affirming parents have been shown to not improve the mental health statistics of transgender-identified children.⁷⁸
8. Many diseases affect men and women differently, according to biological sex phenotype. Transgender designations may conceal biological sex differences relevant to medical risk factors, the recognition of which is important for effective healthcare and disease prevention. As accurate documentation is necessary for good patient care, healthcare professionals should document the patient's biological sex and any alterations of gender characteristics in the medical record.^{2,13,54,57,79,80,81} It is appropriate and should not be interpreted as disrespectful for healthcare professionals to discuss their patients' biological sex with them as part of their medical care.^{80,81}
9. For the overall health of the patient, the healthcare professional should be forthright with the patient that addressing the individual's sexual reality is necessary for appropriate medical care and should not be interpreted as disrespect.

CMDA Recommendations for the Christian Community

1. A person questioning or struggling with gender identity should evoke neither scorn nor enmity, but rather the Christian's concern, compassion, help, and understanding. Christians must respond to the complex issues surrounding gender identity with grace, civility, and love.
2. Christians should avail themselves of opportunities to help the larger society understand that male/female sexes are complementary and permanent. Both are good and part of the created order. For the reasons elaborated above, CMDA believes that attempting to define gender as fluid and changeable through technical means will have grave spiritual, emotional, cultural, and medical repercussions.
3. The Christian community, beginning with the Christian family, must resist stereotyping or rejecting individuals who do not fit the popular norms of masculinity and femininity. At the same time, parents should guide their children and adolescent minors in appropriate gender identity development. For children and adolescents experiencing gender dysphoria,

the Christian community should provide appropriate role models and biblically informed guidance.

4. The Christian community must condemn hatred and violence directed against those struggling with questions of gender identity.
5. Since Christians are to love their neighbors as themselves, they are to love those struggling with gender dysphoria or incongruence of desired gender with biological sex. Love for the person does not condone or facilitate gender transitioning treatments.
6. In obedience to God who commands his followers to love one another, and for the sake of the common good, Christians should welcome inclusion of transgender-identified individuals into their communities, as we are all broken and sinners, not more or less valuable than each other. Transgender-identified individuals have the same rights shared by all other humans. We oppose granting special rights and privileges based on transgender identification. These special rights can negatively impact the rights of others (e.g., bathroom designations that allow biological males access to shared female restrooms or showers, female athletic competitions that give participating biological males an unfair physiologic advantage, affirmative actions, or claims for unnecessary medical interventions).
7. The Christian community is to be a refuge of love for all who are broken – including the sexually broken – not to affirm their sin, nor to condemn, 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 repentance and faith in Jesus Christ and the life-changing power of the Holy Spirit. Though healing may be incomplete on earth, the promise of complete healing for those who are in Christ will ultimately be fulfilled in heaven.

CMDA Recommendations for Christian Healthcare Professionals

1. CMDA advocates that all Christian healthcare professionals provide ethically and medically competent care to all patients, including those who identify as transgender. Such care requires compassion, an open and trusting dialogue, a genuine effort to understand and respond to the patient's psychological distress when present, and acceptance of the person without 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 dysphoria is to help them understand that they are people God loves and who are made in his image, even when their choices cannot be validated. Christian healthcare professionals should validate their right as individuals in a free society to make decisions for themselves. This right, however, does not extend to obligating Christian and other healthcare professionals to prescribe medication or perform surgical procedures that are harmful (see CMDA Statement on Healthcare Right of Conscience).
3. CMDA believes that Christian healthcare professionals should not initiate hormonal and surgical interventions that alter natural sex phenotypes. Such interventions contradict one of the basic principles of medical ethics, which is that medical treatment is intended to restore and preserve health, and not to harm.
4. CMDA believes that prescribing hormonal treatments to children or adolescents to disrupt normal sexual development for the purpose of attempting gender reassignment is ethically impermissible, whether requested by the child, the adolescent, or the parent (See

CMDA Statement on Limits to Parental Authority in Medical Decision-Making, and
CMDA Statement on Abuse of Human Life).

5. Supporting a patient's pursuit of gender transitioning procedures is neither loving nor the best means to help that individual who is experiencing gender dysphoria.

CMDA Recommendations Regarding Nondiscrimination

1. Mutual respect and civil discourse are cornerstones of a free society, and so is truthfulness. In the context of health care, identification of sex and gender has both interpersonal and medical implications. In regard to interpersonal communication, the healthcare professional should respect how a patient wishes to be addressed, including pronoun preferences, within reason. In regard to medical documentation, the medical record should document the sex observed at birth even when the patient expresses a different gender preference or has obtained a legal change in gender status.
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 and love that Jesus modeled and commanded us to show all people. When questioning transgender ideology, Christian healthcare professionals should do so with an attitude of humility and love.
3. Those who hold to a biblical or traditional biological view of human sexuality, including CMDA members, should be permitted to question transgender ideology 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 their desire to adhere to biological and medical reality as a 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 Christian and other healthcare professionals should not be coerced or mandated to provide or refer for services they believe to be morally wrong or medically 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 with gender dysphoria and who request assistance with accepting and maintaining their biologic sex and gender identity.

*Revised from 2016 CMDA Statement Approved by Board on January 30, 2021
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May 2, 2021, virtual*

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.*

Vaccines and Immunizations

Introduction

Immunizations benefit the health of both individuals and the broader community. Individuals are helped because immunizations prevent infectious diseases. Fewer infectious diseases then circulate through communities, decreasing the rates of illness and death. Regrettably, many persons remain unimmunized or under-immunized. In most parts of the world, under-immunization is due to lack of access. In more affluent countries, under-immunization most often results from a lack of comprehension of, or disagreement about, the protection that vaccines provide and how much they are at risk. This leads to either a failure to obtain vaccines on the recommended schedule, or to an outright refusal to vaccinate. Ethical issues regarding vaccines include: the tension between individual rights and community benefit, methods of vaccine development, and vaccine distribution in the event of vaccine scarcity.

A. Biblical

1. We do not own our bodies. All are God's creation (Genesis 1:27). Christians have been bought with a price (1 Corinthians 6:19-20).
2. We have a responsibility to care for our children (Ephesians 6:4, Matthew 7:11).
3. We have a responsibility to care for ourselves (1 Corinthians 3:16-17).
4. We have a responsibility to care for our neighbor (Matthew 22:39).
5. Our neighbor is anyone who comes into our path who needs our care (Luke 10:29-37).
6. Jesus cares about the vulnerable, including children and others who depend on adults to make decisions for them (Luke 18:16). As followers of Christ, we should care for the vulnerable (James 1:27).

B. Historical: Immunization milestones:

1. A smallpox vaccine was developed and promoted by Edward Jenner in 1798.¹
2. A rabies vaccine was developed by Louis Pasteur in 1885.¹
3. A diphtheria vaccine was developed in 1913, a pertussis vaccine in 1914, and a tetanus vaccine in 1927. They became a combined vaccine in 1948.¹
4. An influenza (flu) vaccine was first introduced in 1945.¹
5. The inactivated polio vaccine (Salk) was introduced in 1954 followed by the oral live polio vaccine (Sabin) in 1962.¹
6. A mumps vaccine became available in 1967, a measles vaccine in 1968, and a rubella vaccine in 1969. They were combined into the MMR in 1971.¹
7. Smallpox was declared eradicated by the WHO in 1980.³
8. Since 1980, vaccines have been introduced to prevent *Hemophilus Influenza* type B, *Streptococcus pneumoniae*, Hepatitis A, Hepatitis B, rotavirus, meningococcus, varicella, and others.¹
9. Rubella was declared to be eliminated from the United States in 2004.⁴
10. Polio is endemic in only a few countries in the world.⁵
11. The success of vaccines is demonstrated by significant decreases in morbidity and mortality of vaccine-preventable illnesses over the past century. (See Appendix A)

C. Medical

1. Immunizations carry a minuscule risk of significant harm to any given individual. Transient fever and pain at the injection site are the most common adverse side effects.⁵⁻⁷ Very rarely, patients may experience serious reactions, such as fainting (from the injection, not the vaccine), anaphylaxis, or Guillain-Barré syndrome. Any serious reaction should be reported to the United States Vaccination Adverse Effects Reporting System (VAERS).⁸
2. Vaccines are developed for illnesses that result in significant morbidity and mortality. (See Appendix B)
3. Vaccine-preventable illnesses have become less common, significantly reducing disease and death among infants and young children.⁵
4. Vaccine schedules balance early protection with immune response. Most vaccines in early infancy require multiple doses. Some vaccines (e.g. MMR) require a child to reach a certain age before they are effective. Some vaccines require boosters at later times.⁹
5. Alternate schedules that delay vaccination provide no benefit, and leave children at risk for vaccine-preventable disease for a longer period of time.^{9,10}
6. A small minority of persons have medical conditions that prevent them from receiving, and thus directly benefiting from, immunization.⁹ They can be protected from exposure to the disease, however, if enough of the population is vaccinated to provide herd immunity.
7. Many medical conditions, such as autism, first become evident during the first few years of life, and orthostatic intolerance may become evident in puberty, yet these conditions are unrelated to vaccination. Correlation of timing of disease diagnosis and vaccination does not prove causation by the vaccine.⁹⁻¹¹
8. No credible scientific study has proved causation of developmental disorders, such as autism, by an immunization product.^{9,12}
9. Some diseases require an immunization rate of 90% or greater to protect, by means of herd immunity, those who are unable to be immunized.¹³ Thus, the decision to not vaccinate does not affect the individual alone, but may place others in the community at risk.
10. The role of vaccines in public health varies by the nature of the disease targeted. Some vaccine-preventable diseases, such as measles, rubella, and influenza, are easily transmitted and so their vaccines benefit the entire population. Other diseases, such as tetanus and rabies, protect an individual or a small group of people, rather than the entire community. Still other diseases, such as HPV, are related to lifestyle choices, and their vaccines require individualized discussion (See CMDA scientific statement on HPV vaccination).¹⁴
11. There are occupational, demographic, and international travel reasons for specific vaccinations (e.g., yellow fever, rabies, Japanese encephalitis, dengue fever, and cholera).¹⁴ Consulting an appropriate adviser is recommended.

D. Ethical

1. Vaccine development

- a. Abortion is morally reprehensible. (See CMDA statement on Abortion). Several vaccines have been developed with the use of cell strains derived from electively aborted fetuses.¹⁵
- b. Cell strains currently used for some vaccine manufacturing are many cell generations removed from the original abortion done over 50 years ago.¹⁵
- c. In the U.S., (as of 2020) FDA-approved vaccines preventing rubella, varicella, and hepatitis A are produced using fetal cell strains. The adenovirus vaccine also uses fetal cell strains, but it is used infrequently. There are no non-fetal cell strain options in the U.S. for those four vaccines. There are two rabies vaccines, one of which uses fetal cell strains and one which does not.¹⁶
- d. Advocating for the development of vaccines using non-fetal cell strains should be encouraged. Those who consider the use of fetal cell strains as morally problematic can petition manufacturers and the FDA to produce vaccines, both current and future, without these cells.
- e. Whether to use current vaccines developed with fetal cell strains is a disputed matter. While undesirable, it may be permissible, or even encouraged, for the following reasons:
 1. One incurs moral responsibility by having a choice. The healthcare professional recommending the vaccine and the patient receiving it did not intend or have any voice in the original immoral act of obtaining fetal tissue, but do intend the beneficial effect of the vaccine.
 2. The time separation from the development of the fetal cell strain and current vaccine may reduce moral complicity. The refusal to use the vaccine will not prevent the original immoral act.¹⁷⁻¹⁹
 3. The potential benefit from receiving the vaccine may outweigh the past harm. Refusal to be vaccinated because of the original immoral act could cause injury to many persons, most notably children, to whom we have a particular moral obligation to protect from harm.^{13,14}
 4. Of note is that no additional fetal tissue is procured for the manufacture of currently used vaccines.¹⁵ The two fetal cell strains used for the rubella, varicella, hepatitis A and adenovirus vaccines came from two abortions, one in 1962 and one in 1970.
- f. Continued use of vaccines from fetal cell cultures does not support, require, or justify abortions for future vaccine development or production. Alternatives to fetal cell strains should be developed and used for all future vaccines.¹⁶

2. Individual Rights and Community Benefit

- a. Adults have an obligation to make decisions in the best interests of their minor children. The person making the decision is often not the person (i.e., the minor child and the child's contacts) who will either benefit or be harmed by that decision.
- b. Adults exercising the right to refuse vaccines for themselves will not be the only person(s) harmed if they transmit a vaccine-preventable illness (e.g., influenza) to unvaccinated individuals in the community.

- c. As members of a community, all persons have an obligation to consider the needs of others, themselves, and their families. Individuals who have not received appropriate immunizations (e.g., MMR) should abstain from activities that endanger the vulnerable (e.g., working in the church nursery, caring for unimmunized children, the elderly, or the immunocompromised). People who work with individuals at risk (e.g., HCPs, childcare workers, and teachers), have additional obligations beyond those of the general public to help safeguard the health and well-being of others.
 - d. Medically eligible persons who refuse vaccination should be encouraged to recognize that they benefit from the vaccination of others via herd immunity. Their immunized neighbors and community contribute to their protection from infectious diseases.
 - e. Continued monitoring of vaccines for safety and effectiveness is essential for the general public's confidence in current vaccines and the development of new vaccines.
3. Vaccine distribution in the event of scarcity (see CMDA statement on Triage and Resource Allocation).

E. The Role of Society and Government

1. The role of government in immunization is to encourage the protection of all its citizens, including the vulnerable who are at increased risk because of health conditions or age.
2. The right of government to mandate immunizations was established in 1905 by the U.S. Supreme Court in *Jacobson v. Massachusetts*, which held that individual liberty is not an absolute right but is subject to the state's police power in order to protect the health and safety of its people.²⁰
3. All states within the U.S. mandate immunizations for school and daycare attendance. All states allow medical exemptions. Some states allow exemptions for religious or philosophical reasons.²¹
4. The Centers for Disease Control and Prevention (CDC) has the responsibility to monitor the safety of vaccines in the U.S.²²
5. The U.S. government has created the Vaccination Adverse Effects Reporting System (VAERS).⁷ The National Vaccine Injury Compensation Program may provide compensation for the rare situation in which an individual may experience a significant adverse response to a vaccination.²³
6. Government and HCPs are responsible for providing accurate information regarding vaccines and for respectfully countering myths and misinformation that cause fear and vaccine refusal.

F. Vaccine Refusal

1. Many internet sites that claim to educate regarding vaccines have very informative-sounding names but are actually anti-vaccine propaganda and contain erroneous statements.²⁴
2. Alternative vaccine schedules that elongate the vaccine administration process leave the patient vulnerable to vaccine-preventable diseases for an extended period of time.

3. Christian HCPs may be aware of vaccine-preventable illnesses present in their church community. To protect the vulnerable, they should make their church leadership aware that such a risk exists, provided there is no breach of patient confidentiality.
4. HCPs should be aware that people who refuse vaccines may travel to areas and countries where vaccine-preventable infectious diseases are common, and may thus place others at risk if they fall ill.
5. An individual's refusal to be vaccinated may have significant negative consequences, such as reduced eligibility for employment, education, or military service.

G. Health Care Professional (HCP) Responsibility

1. HCPs should be familiar with, and communicate freely, the benefits of immunizations.
2. HCPs should seek out and use vaccines produced without the use of fetal cell strains, when possible. HCPs should encourage future development of vaccines without fetal cell strains.
3. The HCP's continued care for patients who refuse vaccines is the ideal. After deliberation, a HCP may make the difficult decision to discharge a patient from the practice. The following should be considered:
 - a. The risk to other patients in the practice
 - b. The parent or patient's willingness to acknowledge the risks of refusing vaccines, and documentation of the discussion
 - c. The parent or patient's willingness to collaborate with other parameters of continued care (e.g. keeping well appointments, reminding staff of immunization status when ill)
4. HCPs should not recommend an alternative vaccination schedule.
5. HCPs should be aware of guidelines for vaccines.

Conclusions

1. Vaccines have significantly reduced the incidence of life-threatening infections and have saved lives.
2. Vaccines are an important part of maintaining health, especially in children.
3. Significant adverse events from vaccines are rare.
4. Vaccines decrease and sometimes eliminate the risk of significant illness and their sequelae.
5. HCPs should advocate for vaccine production that does not use fetal cell strains regardless of their origin. Induced pluripotent stem cells offers a non-controversial source of tissue for culture.
6. HCPs should be aware of the abundance of vaccine misinformation which results in vaccine refusal. This misinformation should be countered with accurate information, patient and respectful discussion, and compassion.
7. HCPs should use their expertise to encourage vaccine usage within their communities and churches.

Policy Considerations

- HCPs should encourage the FDA to facilitate new vaccination development and approval using non-fetal cell strains. These should be fast-tracked.
- HCPS should advocate for the rubella vaccine to be removed from the MMR and offered as a separate vaccine, since it is produced in a fetal cell strain, whereas the measles and mumps vaccines are not.
- HCPs should advocate for rubella vaccine to be made without the use of a fetal cell strain, as it was before 1979, when the current vaccine was licensed.

*Approved by the House of Representatives
Passed with 41 approvals, 1 opposed, 0 abstention
May 2, 2021, virtual*

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*

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.*

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