

The Anabaptist Tradition

Religious Beliefs and Healthcare Decisions

By Joseph J. Kotva Jr.

Mennonite, Brethren, Amish, and Hutterite communities are the main heirs of the Anabaptist movement. This movement grew out of the Protestant Reformation in the early 16th century. Following years of Bible study, a small group of young scholars concluded that the Reformation leaders, including Martin Luther and Ulrich Zwingli, were not radical enough in their use of Scripture to criticize church practices. While the Anabaptist critique included questions about the mass, the use of images, and the morality of church officials, the argument quickly centered on the role of baptism. On the basis of passages such as Matthew 28:19-20, these young radicals argued that baptism was solely for believing adults, since infants and small children cannot understand the teaching about salvation or repent and promise to live lives of costly obedience to Christ.¹

The movement's first adult baptisms took place in January 1525, in Zürich, Switzerland. This new movement was immediately declared illegal throughout Europe and its adherents were denounced as "Anabaptists"—that is, re-baptizers. The movement was declared illegal, largely because the radicals' insistence on adult baptism and voluntary membership in the church was rightly seen as a threat to the social fabric of Europe. A central symbol in the centuries-old link between church and state, infant baptism conferred both church membership and citizen-

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ship. By insisting on adult baptism, the Anabaptists were denying the state's authority in matters of the church and were pulling apart the religious and political threads of Europe's social fabric.

Within months of the first "re-baptism," the Anabaptists were fleeing for their lives. Driven by persecution and missionary zeal, Anabaptism spread to many areas of Europe. Thousands of Anabaptists were imprisoned, tortured, burned, drowned, and even dismembered by both Protestant and Catholic authorities. Many stories of this harsh persecution and the witness of the early Anabaptists are found in the more than 1,100 pages of the *Martyrs Mirror*—until recently, the book most frequently found (except for the Bible) in Mennonite homes.

The Anabaptists emphasized the authority of Scripture and salvation by grace through faith in Christ. However, they understood these emphases differently than both the Catholic Church and the Protestant reformers.² For instance, the Anabaptists did not entrust the interpretation of Scripture to individuals or scholars or the church hierarchy. Instead, the Scriptures were to be read by all believers who had received the Holy Spirit, their meaning was to be discerned in the context of the believing community, and every interpretation was to be tested against the Gospels' stories of Christ's life and words. The Anabaptists also differed from the reformers by asserting that to accept God's forgiveness in faith was to set out on the way of discipleship—a journey, enabled by the Holy Spirit, of following Christ in every aspect of life, including simplicity, accountability within Christian community, and love of enemy. Combined with the insistence on voluntary baptism, these commitments led the Anabaptists to claim that the true church would be a visible church. Distinct from the state and separate from the evils of the world, the true church is to be visible through the transformed lives of its members and their commitment to mutual support and accountability.

Mennonites, the largest group of Anabaptists,

get their name from Menno Simons, a gifted Dutch Catholic priest who joined the Anabaptist movement in 1536. The Brethren, the next largest group, derive from a combination of Radical Pietist and Anabaptist influences. Beginning in early 18th century Germany, the Brethren fled to North America almost immediately, seeking religious liberty and economic opportunity. The Amish, the next largest group, take their name from Jacob Ammann, a Swiss Anabaptist leader who separated from other Anabaptist groups in 1693. In an attempt at reform within the Anabaptist movement, Ammann advocated stricter policies of church discipline and simple living. Amish communities are usually more geographically and socially isolated than their Mennonite siblings. The Hutterites, numbering only around 7,000 adults in the United States, take their name from Jakob Hutter, who was tortured and burned alive in 1536.³ The Hutterites go beyond mutual aid to a formal community of goods. Although as geographically separate as the Amish, the Hutterites actively engage the broader society in matters of spirituality and peacemaking.

Contemporary Anabaptist groups have a congregational polity. The center of authority rests largely with the member congregations. However, depending on the Anabaptist group, a regional district or conference may exercise significant authority, often through the role of bishops or elders. The Amish do not have organizations at the denominational level. With Mennonite and Brethren communities, the denominational organizations exercise little control over individual congregations. Instead, these organizations enable congregations and conferences to speak with one voice on matters deemed important and to collaborate in areas of mission, education, publication, mutual aid, and service. Because denominational resolutions and pronouncements arise from a denomination-wide process of collaborative discernment, they represent the broader community's position even while remaining non-binding on individual congregations.

From an Anabaptist perspective, notions of health and illness must be placed in a larger theological context that includes the church *community* and its witness to the *Kingdom of God*, the pervasive power of *sin*, and Christian *stewardship*. One instance of situating health within this larger theological framework is this sentence from the Mennonite Church's Vision Statement (adopted 1995): "God calls us to be followers of Jesus Christ and, by the power of the Holy Spirit, to grow as communities of grace, joy, and peace, so that God's healing and hope flow through us to the world." This larger theological context is likewise evident when the Mennonite Brethren confess, "We believe that God is at work to accomplish deliverance and healing, redemption and restoration in a world dominated by sin."⁴

For Anabaptists, health and healing are partial manifestations of God's redeeming Kingdom, which broke into the world in Christ and will be complete at Christ's return. Health and healing are therefore signs of God's redeeming love. However, by framing issues of health in a kingdom context, Anabaptists insist that health can never be understood in a singularly physical sense. Moreover, understandings of health must be ordered by kingdom priorities and realized in the context of restored relationships. Thus, one who is physically well is actually unhealthy if she is not at peace with God or the church or lives a life of selfishness. Conversely, one who is approaching death is largely healthy if she loves God, is cared for by the church, and has lived a life of justice and mercy.⁵

The centrality of the kingdom for understanding health is captured by Erland Waltner, former President of Mennonite Health Association, when he describes the search for physical, spiritual, and emotional well-being "as fitness for kingdom life and service."⁶ For people whose life together should witness to God's kingdom, physical health cannot become an idol sought for its own sake; nor should health be sought primarily to avoid suffering or to maximize our years on earth. Instead, health is valued pre-

cisely because it allows us to love God and serve our neighbor as a witness to God's inbreaking kingdom.

For Anabaptists, the church community is central to the connection between kingdom and health. The church is "a sign of the kingdom of God." As a distinct, recognizable body, "the church is called to witness to the reign of Christ by embodying Jesus' way in its own life and patterning itself after the reign of God." Believing that Christ is already Lord (although unrecognized by the world), and empowered by the Holy Spirit, the church strives to pattern its current life "after our life together in the age to come." Thus, every aspect of the church's life—from its internal life of fellowship and mutual aid to its external life of proclamation and relief work—is to show "the world a sample of life under the lordship of Christ."⁷

This emphasis on the church as a sign of the kingdom helps explain why Anabaptists cannot talk about health and illness without talking about restored relationships. From an Anabaptist perspective, the salvation that God offers, the kingdom that God is bringing, simultaneously involves being "reconciled with God and brought into the reconciling community of God's people."⁸ Thus, the most fundamental notion of health concerns well-being in our relationships with God and others, especially fellow believers in the church. All other aspects of health (physical, psychological, economic, etc.) derive their orientation from this basic focus on restored relationships.⁹

The emphasis on the church as a sign of the kingdom also helps to explain the Anabaptist insistence on mutual aid and bearing each other's burdens—practices that are directly related to issues of health and illness. Since the church is "a visible body of Christ mirroring the kingdom of heaven . . . love and corporate care of members . . . [is] simply assumed to be a norm of redeemed behavior."¹⁰ Anabaptist groups accept the reciprocal responsibility of members within the community to care for each other's emotional, social, spiritual, material, and

physical needs.

At one level, such mutual care implies economic interdependence and security. The Amish farmer knows that if he gets sick, fellow church members will plow his fields and help pay the hospital bills. Similarly, an urban Mennonite who lacks health insurance can share the cost of insurance with the local congregation and denominational institutions.

At another level, mutual care means that one is not alone in illness and suffering. Remaining present with the sick is a shared responsibility of the entire believing community, not just the responsibility of pastors and deacons or elders. This responsibility is expressed in ways ranging from sitting at the bedside to providing meals for the sick individual's family.

At still another level, mutual care means that "in all complex ethical decisions regarding life and death, we seek to offer . . . support and counsel in the context of the Christian community."¹¹ Anabaptist groups insist that hard decisions, including serious medical decisions, belong in the context of the prayerful community. Individuals need not, indeed should not, make such decisions in isolation. They should instead seek the wisdom of the church community, usually in the form of a small group. Anabaptists insist, moreover, that such communal moral discernment consider the repercussions for the church community of any proposed course of action.

As health and healing are manifestations of God's coming kingdom, suffering and illness are manifestations of sin and its consequences. Although Anabaptists emphasize the ability of believers in community to live faithful and obedient lives, most Anabaptist groups have a deep sense of sin's corrupting power. Anabaptists recognize that personal sin can be the cause of suffering and illness. Such illness can become an opportunity to repent of one's sins and learn to rest secure in God's forgiveness.¹² However, Anabaptist groups seldom attribute illness or suffering to personal sin.¹³ Instead, Anabaptists have a systemic or cosmic sense of sin and its

relationship to suffering: "Through sin, the powers of domination, division, destruction, and death have been unleashed in humanity and all of creation." Indeed, "governments, military forces, economic systems, educational or religious institutions, family systems, and structures determined by class, race, gender, or nationality are susceptible to [the] demonic spirits" unleashed by sin.¹⁴ Given this systemic understanding of sin, Anabaptists readily assume a connection between suffering and sin without thereby assuming the individual sufferer's culpability.

Because Anabaptists frame this broad sense of sin within a focus on the kingdom, they are free to "recognize and be grateful for whatever ways God's healing comes to us," whether through prayer and anointing with oil, through exorcism, or through physicians and therapists.¹⁵ Whatever the mechanism, true healing is a gift of God and a sign that sin's hold on the world is not final. Precisely because Anabaptists see sin as a real power enslaving humanity and corrupting creation, they see true healing as a real manifestation of God's redeeming Kingdom.

This sense of sin as a power in the world also explains the meaning that Anabaptists find in suffering. Suffering that is a result of discipleship, especially "suffering for the right without retaliation," is seen "as sharing in the sufferings of Jesus."¹⁶ Suffering that comes because we refuse to repay evil for evil is for Anabaptists a part of discipleship and, therefore, a participation in Christ. So, too, suffering that derives indirectly from discipleship—for example, illness that comes from a life of solidarity with the poor or sustaining an untimely pregnancy—is seen by Anabaptists as participating in Christ's redemptive suffering.¹⁷ Such discipleship-based suffering is meaningful as suffering for the kingdom and as a participation in Christ's overcoming of sin's power in the world. The many forms of suffering that do not derive from discipleship are seen as signs of sin's continuing power in the world and a reminder that we await the full realization of the Kingdom. In all cases of suf-

fering, Anabaptists strive to trust the sufficiency of God's grace and the love of the believing community.

The other theological element that must be mentioned here is Christian stewardship. "We believe that everything belongs to God, who calls us as the church to live as faithful stewards of all that God has entrusted to us."¹⁸

Anabaptists have a strong tradition of stewardship, including stewardship of our physical, psychological, and emotional health. An understanding of stewardship, rather than a preoccupation with personal sin, explains why Anabaptist groups exhibit lower levels of smoking and excessive drinking than the broader population. Over the last several decades, an understanding of "whole-life stewardship" led most Anabaptist groups to develop congregational and denominational programs promoting lifestyles consistent with health and wellness.¹⁹

An emphasis on stewardship also explains why Anabaptists sometimes reject costly therapy and life-sustaining treatment even when the individual or community can afford them or the treatment would be covered by insurance. Such treatments can be rejected as "poor stewardship"—that is, the misappropriation or misuse of God's resources. Thus, the Mennonite Church General Assembly in 1993 affirmed the "call on both our health care professionals and members to exercise greater restraint and stewardship in the utilization of healthcare resources." With the same rationale, the Mennonite Church publicly affirmed the idea of a national healthcare system that would limit the range of medical services that people "might want or need" so that "all people . . . [would] have access to basic preventative, curative, supportive, and emergency services."²⁰

THE INDIVIDUAL AND THE PATIENT-CAREGIVER RELATIONSHIP

Based on their commitments to community and reconciled relationships, Anabaptists emphasize individual autonomy far less than is common in contemporary American medicine. Thus, Anabaptists frequently involve family, pastors, church elders, and other church members in their decision-making. This involvement can be so extensive that clinicians deem it a violation of the patient's autonomy or confidentiality. While it is possible for fellow church members to exercise undue pressure on the patient, the caregivers are more likely witnessing the patient's faith commitments at work through the inclusion of the community's wisdom and interests in the decision-making process.

Anabaptist commitments to nonviolence and freedom of conscience also affect the patient-caregiver relationship. These commitments imply, for instance, that Anabaptist healthcare professionals must respect choices by individuals that conflict with their own moral commitments.

Such professionals must not violate the patient's or client's conscience or emotional well-being by attempting to impose their own convictions. Conversely, those professionals need not participate in procedures that are contrary to their moral convictions, including, for example, abortion. When support for decisions not to participate is lacking in broader society, Anabaptist healthcare professionals should anticipate receiving moral and economic support in the congregation and denomination.²¹

CLINICAL ISSUES

Informed consent, truth-telling, and confidentiality

Anabaptist convictions about nonviolence, truth-telling, humans as created in the image of God, and the importance of voluntary commitments²² provide the foundation for a strong support of

complete candor and confidentiality in the health worker-patient relationship.

Advance directives and proxies

Anabaptist groups encourage the use in tandem of both living wills and proxies. Anabaptist groups view advance directives not as an instrument of autonomy, but as an opportunity to express Christian faith. For example, in 1993 the Mennonite Church General Assembly assert-

ed: “We commit ourselves to completing advance directives (e.g., living wills and proxies) as an affirmation of our beliefs about life and death and as a symbol of our commitment to stewardship and justice.”²³ The merits of advance directives include protecting the family’s emotional and financial well-being, witnessing to belief in the resurrection, and freeing resources for the health care of others.²⁴

FAMILY, SEXUALITY, AND PROCREATION

Anabaptist groups greatly value family life, but they are clear that “in the kingdom of God our family ties take second place to obeying the will of God.” In addition, the “community of faith which emerges through belief in Jesus Christ is family for believers.”²⁵ Marriage and biological family thus involve penultimate commitments. Marriage and biological family find their proper orientation and place when set within the more fundamental commitment to serve God through the church, the family of faith. This focus on the faith community as a family explains why many Anabaptist groups emphasize that “singleness is honored equally with marriage, sometimes even preferred.” Since one already has a family in the church, singleness is an option that may offer “unique opportunities to advance the kingdom of God.”²⁶

Anabaptists believe that marriage is “to be a covenant between one man and one woman for life.” This covenant “is meant for sexual intimacy, companionship, and the birth and nurture of children.”²⁷ Most Anabaptists view the marriage relationship as one of mutuality and equality, where inequality and subordination are manifestations of human sinfulness.²⁸ However, some Amish and conservative Mennonite groups have a more hierarchical view of the family, with the husband/father exercising clear authority over the wife and children.

While all people need relational and emotion-

al intimacy, “sexual intimacy rightfully takes place only within marriage.”²⁹ This understanding precludes premarital, extramarital, and homosexual sex. Within the marriage context, however, sexual intimacy is seen as a good gift from God meant “for pleasure and closeness and for procreation.”³⁰

Given these understandings of marriage and sexual intimacy, the vast majority of Anabaptists consistently reject homosexual genital activity, including sexual activity between same-sex partners in a committed relationship, as sinful. Despite the majority support for this position, the question of how to regard homosexual relationships has been the most contentious issue of the last several decades within Anabaptist communities. There are strong dissenting voices, including the Brethren/Mennonite Council for Lesbian and Gay Concerns, which has published a newsletter-style periodical (*Dialogue*) for 23 years. There are also congregations that have been placed under district discipline for their acceptance of same-sex partnerships. Yet, in July 2001, the largest Anabaptist group reaffirmed the teaching position of previous church “statements describing homosexual, extramarital and premarital sexual activity as sin.”³¹

This rejection of homosexual sexual activity is not meant to be a “rejection of those . . . with a different sexual orientation” or a “lack of compassion for their struggle to find a place in

society and in the church.”³² Indeed, sympathy with this struggle led the Mennonite Central Committee in 1998 to endorse a letter sent by various Protestant church agencies to congressional representatives urging rejection of a bill that would legalize discrimination against federal employees on the basis of sexual orientation.³³

All Anabaptist groups view children as “a gift from God.”³⁴ Consequently, “children are to be loved, disciplined, taught, and respected in the home and in the church.”³⁵ Children are also taught to honor their parents. Anabaptists do not baptize babies, but they do offer child dedications, at which parents vow “to provide their children with a Christian home” and the church family commits itself to share in that responsibility.³⁶

While maintaining that “sexual purity, believers marrying believers, lifetime marriages, loving families, and fulfilling singleness” are normative,³⁷ Anabaptists also recognize that “some in the church experience divorce, abuse, sexual misconduct, and other problems that make marriage and family life burdensome and even impossible.” In these situations, the church strives, however imperfectly, to be a “reconciling and forgiving community [that] offers healing and new beginnings.”³⁸

CLINICAL ISSUES AND PROCEDURES

Contraception

Most Anabaptist groups readily accept the use of various contraceptive methods. In 1961 a Mennonite statement on parenthood includes the assertion that “we do not regard as evil the reasonable spacing of children through methods approved by Christian physicians.”³⁹ By 1974, a study book on abortion for the General Conference Mennonite Church mentions oral contraceptives, mechanical barriers, spermicides, and the rhythm method as appropriate methods for preventing pregnancy.⁴⁰

The main rationales for accepting contraception are stewardship and preventing the unwanted

pregnancies that often lead to abortion. Regarding the former rationale, a 1985 Mennonite study book says that “our understanding of Christian stewardship envelops all areas of our lives, including that of family planning.”⁴¹ The context of this statement suggests concern for Christian stewardship of both family finances and the earth’s ecosystem.⁴²

Regarding the latter rationale, a 1980 Mennonite statement on abortion says that “where children are not wanted, proper contraception should be used to prevent pregnancy. We believe that many abortions could be prevented if persons would take responsibility for sexual behavior.”⁴³ While wanting to maintain the importance of chastity outside of marriage and faithfulness within marriage, most Anabaptists would advocate the use of contraception for anyone who is sexually active and does not wish to become pregnant.⁴⁴

The Amish constitute a probable exception to this affirmation of contraceptive methods. Amish communities distrust the world’s values and are very cautious in their appropriation of new technology—recognizing that new technology frequently has unforeseen negative consequences for community life. When this apprehension is combined with the great value that Amish place on children and large families, it is likely that many Amish communities will frown on contraception.

Sterilization

A 1974 study for the General Conference Mennonite Church includes sterilization as an acceptable means of pregnancy prevention. This study recommends vasectomy as the preferable form of sterilization.⁴⁵ Vasectomies are common among married Anabaptist men who have children.

New reproductive technologies

Anabaptist groups offer a cautious acceptance of in vitro fertilization (IVF). The acceptance comes from the high value placed on children within families. The cautiousness relates to

questions of stewardship—whether pursuing this course is the best use of time and money—and fears that IVF is too closely associated with practices that diminish human dignity, such as warehousing fertilized eggs and using selective abortion to reduce risk in cases of multiple gestation.⁴⁶

There is a debate among Anabaptists as to whether artificial insemination by donor (AID) is sometimes acceptable. AID was affirmed as a possible blessing for infertile couples in a Mennonite study document. This judgment has been challenged on grounds that it gives inadequate attention to the negative consequences for a broad range of familial, marital, societal, and psychological considerations.⁴⁷

While there are no official statements, it is clear that Anabaptists reject the use of surrogate mothers. Besides questions of stewardship, this rejection is based on several interrelated concerns: introducing a third party into the marriage relationship; unnecessarily breaking the bond formed between mother and child during pregnancy; using another's body to achieve our ends, and turning children into commodities.⁴⁸

Disease treatment of pregnant mothers

There are no official statements on this topic.

Abortion

While there are differences of opinion within the Anabaptist churches about when abortions might be justified, numerous church-wide discussions and official statements over several decades show remarkable uniformity in their approach to this question.⁴⁹ First, the vast majority of intentional abortions, especially those used as a mechanism of family planning or contraception, are viewed as wrong, representing sinful acts that are not pleasing to God. In explaining this view, Anabaptist churches do not appeal to rights language or to arguments about the personhood of the human fetus. Instead, the explanations are theological: life is a gift from God, and that gift deserves respect. We (including the unborn) have incalculable

value simply because we are loved by God.

Given their communal orientation, Anabaptists also affirm the contribution that children make to the community. Therefore they ask about the long-term ramifications for community life when the unborn are not valued highly. Anabaptists insist that we recognize that decisions to terminate pregnancy affect the entire church community directly or indirectly.

Second, despite the firm opposition to abortion, there is a near-universal rejection of efforts to promote legislative initiatives that would prohibit abortion. The commitment to nonviolence, a strong sense of the church-state distinction, and the expectation (expressed in adult baptism) that Christian moral convictions will differ from those of the larger society, make Anabaptists ready to abandon legislative control of the larger culture.

Third, there is a recognition of the multiple, complex social conditions that contribute to unwanted pregnancies and the resort to abortion. Consequently, Anabaptists focus on alternatives to abortion and on programs that address the underlying causes. This focus includes elements such as promoting adoption and responsible sexual behavior. It also includes programs to assist unmarried pregnant women, single mothers, and families with children with disabilities. Overall, there is a commitment to work toward a society that values women and children, childbearing and child rearing, family life, and mutuality between women and men.

Fourth, the communal emphasis means that in those rare situations of genuine conflict between mother and unborn child, prayerful discernment should be sought within the context of the believing community, usually in a small group setting. This communal emphasis also means a commitment to stand with those enduring difficult pregnancies and to share in the responsibility of raising the children.

Finally, there are repeated reminders against judgmental attitudes toward those with different convictions and repeated calls to show care for those who have had abortions.

Care of severely handicapped newborns

There are no official statements regarding neonatal intensive care for severely handicapped newborns. The high regard for all children, the values of stewardship and communal discernment, and belief in the resurrection would play a role in these decisions.

Within Anabaptist circles there is, however, a tradition of caring for children with moderate to

very severe disabilities. There is also a quantity of literature that addresses parental struggles, recounts efforts at community support, and describes what people gain in love, self-knowledge, and knowledge of God while learning to care for these children. One such resource is the quarterly publication, *Dialogue on Disabilities*, now in its twenty-second year.⁵⁰

GENETICS

There are no official statements regarding genetic research and its ramifications. Anabaptist groups are just beginning serious conversations about how the church should respond to the various developments in genetic technology. However, it is clear that Anabaptist groups would reject germ line efforts at “enhancement” and are concerned about the ways in which the use of genetic technology may exacerbate problems of racial or gender discrimination and the economic disparities between rich and poor.⁵¹

CLINICAL ISSUES

Genetic testing and counseling

Most Anabaptist groups would support “genetic counseling where genetic diseases are possible.”⁵²

Sex selection

All Anabaptist groups would agree with this statement: “We believe that prenatal screening techniques should be permitted only for diagnosing the most serious genetic problems and certainly not for the determination of sex or other genetic characteristics.”⁵³

Selective abortion

The tradition’s strong opposition to abortion and the great value placed on fetal life rule out selective abortion except in the most extreme cases, i.e., when the mother’s life is endangered or when it is impossible to carry all the fetuses to term. In such cases, the mother/family should be surrounded by the church community for discernment and support.

Gene therapy

There are no official positions on gene therapy.

ORGAN AND TISSUE TRANSPLANTATION

There is among Anabaptists a certain ambivalence regarding organ and tissue transplantation. The procedures themselves are not viewed as problematic, and the Anabaptist emphases on loving service to neighbor and mutual aid would seem to argue for extensive church promotion of organ donation.⁵⁴ Indeed, many Anabaptists do sign organ donation cards. However, among many Anabaptists, the high cost and limited availability of transplants are “viewed as symbolic of the excess and individualism in health care which thwarts every attempt to provide basic care and equality in the health care system.”⁵⁵ As a result of this ambivalence, Anabaptist churches do not actively promote or discourage organ donation and, in consultation

with their communities, some Anabaptists will decline to be placed on recipient lists.

CLINICAL ISSUES

Use of fetal tissue

There are no official statements on this issue. However, the tradition’s high regard for fetal life, along with concerns about encouraging future abortions, means that Anabaptist groups would reject harvesting of tissue or organs from aborted fetuses for use in transplantation or research.⁵⁶

MENTAL HEALTH

Anabaptist groups, especially the Mennonite churches, have an extensive tradition of offering care and services to those suffering from mental illness. During World War II, thousands of conscientious objectors (the majority from Anabaptist traditions) were assigned to two- to four-year service terms in state mental hospitals and training schools for the mentally retarded through Civilian Public Service (CPS). The conditions in the state hospitals were deplorable. By sharing their observations with the public, in part through a 1946 issue of *Life* magazine, the CPS men helped effect reform in these institutions. More important, these men helped establish change through the quality of their service—by working hard and showing genuine care and interest in the patients. The CPS men also engaged in educational efforts to help them better prepare for their work in these hospitals.

Out of this direct involvement with mental illness, Mennonites began to develop “a vision

of what might be done with rightly motivated psychiatric aides and mental health professionals.”⁵⁷ This vision led to the establishment of the Mennonite Mental Health Services, various other mental health programs, and several church-related psychiatric hospitals.

Currently, of the few church-related psychiatric hospitals in North America, over half of them are affiliated with the Mennonite church. Like other such hospitals, these institutions use a variety of therapeutic strategies and strive for a high level of professional competency. They also strive to respect individuals as children of God and to offer, but not impose, the resources of faith and community. Services are provided to all faith groups. At the congregational level, there are repeated reminders within the Mennonite churches of the need to be welcoming communities that offer emotional and economic support for people struggling with emotional and mental illness.⁵⁸

MEDICAL EXPERIMENTATION AND RESEARCH

There are no official church statements regarding the issues surrounding medical experimentation and research.

DEATH AND DYING

For Anabaptists, death is not the greatest evil, nor one to be avoided at all costs. While differing on whether there is an afterlife that begins immediately after death, Anabaptists agree that “since Christ destroyed the power of death . . . believers need not be afraid of death, the last enemy.”⁵⁹ Anabaptists look forward to God’s final victory over the powers of evil and sin, to the resurrection of the dead, and to the kingdom come in full.

In Anabaptist communities, death is an occasion for community support of the bereaved. Members gather around the family, support them, and offer their services. When the deceased has died well, often the gathering is not only an occasion to mourn the loss of a loved one but also a time to celebrate the well-lived life of a fellow believer.

CLINICAL ISSUES

Suicide, assisted suicide, and active euthanasia
Anabaptists believe that “God values human life highly.” Moreover, life is a gift and a trust that is not at our disposal. Anabaptists therefore reject “procedures designed to take life, including . . . euthanasia . . . and active suicide, . . . [as] an affront to God’s sovereignty.”⁶⁰ These procedures violate the sanctity of life and usurp God’s role in determining the time of our death.

Suffering and pain are an inevitable part of life in a broken world. Thus, rather than seeking to determine the time of their own deaths, Anabaptists seek God’s “grace to suffer with dignity.”⁶¹ In times of pain and suffering, Anabaptists will gratefully accept palliative care

as a sign of grace and accept the community’s efforts to share in the suffering and pain.

Forgoing life-sustaining treatment

Because they believe in the resurrection and do not view death as the last word or the worst evil, Anabaptists see it as often appropriate to stop procedures or forgo treatments that simply impede an inevitable, natural death. To some, this position will appear to contradict Anabaptist convictions regarding euthanasia and suicide. However, for Anabaptists there remains an important distinction between aiming at death and allowing people to die.⁶² The former implicitly rejects God’s rule over our lives; the latter accepts God’s timing for our deaths. Because the application of such distinctions is often quite difficult in practice, Anabaptists trust that “these kinds of decisions are best made in community—with the individual, the family, the physician, and a praying church family cooperating and seeking a wise decision.”⁶³

Last rites, burial, and mourning traditions

Anabaptist groups do not have “last rites.” The funeral and burial services include the liturgical elements of singing, scripture reading, prayer, and sermons. Anabaptist services tend to be much less formal than most Protestant or Catholic liturgies. Anabaptist funeral and mourning traditions usually include significant story sharing by the family and church community. Most Amish communities are more immediately involved in the burial process: family members or others in the community will make a simple wooden casket and the casket will be physically buried by members of the church community.

NOTES

1. C. Arnold Snyder, *Anabaptist History and Theology: An Introduction*, 54-55.
2. C. Arnold Snyder, *From Anabaptist Seed*; Walter Klaassen, *Anabaptism: Neither Catholic Nor Protestant*.
3. Kraybill and Hostetter, *Anabaptist World USA*, 25, 33.
4. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 55.
5. For example, Mennonite Mutual aid, *Congregational Health Ministries*, 3-5; Mennonite Church General Assembly, "Resolution on Health Care in the United States."
6. Waltner, "New Call to 'Health-Making'"; Waltner, "Health and Wholeness in Christ," 2.
7. *Confession of Faith in a Mennonite Perspective*, 42, 90.
8. *Ibid.*
9. Willard S. Krabill, *I'm Not Whole Without You: Wholeness and Mutual Aid*, 4-6.
10. Swartley and Kraybill, eds., *Building Communities of Compassion: Mennonite Mutual Aid in Theory and Practice*, 15.
11. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 153.
12. Cf. Waltner, "Toward an Anabaptist Theology of Chaplaincy in Health Care Institutions," 5-6.
13. Graydon F. Snyder, *Health and Medicine in the Anabaptist Tradition: Care in Community*, 64.
14. *Confession of Faith in a Mennonite Perspective*, 31-32.
15. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 62; see also *Confession of Faith in a Mennonite Perspective*, 42-44.
16. *Confession of Faith in a Mennonite Perspective*, 66-67.
17. John Howard Yoder, "The Biblical Evaluation of Human Life," 10.
18. *Confession of Faith in a Mennonite Perspective*, 77.
19. For example, the topic sheets developed by Mennonite Mutual Aid on "Stewardship for Life." These include discussions of nutrition, time management, prayer, exercise, and stress management.
20. Mennonite Church General Assembly, "Resolution on Health Care in the United States."
21. General Conference Mennonite Church, "Guidelines on Abortion," 5; Shantz, comp. and ed., *MCC Canada Resource Packet on Abortion*.
22. *Confession of Faith in a Mennonite Perspective*, 28, 39, 75, 81-83.
23. Mennonite Church General Assembly, "Resolution on Health Care in the United States."
24. Krabill, *Advance Directives: The Quest for a Good Death*, 10; Mennonite Mutual Aid, *Making Your Wishes Known: Guidelines for Creating Your Advance Medical Directive*, 7-8.
25. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 122.
26. *Ibid.*, 115.
27. *Confession of Faith in a Mennonite Perspective*, 72.
28. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 115.
29. *Ibid.*
30. *Confession of Faith in a Mennonite Perspective*, 73.
31. Mennonite Church USA, *Membership Guidelines*.
32. General Conference Mennonite Church, "Resolution on Human Sexuality." Cf. the virtually identical document: Mennonite Church, "A Call to Affirmation, Confession, and Covenant Regarding Human Sexuality."
33. Mennonite Central Committee, signatory, "Letter in Opposition to Hefley Amendment to H.R. 4104."
34. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 115.
35. *Confession of Faith in a Mennonite Perspective*, 72.
36. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 126.
37. *Ibid.*, 124.

38. *Confession of Faith in a Mennonite Perspective*, 74.
39. Mennonite General Conference, "Statement on Christian Parenthood."
40. Friesen, *Moral Issues in the Control of Birth*, 18, 36.
41. Charles et al., *Human Sexuality in the Christian Life*, 100-101.
42. See also General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 161.
43. General Conference Mennonite Church, "Guidelines on Abortion."
44. The same logic applies regarding the spread of AIDS: "Recommendations for condom use come after the preferable recommendation to abstain or be monogamous" (Mennonite Mutual Aid, *Responding to HIV and AIDS: A Resource Guide for Congregations*, 15).
45. Friesen, *Moral Issues in the Control of Birth*, 18, 37.
46. See section, "In Vitro Fertilization," in Mennonite Central Committee Canada, *Occasional Papers, No. 17: Brief Submitted to the Royal Commission on New Reproductive Technologies*; cf. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 162; Hershberger, "Procreation: Extraordinary Means," 93-101.
47. Charles et al., *Human Sexuality in the Christian Life*, 101-103; Miller, "The Maze of Bioethical Dilemmas," 211. See also section, "Artificial Insemination by Donor," in Mennonite Central Committee Canada, *Occasional Papers, No. 17*.
48. See section, "Surrogacy," in Mennonite Central Committee Canada, *Occasional Papers, No. 17*. Cf. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 117; Miller, "The Maze of Bioethical Dilemmas," 210-11; Hershberger, "Procreation," 98.
49. General Conference of Mennonites in Canada, "Resolution on Abortion"; *Conference on Life and Human Values*; Mennonite Church General Assembly, "Summary Statement on Abortion"; General Conference Mennonite Church, "Guidelines on Abortion"; 198th Annual Conference of the Church of the Brethren, "Statement on Abortion"; Shantz, comp. and ed., *Resource Packet on Abortion*.
50. See also Graber and Graber, *Lessons from Emily*; Preheim-Bartel and Neufeldt, *Supportive Care in the Congregation*; Kotva, "Welcoming the Mentally Handicapped: A Case Study in Christian Character."
51. Cf. section, "Genetic Manipulation," Mennonite Central Committee Canada, *Occasional Papers, No. 17*.
52. General Conference Mennonite Church, "Guidelines on Abortion," 4.
53. See section, "Prenatal Screening," in Mennonite Central Committee Canada, *Occasional Papers, No. 17*.
54. Cf. Ebersole, "Organ Transplants," 109, 111.
55. Scot D. Yoder, "Transplants, Justice, and Health Care Reform: What Can Health Insurers Contribute?" 52.
56. See section, "Foetal Research," in Mennonite Central Committee Canada, *Occasional Papers, No. 17*.
57. Newfeld, ed., *If We Can Love: The Mennonite Mental Health Story*, 27.
58. Horning, *A Christian View of Mental Illness: Understanding and Response*.
59. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 198.
60. *Ibid.*, 153. The reference to "active suicide" is meant to distinguish the active aiming at death in suicide or assisted suicide from appropriate cases of allowing to die by removing life-sustaining technology. In such cases the likelihood of death is recognized, but death is not directly sought. Most Anabaptist groups recognize that numerous factors may play a part in an individual's decision to commit suicide. For example, suicide may be the tragic result of mental illness, and thus grow out of the fallen conditions of creation. Sometimes suicide is an act of fear or despair that may also reflect the community's failure to surround the individual with appropriate comfort care and support. At other times, suicide is an act of hubris whereby humans claim the divine prerogative of determining the timing of life and death. By contrast, allowing someone to die by removing life-sustaining technology (sometimes mistakenly referred to as passive suicide) is often a humble acknowledgement of God's timing and of human limitations in the face of death.
61. *Ibid.*
62. Cf. Kotva, "A View from Two Sides: The Principle and Its Cases."
63. General Conference of Mennonite Brethren Churches, *Confession of Faith: Commentary and Pastoral Application*, 161.

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Introduction to the series

Religious beliefs provide meaning for people confronting illness and seeking health, particularly during times of crisis. Increasingly, healthcare workers face the challenge of providing appropriate care and services to people of different religious backgrounds. Unfortunately, many healthcare workers are unfamiliar with the religious beliefs and moral positions of traditions other than their own. This booklet is one of a series that aims to provide accessible and practical information about the values and beliefs of different religious traditions. It should assist nurses, physicians, chaplains, social workers, and administrators in their decision making and care giving. It can also serve as a reference for believers who desire to learn more about their own traditions.

Each booklet gives an introduction to the history of the tradition, including its perspectives on health and illness. Each also covers the tradition's positions on a variety of clinical issues, with attention to the points at which moral dilemmas often arise in the clinical setting. Finally, each booklet offers information on special concerns relevant to the particular tradition.

The editors have tried to be succinct, objective, and informative. Wherever possible, we have included the tradition's positions as reflected in official statements by a governing or other formal body, or by reference to positions formulated by authorities within the tradition. Bear in mind that within any religious tradition, there may be more than one denomination or sect that holds views in opposition to mainstream positions, or groups that maintain different emphases.

The editors also recognize that the beliefs and values of individuals within a tradition may vary from the so-called official positions of their tradition. In fact, some traditions leave moral decisions about clinical issues to individual conscience. We would therefore caution the reader against generalizing too readily.

The guidelines in these booklets should not

substitute for discussion of patients' own religious views on clinical issues. Rather, they should be used to supplement information coming directly from patients and families, and used as a primary source only when such firsthand information is not available.

We hope that these booklets will help practitioners see that religious backgrounds and beliefs play a part in the way patients deal with pain, illness, and the decisions that arise in the course of treatment. Greater understanding of religious traditions on the part of care providers, we believe, will increase the quality of care received by the patient.



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