The Episcopal Tradition

Religious Beliefs and Healthcare Decisions

By Cynthia B. Cohen

Contents

Part of the "Religious Traditions and Healthcare Decisions" handbook series published by the Park Ridge Center for the Study of Health, Faith, and Ethics

The Episcopal Church is a branch of the Anglican Communion, a worldwide group of self-governing Christian churches that grew out of the Church of England and continue in close association with it. Christianity was brought to England early in the second century, but the English church did not emerge until the seventh century when Celtic and Roman missionaries converted the pagan Angles and Saxons who had taken over what had earlier been largely Christian Roman Britain. Reforms introduced in the sixteenth century distinguished the Church of England as an ecclesiastical body separate from the Church of Rome. These changes, catalyzed by King Henry VIII's several marriages in his attempt to secure a male heir, were grounded in reforms set in motion by Protestants. Thomas Cranmer, whom Henry VIII appointed as Archbishop of Canterbury, the chief clergyman of England, supported making the Bible accessible in English translation and wrote the first *Book of Common Prayer* in 1549 with set services in English. He and other reformers, prompted by a desire to return to the Christianity of the church councils of the first five centuries, carved out an Anglican identity that comprised a unique blend of Roman, Lutheran, Reformed, and Orthodox elements.[1] Their reforms were consolidated by Queen Elizabeth I, who took pains to see that bishops maintained a continuous line of succession from the earliest times. Although a

Cynthia B. Cohen, Ph.D., is a Faculty Affiliate at the Kennedy Institute of Ethics, Georgetown University, Washington, D.C.

Puritan party in the Church of England pushed for a more thoroughgoing reformation that would abandon traditions that were without explicit warrant in the New Testament, they were eventually unsuccessful.[2] In the wake of English colonial expansion, the reach of the Church of England spread to the United States, other parts of Europe, Africa, Asia, Latin America, the Caribbean, and the Pacific, leading to the formation of the Anglican Communion in the mid-nineteenth century.[3]

Colonists brought this reformed Christianity to America when they settled in Roanoke and Jamestown, Virginia, and later in the middle colonies.[4] In the decade following the American Revolution, Anglican settlers sent clergy back to Scotland and England to be consecrated as bishops and upon their return in 1789 established the Protestant Episcopal Church in the United States of America. Even as this uniquely American church retained ties with the mother church, it broke significant new ground in that it was independent of a state connection and included laypersons, along with bishops and clergy, in its governance.[5] Today the Episcopal Church includes about 2.5 million members. In 2000, the Episcopal Church and the Evangelical Lutheran Church in America ratified a concordat establishing a closer relationship between them, although they remain separate bodies. The Episcopal Church also continues to participate in ecumenical conversations with other Christian churches, including the Presbyterian, Roman Catholic, and Orthodox.[6]

The branches of the Anglican Communion in countries around the world are united by their ties to the Church of England through a structure that includes regular meetings of the heads of the national churches, an Anglican Consultative Council, a meeting every ten years of all diocesan bishops called the Lambeth Conference, and recognition of the Archbishop of Canterbury as the head of the communion. The branches of the communion have worship traditions in continuity with the *Book of Common Prayer* in versions distinctive to each and share an historic episcopate. The Thirty Nine Articles, a confessional statement adopted by the Church of England in the sixteenth century, is an important benchmark in Anglican theology, but the communion tends not to define itself confessionally.[7] Richard Hooker, a sixteenth-century theologian, set out the leading Anglican view that theological judgments are to be grounded in the authority of Scripture and reason in light of the understanding and practices of the Christian tradition.[8] Historically, Anglicanism has been comprehensive, including Anglo-Catholics, Evangelicals, and Liberals in one communion and fellowship. Spiritual liberty has been important to Anglicans, and they have exhibited considerable variation in belief without censure. This is evident from the work of such varied Anglican theologians and writers as Jeremy Taylor, John Donne, John Locke, Joseph Butler, Samuel Johnson, Samuel Taylor Coleridge, F. D. Maurice, William Temple, Charles Gore, Evelyn Underhill, T. S. Eliot, C. S. Lewis, and Joseph Fletcher.

The governance of the Episcopal Church is carried out by a bicameral legislature comprised of the House of Deputies, which includes both laypersons and clergy, and the House of Bishops. They meet and deliberate separately at the major gathering of the church, the General Convention, which is held every three years. Either house may initiate resolutions, but the concurrence of both is required for their adoption. Between sessions of the General Convention, the work of the church is carried on by an elected Executive Council of forty members and the Presiding Bishop, who is elected for a nine-year term by the House of Bishops with the concurrence of the House of Deputies.

The Episcopal Church includes 100 dioceses within the United States and eight more outside the country. These are closely affiliated to maintain common doctrine, discipline, and worship. Following its understanding of the apostolic succession, each diocese is led by a bishop consecrated in the historic episcopate. In 1976, the General Convention of the Episcopal Church approved the ordination of women to the priesthood, and in

1988, the first female priest was elected bishop. Each diocese also has a legislative body comprised of clergy and elected representatives of congregations; this body meets annually and elects the diocesan bishop with the concurrence of all other bishops. Also common to each diocese is a standing committee of clergy and laity that shares in the governance of the diocese with the bishop and committees and boards that pursue various spiritual, liturgical, educational, social, and missionary programs. Self-supporting congregations are governed by an elected vestry that, with the concurrence of the local bishop, calls as its pastor a priest, known as the rector, who is responsible for pastoral oversight and administration of the parish.

Anglican moral theologians and ethicists have differed widely in approaches and emphases, including among their number casuists, natural law theorists, principlists, consequentialists, communitarians, liberal individualists, and situation ethicists. They tend to agree that the community, with its past wisdom and experience, shapes the individual conscience and provides the framework of moral values from which reason operates.[9] A distinctively Anglican form of casuistry sprang up in the sixteenth century and continues to provide a leading form of moral thinking within the communion. Its originators viewed this "casuistical divinity" as a comprehensive moral science that included not only the resolution of specific conflicts of conscience but also a systematic body of teaching.[10] They rejected a Roman Catholic approach focused on applying canon law to cases, instead developing broader accounts of Christian faith and life that often combined the moral and the ascetical, i.e. the practices of religion or what is often spoken of today as "spirituality."[11] In particular, the casuists dismissed the "probabilism" of the Jesuits, which held that any probable opinion could justify a moral choice, even if the opposite opinion were more probable. Instead they declared that the more reasonable opinion should be chosen "in the whole conjunction of circumstances and relative considerations."[12]

This reformed casuistry was succeeded in the seventeenth century by an approach grounded more firmly in general moral principles, even as it revealed an empirical strain that took account of the complexity of moral life.[13] Anglican evangelicals and social reformers of the eighteenth and nineteenth century used this approach to campaign relentlessly for social reforms and industrial legislation designed to ameliorate hardship and injustices suffered by the poor.[14] The quest for a distinctively Anglican moral theology was continued in the twentieth century by Kenneth Kirk, who applauded the theological tolerance typical of Anglicanism.[15] "Situation ethics," introduced by Joseph Fletcher in the middle of the twentieth century,[16] utilized a form of casuistry holding that love is the only moral norm, the end justifies the means, and decisions ought to be made in view of the uniqueness of each situation. Although it provoked a storm of protest from Anglican and other Christian moral thinkers, it added yet another moral approach attractive to some Episcopalians.

No single document expresses the final teachings of the Episcopal Church concerning bioethics and health care. Only canon law passed by the General Convention has binding character; canon law, however, generally addresses matters of governance and does not specifically address matters of health. The Holy Bible assumes great importance as a source of fundamental Anglican convictions concerning ethical questions related to health care, exerting much of its influence through the *Book of Common Prayer*, with its largely biblical content.[17] Episcopalian understandings of questions of medical ethics and health care have also been enhanced by a variety of other writings, including reports from the House of Bishops; pastoral letters from the presiding bishop and diocesan bishops; reports and special studies from standing commissions, committees, and task forces of the General Convention; resolutions of the General Convention; reports and special studies from Executive Council committees; and articles and

books by Episcopal scholars at seminaries and other academic institutions.

The Standing Commission on National Concerns of the General Convention includes among its concerns issues that until 1997 had been the responsibility of the Standing Commission on Human Affairs and Health, particularly questions of health and bioethics. In 2000, an End-of-Life Task Force of the standing commission published a report that has been circulated widely as a teaching document within the Episcopal Church and the wider Anglican Communion.[18] The Task Force on Ethics and the New Genetics of the Executive Council is expected to complete a report on genetic testing, gene transfer, and their connections with the new reproductive technologies and cloning in 2003 or later. It will also consider ethical questions surrounding stem cell research. The Committee on Medical Ethics of the Diocese of Washington has published several books related to health care and bioethics that have provided additional resources for members of the Episcopal Church. They address advance directives (with a service for a time when life-sustaining treatment is withdrawn), assisted suicide and euthanasia, care of those who are critically ill and dying, and genetic testing and counseling.[19]

Episcopalians also take heed of the reports and pastoral letters of the Lambeth Conference of the Anglican Communion,[20] resolutions of the General Synod of the Church of England, reports of its Board for Social Responsibility,[21] and resolutions and reports from other branches of the Anglican communion. These wide-ranging resources reveal the mind of the church, but none is considered juridically binding upon Episcopalians.

THE INDIVIDUAL AND THE PATIENT-CAREGIVER RELATIONSHIP

The value of the human body is stressed, not denied, in Anglican thought. The communion teaches that the incarnation—the belief that God became human, thus experiencing human life in body, as well as mind and spirit—indicates that human embodiment is important. This, in turn, means that we are to care for our bodies as temples of God. We are to promote our physical health by seeking medical treatment, engaging in preventive care, following healthy diets, performing regular exercise, and avoiding substance abuse.[22]

Healthcare professionals play an important role in assisting individuals to achieve those ends. Given the importance of the values of fidelity and community in Anglicanism, the End-of-Life Task Force declared, the patient-healthcare professional relationship should be one that is collaborative and collegial.[23] Professionals should establish caring relationships with the sick and suffering, recognizing that human beings are not isolated atoms, but are essentially social in nature. They are, as Hooker observed, "sociable parts united into one body . . . bound each to serve unto other's good."[24] Thus, service to others, including caring for those with impaired health, and consideration of the good of the whole are important Episcopalian values.

Patient values and preferences play an important role in medical care decision making for Episcopalians. The Anglican tradition recognizes that adults with the capacity to make decisions have the right and responsibility to choose among treatment options and to refuse available treatments when they consider doing so morally appropriate.[25] Individual autonomy, for Anglicans, is set within the context of our relation with God and others. This means that we are not only free to choose, but to choose in ways that are rooted in our lives in community and in God's purposes. This emphasis on individual choice with regard to care of the body is grounded in the recognition of human dignity. Such dignity derives from the special relationship in which each human being

stands to God, rather than any particular qualities that an individual may possess. The dignity of each person means, the noted theologian William Temple stated, that "the Church must make respect for freedom its most fundamental principle of action."[26]

Healthcare professionals are also individuals of great worth whose choices must be respected. When patient healthcare requests would violate the moral or religious principles of healthcare providers, they should seek other caregivers willing to carry out those requests and should transfer such patients to their care. Carrying out such transfers exhibits respect for the freedom and responsibility of patients to make important decisions about their own health care.[27]

Healing is not only of the body. The General Convention of 1991 observed that healing is of the whole person—spirit, mind, and body.[28] Therefore, others in addition to healthcare professionals can offer an efficacious ministry of spirit and mind. A church commission has recognized that along with healthcare professionals, clergy and spiritual healers serve as agents through whom God works to achieve human health.[29]

Clinical Issues And Procedures

Informed consent

Anglicans share the conviction that healthcare professionals should speak openly with patients about their condition and therapeutic alternatives. They should inform them of the probable benefits and risks of available treatment options and give them the opportunity to give or to withhold their consent to a chosen course of therapy.[30] Disclosure of information and observations by healthcare professionals, the End-of-Life Task Force observed, should take account of the individual patient's worldview, cultural background, and moral framework. "The need to be sensitive to our relational, as well as our informational needs may be particularly important outside a generalized Anglo and middle-class culture."[31]

Parents should serve as custodians for children for whom healthcare decisions must be made, acting with a commitment to their physical, emotional, and spiritual well-being. There is a presumption that ordinarily their decisions represent considered judgments about the good of the child.[32] The End-of-Life Task Force recognized that decisions about medical care for children are appropriately made by their parents in most cases "because of the love that binds them together and because they have a history of life together in which they have shared values, joys, and sorrows."[33] Children who are very young cannot be considered capable of participating in decisions on their behalf. As they mature, however, they can make thoughtful and fitting decisions about their care. Most physicians and medical ethicists recognize the importance of seeking the assent—rather than consent—of a child who is sufficiently mature to participate in decisions directly affecting her health, physical integrity, or possible death.[34]

Truth-telling and confidentiality

The Anglican tradition stresses both honesty—accurately speaking what one believes to be the truth—and candor—volunteering information of relevance when not specifically asked for—in health care.[35] Patients cannot carry out their responsibilities to make healthcare decisions without accurate information. Furthermore, honest communication among persons is fundamental to Christian life, for unless we acknowledge the dignity, personhood, and status of others as neighbors to be treated openly and honestly, we fail in our duty to promote right relationships with others.

There are important issues of timing and wording that arise when caregivers communicate troubling news. To speak the truth in love (Ephesians 4:15) requires professionals to avoid uttering the truth in ways that can terrify or estrange a vulnerable person.[36] Moreover, the failure to be trustworthy and to retain confidences erodes any relationship. Therefore, confidentiality is also demanded as a component of the relationship between healthcare professional and patient.[37]

FAMILY, SEXUALITY, AND PROCREATION

The importance of the physical nature of marriage is emphasized in the words of an early English service, spoken by the man as he places a ring on the finger of the woman's hand, "With this ring, I thee wed: with my body I thee worship." Richard Hooker, the noted sixteenth-century Anglican theologian, commented about this phrase:

> Parties married have not anie longer intire power over them selves but ech hath interest in others person, it cannot be thought an absurd construction to saie that worshipping with the bodie is the imparting of that interest in the bodie unto another which none before had save onlie our selves.[38]

John Donne, in his sermons, reiterated the Anglican view that the joining of two persons, body and soul, in matrimony is not inferior, unworthy, or unclean.[39] Sexuality is to be tied to the embrace and care of the other in a loving relationship.

There is considerable difference of opinion within the Episcopal Church and the Anglican Communion in general about the moral acceptability of homosexual relations. Despite such disagreement, the Episcopal Church has been generally supportive of the needs of lesbian and gay persons and has remained open to continued study and dialogue about human sexuality.[40] In 1991, the General Convention adopted a resolution affirming that "physical sexual expression is appropriate only within the lifelong monogamous 'union of husband and wife in heart, body, and mind' intended by God for their mutual joy."[41] In 1994, a document from the House of Bishops, *Continuing the Dialogue*, was endorsed for purposes of study by the General Convention.[42] In 2000, the *Cambridge Accord* was endorsed by the General Convention.[43] This document, developed by bishops of the Anglican Communion in 1999, stated that no homosexual person should be deprived of liberty, personal property, or civil rights because of his or her sexual orientation, that acts of violence and degradation against homosexual persons are wrong, and that every human being deserves to be treated with dignity and respect. The 2000 General Convention, in response to a call for dialogue by the Lambeth Conference of 1998, reaffirmed that those on various sides of this controversial issue "have a place in the Church" and vowed to continue the process of mutual discernment concerning human sexuality.[44] It also stated that those who are living together in committed relationships should avoid promiscuity, exploitation, and abusiveness.[45] Further, it called on congregations to establish "safe spaces" for lesbians and gays.[46]

Marriage, grounded in mutual trust, acceptance, and service, is not exclusively a private matter within the Anglican tradition, but is also rooted in the community. In the twentieth century the Anglican Communion tempered an earlier emphasis on procreation as a primary end of marriage, adopting a more explicit recognition that mutual affection, support, and care are at its core. In so doing, it set aside a position derived from Augustine's view of sexual intercourse, which considered it illicit unless excused by the intent to procreate. The 1979 *Book of Common Prayer* recognizes the need of married persons to complement and fulfill each other and to establish a durable partnership. This is in accord with the early Christian tradition, in which marriage was closely tied to companionship.[47] Thus, the *Book of Common Prayer* of 1979 sees marriage as primarily grounded in the commitment of man and woman to love one another, for better or worse, regardless of the consequences. The purposes of marriage, according to "The Celebration and Blessing of a Marriage" in the prayer book, are "mutual joy . . . help and comfort" and "the procreation of children . . . when it is God's will."[48] This suggests that, in some situations, which are not necessarily confined to infertility, it may not be God's will that a married couple have children.

Yet the Anglican tradition also recognizes that children are a blessing and a joy in marriage. Children are cherished not only as symbols of the mutual commitment of couples, but also as beings with their own integrity and uniqueness. In the Anglican tradition, couples are gifted with children, rather than entitled to them. Parents serve as their procreators rather than their creators, meaning that children are not their parents' possessions, products, or projects, but their trusts.[49] Children are beings with a fundamental human dignity who should not be seen as extensions of the self or a means of securing identity. They are precious gifts from God who are not to be acquired or specifically designed to meet parental desires or standards of "quality control."

Clinical Issues And Procedures

Contraception

Until the last century, no efficient and reliable means of birth control were available, and consequently pregnancy and childbirth were the usual results of sexual intercourse. The use of contraception was considered illicit. Jeremy Taylor, for one, expressed the older Anglican view that sexual appetite should not be separated from the ends for which it was intended by nature, including the desire for children.[50] The Anglican Communion, however, introduced a new openness to the use of contraception at the Lambeth Conference of 1930, indicating that couples could, without moral onus, pursue responsible family planning to control the number and spacing of children. The Lambeth report was subsequently reaffirmed by several General Conventions of the Episcopal Church, which noted that responsible parenthood requires wise stewardship of the resources and abilities of the family, as well as consideration of the varying population needs of society and the claims of future generations.[51]

Sterilization

What is at stake in sterilization is not just the integrity of the body, but also social relations with others, including our spouse, family and society.[52] Reasons that these relations might justify a decision to employ sterilization, according to a Church of England working party, include the need for lower population growth in a community, the need of a family adequately to provide for its members, and the need of parents for personal satisfaction in one another.[53] Sterilization might also appropriately be considered by those who wish to avoid conceiving children because they are concerned that they would pass on a serious genetic mutation.[54] Important questions that those considering this procedure should ask are: Is sterilization the least drastic means available to attain a necessary end? Has the decision been a collaborative one? Has the person involved considered the effects of sterilization on his or her identity and self-image?[55]

This reasoning, however, does not justify compulsory sterilization. The forced sterilization of families in the People's Republic of China was deplored in a 1994 General Convention resolution.[56] Sterilization of those who are developmentally disabled, an English working party observed, offers them only incomplete protection from sexual abuse.[57] We would do better to integrate such persons "into the life of the community, providing such support and protection as they need in the conduct of their lives," the working party stated. Moreover, our history of eugenic sterilization does not provide reason to believe that we would use this technique wisely in the future to select persons to be sterilized. Smith maintains that "compulsory sterilization is wrong, then, because it involves serious risks to the person of the patient, because of its dubious effect and necessity, and because it is unclear that we can formulate criteria for its fair use."[58]

New reproductive technologies

Questions related to alternative ways of having children have been significant within the Episcopal Church, for they raise the basic question of where to draw limits on human control over natural processes. The General Convention of 1982 approved the use of in vitro fertilization

(IVF), or fertilization of an egg with sperm in a laboratory dish to create a human embryo that is implanted in a woman's uterus for married couples experiencing infertility.[59] Couples considering the use of such reproductive technologies should seek the advice and assistance of a qualified professional counselor, the 1991 General Convention recommended.[60] Moreover, it added, during their deliberations they should consider adoption. The use of artificial insemination by married couples—the impregnation of a woman with the husband's sperm by medical or other artificial means—was affirmed by the Standing Commission on Human Affairs and Health in 1988.[61] The General Convention, however, has not passed a resolution to support the use of this reproductive technique.

The Episcopal Church has not endorsed new reproductive technologies that introduce third party donors into the creation of children. The 1988 General Convention considered artificial insemination by donor problematic.[62] The Standing Commission on Health and Human Affairs of 1988 provided preliminary reflections suggesting that it was morally questionable to hide knowledge of their biological parent from the resulting children and to allow a donor "to refuse moral and legal responsibility for a future child that his or her choice helped procreate." Moreover, revealing the identity of the donor, the commission opined, raises "difficult issues of parenting, family identification for the child, and, potentially, legal issues of parental responsibility."[63] The use of a third party can severely complicate parenting and strain the marital relationship for the spouse who did not contribute gametes to the creation of the future child, the commission maintained.

The General Convention in 1982 and in 1988 rejected another practice involving the use of third parties, surrogate parenthood—contracting with a woman to be impregnated with a male's sperm, bear the resulting child, and deliver that child to the contracting man and his wife.[64] The Standing Commission on Human Affairs and Health pointed out in 1988 that this practice poses physical risks to the surrogate and raises the possibility that she will be exploited economically.[65] The commission called for more complete study of this and other new forms of reproductive technology by the church, keeping in mind the distinctive Christian vision of sexuality, marriage, and parenting.

The standing commission advised that the use of the new reproductive technologies by single women to have children of their own raises a serious moral problem, for the resulting child suffers the deprivation of having only one known parent. Therefore, it is inadvisable.[66]

The Executive Council Task Force on Ethics and the New Genetics is developing a report on ethical questions related to the uses of the new reproductive technologies and cloning. Its completion is expected in 2003 or later.

Uses of human embryos

There is no unanimous view within the Anglican tradition about the moral status of the human embryo. Some maintain that the same protection should be accorded to the newly fertilized egg as to a born human being because the unique genetic component of an individual is largely established at conception. The same individual subject is present throughout the process of prenatal development, they maintain, for they can find no obvious threshold beyond conception by which to discern when the embryo should be considered distinctively different and thus an individual human.[67] Others hold that because the early embryo may divide during its first two weeks into two or more separate fragments, each of which can develop into a distinct human being, the physical basis for human individuality is not settled until the primitive streak has formed at about two weeks and the destination of the cells is settled.[68] Some in this latter group are also reluctant to accept conception as the point at which a living human being is present because a large proportion of embryos (in the range of 75 percent) is aborted spontaneously early in pregnancy. They find it difficult to accept that God calls human beings into life at conception and then allows three-quarters of them to die soon after.

The Standing Commission on Human Affairs and Health stated in 1988 that Christian thought widely judges the use of human embryos for experimentation to be immoral and went on to say that it could not affirm such experimentation for members of the Church.[69] The commission also rejected freezing fertilized human ova "for later thawing, experimentation, possible implantation, or discard" on grounds that the safety and efficacy of this procedure were still in doubt.

Ethical questions surrounding the use of human embryos in stem cell research are expected to be addressed by the Executive Council Task Force on Ethics and the New Genetics in 2003 or later.

Abortion

The Episcopal Church generally takes the question of abortion as a matter of individual conscience, informed by the teachings of the church, the counsel of religious advisors, and the law. It opposes both abortion on demand and an absolute ban on abortion, tending to support it for the sake of the life or health of the woman. The General Convention of 1994 reaffirmed earlier statements that regard abortion as having a tragic dimension and as a practice to be carried out only in extreme situations, not as a means of birth control, family planning, sex selection, or convenience.[70] Those considering abortion are urged to seek the counsel of members of the Christian community and the sacramental life of the Church as they explore alternatives to abortion, including but not limited to having and raising the child, asking another family member to raise the child, or giving up the child for adoption. Any proposed legislation regarding abortion, the General Convention of 1988 stated, must support respect for individual conscience.[71] The church's approach to abortion, however, has not been without its internal critics, who maintain, among other points, that the church's position is self-contradictory in that it affirms the sacredness of human life and yet allows the destruction of human fetal life.[72]

In 1991, the General Convention opposed legislation requiring that parents be notified or required to consent when a minor seeks an abortion, unless such laws allow the minor to consult with a responsible adult outside the courtroom setting when she is unable to notify parents or where family dysfunction may put her "at serious physical, psychological or emotional risk." In this context, a "responsible adult" is a person such as a clergy person, teacher, guidance counselor, mental health professional, or other family member.[73]

GENETICS

There is a long tradition of thought within Anglicanism that encourages us to pursue knowledge and develop more accurate ways of understanding the natural world. The conviction that humans are called to shape and renew the natural order undergirds Anglican moral thinking.[74] As stewards of creation, humans are to mend and transform the world in ways that accord with God's purposes. In particular, we are to use our God-given capacities for scientific knowledge to alter the progression of disease.[75] Yet our obligations as trustees of God's creation also constrain our interventions into nature, requiring us to respect its integrity and order. The Christian tradition sets out limits to what we may do with and for our own bodies. There is common agreement that they are not to be treated as mere instruments but are to be honored in their own right.[76] Therefore, we are to proceed cautiously with our efforts to understand and rework the human genome, responding to disease and disability in ways that fulfill God's intentions for us.

Clinical Issues And Procedures

Gene therapy

In 1985, the General Convention acknowledged the importance of research into the human genome, recognizing its potential benefits even as it noted the ethical concerns that such investigations raise. It encouraged "genetic engineering research to increase human understanding of vital processes, recognizing that human DNA is a gift of God, at the center of life and directing our development, growth and functioning."[77] A 1988 report of the Standing Commission on Human Affairs and Health endorsed studies involving gene therapy that are approved by independent, adequately informed peer review boards and are intended for publication in recognized scientific journals.[78] In accord with these resolutions, the 1991 General Convention stated that there is no theological or ethical objection to gene therapy that is aimed at prevention or alleviation of serious suffering and poses no undue risk to the patient.[79] It also indicated that the Episcopal Church has "no theological or ethical objection against the production and use of medicinal materials by means of genetic manipulation for therapeutic or diagnostic purposes aimed at the prevention or alleviation of serious suffering."[80] The question of whether to intervene into the germline by altering the genes of sperm, egg, or embryo to alter the genetic makeup, not only of a new person but of that person's descendants, is currently under discussion within the Episcopal Church. If it can be used to eliminate terrible disease within a family, a prominent Episcopal thinker has maintained, that would be a gift of God that we should celebrate.[81] However, the possibility of using this and other forms of genetic intervention to enhance tomorrow's children is troubling, not least because of the possibility of the abuse of power and the impossibility of changing the results.

Genetic testing and counseling

As stewards of creation, we have an obligation to pursue knowledge and to care for creation by using our growing capacity for genetic testing in ways that serve God's purposes, a report from the Committee on Medical Ethics of the Diocese of Washington stated.[82] Yet in our brokenness, we may misuse this gift God has given us for our own glory, power, and wealth. Therefore, we need to become aware not only of the benefits of such testing, but also of its drawbacks for us as individuals and for our society. The many benefits of genetic testing include that it may reduce our anxiety and uncertainty, lead us to investigate possible treatment or eliminate the need for treatment, assist us in making decisions about the future, inform our decisions about having children, and draw us closer together as families. Yet such testing can also heighten our anxiety, yield results that are difficult to interpret, create uncertainty, impair planning for the future, expose us to discrimination in insurance and employment, and strain family relationships. The General Convention of 1991 recognized some of these disadvantages of genetic testing and maintained that "the use of results of genetic screening of adults, newborns and the unborn for the purpose of discrimination in employment and insurance is unacceptable."[83] Consequently, deciding whether to undergo genetic testing is not easy. It is advisable for those contemplating it to call upon genetic and pastoral counselors for assistance in deciding whether to proceed.[84]

It is also wise, the Committee on Medical Ethics of the Diocese of Washington observed, for us to discuss the possibility of testing beforehand with our family and to reach an understanding about how other family members will respond to our test results.[85] The decision by one person in a family is not an isolated one, but has implications for other family members as well. When a family has a history of a serious genetic disorder and one of its members tests positive for the relevant gene, others in the family will have to decide whether they, too, wish to learn whether they have the gene. Thus, consultation with family members in advance can prepare others for the possibility that they, too, may

have to confront the decision whether to be tested.

Genetic testing also creates certain social risks, for it opens the door to the reintroduction of eugenics into our community. Decisions by individuals to use prenatal testing to abort fetuses with disabilities or unwanted characteristics might, when taken together, have a disastrous cumulative effect. They might create a culture in which those who are "defective" are weeded out, and only those who are deemed of excellent quality—according to sometimes arbitrary and perverted standards—are considered worthy of coming into the world. While it is tempting to want to bring a "perfect" child into the world, such a desire is unrealistic and uncharitable. Christians should embrace diversity within the human family and the equal value of all of God's children as they work to overcome social stereotyping, the committee maintained.[86]

ORGAN AND TISSUE TRANSPLANTATION

The Episcopal Church has supported the use of organ transplantation and encouraged members to consider seriously the opportunity to donate organs, blood, and tissue after death so that others may live.[87] Decisions about donations should be made well ahead of time so that any tissues or organs needed for donation may be removed as soon after death as possible.

The Standing Commission on Human Affairs and Health raised important questions in 1988 about ways in which organ transplantation should and should not be used. Often this procedure is not morally problematic. Accepting tissues such as cornea or skin can enhance the quality of life of a person without imposing serious burdens. However, the situation is morally more complicated in the case of organs such as kidneys, the pancreas, or the heart. The Standing Commission on Human Affairs and Health in 1988 recommended careful reflection about such questions as: What is the risk to living donors? Is one obliged to undergo severe burdens to avoid death or, to the contrary, should one forgo transplantation that would be disproportionately burdensome? Because these questions are complex, the commission urged further study.[88]

The General Convention of 1991 urged members of the church to consider seriously the opportunity to donate organs after death. Such decisions should be clearly stated to family, friends, church, and attorney.[89] Although it is morally appropriate to decide to donate an organ to another in need, special care must be taken by those making inquiries to avoid coercing living donors.[90]

The conception and deliberate abortion of fetuses to obtain fetal tissue for medical research was rejected by the 1991 General Convention, as was the use of fetal tissue aborted for profit.[91] The convention recommended further study of the use of tissue from fetuses that have been aborted to save the life of a woman.

MENTAL HEALTH

The needs of those suffering from mental illness have been of particular concern to the Episcopal Church. The General Convention of 1985 called for the development of a means of assisting homeless persons who are mentally ill, and lack an adequate support system, by various agencies of the church and other social agencies and the healthcare delivery system.[92] The General Convention in 1991 reiterated this concern and encouraged initiating programs to equip clergy and laity to minister to the mentally ill and their families. More specifically, it called for the development of "support groups, drop-in centers, housing and employment opportunities" for those with mental illness, particularly the homeless.[93] Dioceses, congregations, and individual parishioners were encouraged to become advocates for funding to provide comprehensive community-based services, hospital care, and research into the causes and treatments of mental illness. The National Alliance for the Mentally Ill was recommended as a resource for congregations and families of the mentally ill in a 2000 resolution.[94]

DEATH AND DYING

Early Anglicans, who lived in a society in which plague swept away vast numbers of people, childbirth often ended in death, and medical practice was relatively ineffective, drew a close connection between sickness, death, and sin. Thus, the "Great Litany," published in 1544, ended with the prayer: "Have pity upon us miserable sinners, that now are visited with great sickness and mortality, that like as thou didst command thy angel to cease from punishing, so it may now please thee to withdraw from us this plague and grievous sickness."[95] A steady flow of books taught those who were sick to repent, meditate upon "last things," and die well (*ars moriendi*). Chief among these tracts was Jeremy Taylor's guide to holy dying, which emphasized the need to prepare for death over a lifetime, but especially when visited by sickness.[96]

Twentieth-century Anglicans no longer see sickness as inevitably ending in death or primarily as punishment for sin. The 1979 *Book of Common Prayer* tends to view illness as a result of a disordered universe, rather than as punishment directed against evil doers. Thus, it offers the prayer to God that the sick, "accepting your healing gifts through the skill of surgeons and nurses . . . may be restored to usefulness in your world with a thankful heart."[97] Death, in the service for burial of the dead, is viewed as comforting rather than condemning, triumph rather than defeat.[98] The End-of-Life Task Force asserted that "Christian faith enables us to look upon our own dying, and that of people we love, as a journey with Christ through death into the life of God."[99]

Clinical Issues and Procedures

Forgoing life-sustaining treatment

Human beings are precious, cherished creations of God, yet their lives need not be extended at all costs. When individuals are near the end of life and medical powers cannot change their course toward death, there is no moral obligation to prolong their dying. In such circumstances, it is morally appropriate to withhold or withdraw life-sustaining treatment and to allow their lives to come to their end.[100] Although it can be enormously difficult to acknowledge that someone who is deeply loved cannot be kept alive, recognizing when this is the case and removing burdensome medical measures to allow the natural

course of events to proceed is an act of care and compassion.[101]

Decisions to withhold or withdraw life-sustaining treatment should be made by the individuals whose lives are affected. However, as the End-of-Life Task Force reaffirmed, when such individuals no longer have decision-making capacity, a surrogate—or family members when no surrogate has been named—should make decisions about the use of such treatment on the basis of the values and preferences the patient had expressed earlier.[102] Caregivers should allow those who are near the end of life to die peacefully in a setting that enables them to maintain dignity free from unwanted and inappropriate technology. When persons are in a comatose state from which there is no reasonable hope of recovery, it is ethically sound to contemplate withholding or removing life-support, including artificial nutrition and hydration.[103]

Not only adults, but also newborns and children for whom cure is not possible and who face a life that amounts to a form of dying should not be subjected to useless life-sustaining treatment. Instead, they should be provided with all available comfort measures as their lives come to an end.[104] Children who are developmentally disabled or mentally challenged should not be considered to be dying solely on account of their disabilities and should receive care that is appropriate to their needs.

A service for a time when life-sustaining treatment is withdrawn, developed by the Committee on Medical Ethics of the Diocese of Washington, offers pastoral support to those who are dying and to their caregivers during the removal of technological medical support.[105]

Suicide, assisted suicide, and euthanasia

Reports from within the Anglican Communion express the almost universal Christian belief that suicide is wrong and that assisting persons to kill themselves or killing them outright is also wrong.[106] Our lives are not our own, to dispose of at will, but are a gift from God, to whom they ultimately belong. Suicide is the expression of a refusal to trust in God, an embracing of death for its own sake, a form of self-justification. The great moral danger of suicide and assisted suicide is that they will be egotistical and manipulative, symbolic of an unwillingness to play the role of dependent when it falls to our turn. Moreover, the end of a person's life is not simply a private matter, but has import for those who surround the person.

The question whether it is more compassionate to kill those who are in excruciating pain and suffering near the end of life, rather than allow them to die in misery, can arise in unusual, extreme cases. Any honest person will acknowledge that he or she would wish for a hastened death in such circumstances.[107] However, there should be no need for anyone to undergo such radical suffering today. The End-of-Life Task Force declared: "Where there are drugs available to hand to a despairing person near death so that he or she can commit suicide, there are also drugs available to provide to that person that will afford relief from pain and allow a peaceful death."[108] *Agape* or neighbor love may be "better expressed and more deeply nourished by the careful accompanying of a person in his dying than by any established practice of voluntary euthanasia."[109] The Anglican Communion has consistently held that euthanasia should not be legalized, for if this practice were to become socially accepted, those who are vulnerable, such as the elderly and chronically ill, might well feel that they had to cope with the question, "Why aren't you dead yet?"[110] Some might be pressured into ending their lives in order to relieve others of the burden of their care rather than because of pain and suffering that they experience. Others might elect assisted suicide to save their families the costs of maintaining them in a healthcare system that might drain them of their life savings. Rather than allow such persons to end their lives prematurely for the sake of others, we should reemphasize that we value all who are living and wish to provide them with care and support as their lives draw to a close.

Proxy decision making and advance directives

Several reports from church working groups and General Conventions have encouraged the use of advance directives by individuals to inform relatives, friends, and future caregivers about the sort of treatment they wish to receive near the end of life should they become unable to speak for themselves.[111] Ethical questions related to preparing such documents are specifically addressed in a book from the Committee on Medical Ethics of the Diocese of Washington.[112] It points out that it is important to prepare these documents *before* a serious illness so that those caring for persons near the end of life will know whether or not they wish to have life-sustaining treatment, what sorts of supportive care they want, and whether or not they plan to donate organs and tissue to others. It urges Episcopalians to discuss their advance directives with family members and friends as they develop them, so that those close to them will be aware of their values and concerns and will be able to make medical care decisions for them should they later become decisionally incapacitated.

Pain control and palliative care

It is widely accepted within the Anglican Communion that caregivers have an obligation to provide palliative care and pain-relieving medication to those nearing the end of life, even if this should inadvertently shorten the lives of the dying.[113] The General Convention of 1994 emphasized that "palliative treatment to relieve the pain of persons with progressive incurable illnesses, even if done with knowledge that a hastened death may result, is consistent with theological tenets regarding the sanctity of life."[114] As the report of the End-of-Life Task Force points out, recent research indicates that providing medication to patients to alleviate pain in doses that are gradually increased to meet their individual needs rarely shortens their lives.[115] Instead, giving such drugs in carefully titrated doses prolongs the lives of many who are near death because they become more comfortable and more apt to take greater amounts of nourishment.

However, there is a pressing need to provide more adequate and extensive palliative care for those approaching death. Several General Conventions have urged healthcare professionals, families, patients, and legislative bodies to prevent intolerable suffering among the dying caused by the underuse of pain medication, including narcotic drugs.[116] The General Convention of 2000 urged the healthcare professions to improve the quality of palliative care by offering physicians and nurses more extensive education about the most recent research. It specifically declared that healthcare professionals should provide sufficient levels of pain-relieving drugs to those near the end of life to relieve their pain and discomfort and should make timely referrals to hospice for them.[117]

Hospice care

The great renewal of care for the dying, the hospice movement, originated with the work of Dame Cicely Saunders, a physician and nurse whose outlook has been deeply formed by Anglican practical piety. The basic goal of the hospice movement, to provide comprehensive end-of-life care that will achieve a good quality of life for each person by meeting his or her physical, emotional, and spiritual needs, has been widely approved within the Anglican Communion. The concept of hospice was introduced in 1976 in the first edition of *On Dying Well*, a Church of England report to which Dame Cicely contributed.[118] It has since been embraced in subsequent reports from within the Anglican Communion, including those from the Episcopal Church.[119] The General Convention of 2000 strongly supported the goals of providing interdisciplinary hospice care and communal support for the patient and family during the dying process, as well as care for families during bereavement.[120]

SPECIAL CONCERNS

Justice and Access to Health Care

American healthcare system

Historically, the Anglican Communion has been actively involved in the provision of health care. Many of those practicing medicine and surgery in England and America before the nineteenth century were clergy. As the subject matter of medicine became more complex, however, fewer Anglican clergy found themselves able to devote time to the study of both theology and medicine, and the medical and clerical professions gradually developed separately. Even so, the close historical connection between pastoral caregivers and medical practitioners, as well as the theology of healing of the Anglican tradition (see above, "The Individual and the Patient-Caregiver Relationship") has made the communion deeply committed to ensuring that all persons receive health care of good quality in a just manner. As hospitals and other healthcare facilities were developed in England and the United States, it was not uncommon for them to be established under Anglican auspices. Moreover, as the Anglican Communion spread, various branches of the communion sent medical missionaries to found hospitals in various parts of the globe. Hence, by the twentieth century, the provision of health care formed a major element of Anglican church life.[121]

The General Convention has expressed its concern about the provision of adequate health care for those in need many times over the years. For instance, in 1985 it called for the creation of a national commission on healthcare reform and urged congregations to increase their support for such health services as food kitchens, shelters for the homeless, legal aid centers, and neighborhood health clinics.[122] In 1988, it urged the church's Office of Government in Washington, D.C., to advocate for "all persons suffering from illness by creating appropriate levels of cost-effective healthcare, for example, hospices and alternative healthcare facilities."[123] In 1991, it decried the inequitable healthcare delivery system of the United States and called for universal access to health care.[124] It also enunciated four principles regarding health care that included care of the whole person—physiological, spiritual, psychological, and social—and attention to preventive care.[125] Moreover, it encouraged the creation of legislation offering comprehensive medical benefits at all levels, including "diagnostic tests, primary and tertiary care for acute and chronic conditions, rehabilitation care, long-term care, mental health services, dental care and prescription drugs."[126]

Increased attention to matters affecting the health and health care of women, including "domestic violence, AIDS, heart disease, breast, ovarian and endometrial cancer, safe and effective contraceptives, and other methods of pregnancy prevention, maternity care, menopause and chronic illnesses unique to or prevalent among women" was called for by the 1994 General Convention.[127]

In 2000, the Office of the Bishop for Armed Services, Healthcare and Prison Ministries was directed to convene an association of Episcopal healthcare groups and individuals to advocate for a healthcare system in which all may be guaranteed decent and appropriate primary health care, keep abreast of the changing healthcare market, and collect resources related to access to healthcare for the use of the church at all levels.[128] The formation of this Episcopal healthcare association was begun in 2001.

HIV/AIDS

As the wide and terrible scope of the AIDS epidemic became apparent, the Anglican Communion responded with a host of measures designed to bring care and comfort to those afflicted with this disease. In 1985, the General Convention recognized "with love and compassion the tragic human suffering and loss of life involved in the AIDS epidemic" and repudiated "indiscriminate statements which condemn or

reject the victims of AIDS." It went on to urge the development and funding of programs of awareness, education, and prevention concerning AIDS and of ministry to those affected by this illness.[129] Resolutions adopted by succeeding General Conventions repudiated discrimination against those with AIDS; approved of anonymous testing and counseling for HIV; urged the creation of accessible drug treatment, needle access, and safe sex programs, and urged monogamy in sexual relationships; and authorized funds for AIDS education programs in dioceses and congregations.[130]

An Episcopal Commission on AIDS and a National Episcopal AIDS Coalition were established to focus on the theological, ethical, and pastoral concerns raised by this illness; develop strategies to increase awareness of the AIDS crisis throughout the church; and advocate concern for those affected with HIV/AIDS to the world.[131] In 1997, these bodies were authorized to convene consultations to examine the impact of HIV/AIDS in communities of color, clarify the role of racism in responding to AIDS, and identify actions that Episcopalians should take in response to such racism.[132]

In 1991, the General Convention set out "Ten Principles for the Workplace" to govern the way in which Episcopalians relate at places of employment to people with HIV/AIDS. These principles support the equal rights and opportunities of those with this illness, nondiscriminatory employment policies, educational programs about HIV/AIDS, protection of the confidentiality of employees' medical records, appropriate infection control procedures, and prohibition of pre-employment or workplace HIV screening.[133] The Washington Office of the Episcopal Church was instructed to work for increased funding, research, preventive education, and comprehensive service delivery related to those with HIV/AIDS at all levels of government.[134] Aware that a global AIDS epidemic was developing, the General Convention urged various international agencies to respond to the emerging AIDS crisis.[135]

Alcohol And Drug Abuse

The 1985 General Convention declared that alcoholism and other forms of substance abuse are treatable disorders that can affect any individual, "regardless of financial situation, education, employment, race or creed."[136] These conditions affect not only their victims, but also family and friends. Furthermore, they represent a major health concern for our society.[137] The General Convention encouraged each diocese to appoint a committee to educate members about the nature, prevention, treatment, and pastoral care of alcohol and drug abusers and their families. Spiritual care should be provided to those addicted to substances, it specifically stated in 1991.[138] The National Episcopal Coalition on Alcohol (NECA), devoted to addressing the problem of chemical dependency among church members, has been commended for its work by the General Convention.

Employees of the Episcopal Church who are alcohol or drug dependent have been of special concern to the church. The General Convention of 1985 maintained that they should be offered treatment and counseling during recovery and that every effort should be made to offer them job protection and re-employment, as well as salaried sick leave should they require hospitalization.[139]

The author would like to thank the following individuals for their perspicacious comments on portions of an earlier draft: The Rev. Jan C. Heller, Ph.D., Timothy Sedgwick, Ph.D., David H. Smith, Ph.D., and The Rev. Joseph W. Trigg, Ph.D.

NOTES

1. Haugaard, "From the Reformation."
2. Avis, "What Is Anglicanism?"
3. Butler, "From the Eighteenth Century"; Wright, "Anglicanism."
4. Pritchard, *A History*.
5. Ibid.
6. Tanner, "Ecumenical Future."
7. Chadwick, "Tradition"; Avis, "What Is Anglicanism?"
8. Hooker, *Lawes*, V.23.1.
9. Chadwick, "Tradition."
10. Wood, "Anglican Moral Theology/Ethics."
11. Sedgwick, *Christian Moral Life*.
12. Taylor, *Doctor Dubitantium*.
13. Butler, *Fifteen Sermons*.
14. Wood, "Anglican Moral Theology/Ethics."
15. Kirk, *Conscience and Its Problems*.
16. Fletcher, *Situation Ethics*.
17. Booty, "The Anglican Tradition."
18. Cohen et al, *Faithful Living*.
19. Respectively, Committee on Medical Ethics, *Advance Directives; Assisted Suicide; Christian Death;* and *Genes and Choices*.
20. Lambeth Conference, *Official Report*.
21. Board for Social Responsibility, *On Dying Well; Personal Origins;* and *Sterilization*.
22. Resolution A098, *Journal of the General Convention* 1991; hereafter *JGC*.
23. Cohen et al, *Faithful Living*, 61–65; Smith, *Health and Medicine*, 54–63.
24. Hooker, *Lawes*, I.3.5.
25. Cohen et al, *Faithful Living*, 61–62.
26. Temple, *Christus Veritas*, 219.
27. A093a, *JGC* 1991.
28. A062, *JGC* 1991.
29. *JGC* 1964, 654.
30. Cohen et al, *Faithful Living*, 63.
31. Ibid., 64.
32. Smith, *Health and Medicine*, 54.
33. Cohen et al, *Faithful Living*, 70.
34. Ibid.
35. Ibid., 62–65.
36. Ibid., 64–65.
37. Smith, *Health and Medicine*, 15.
38. Hooker, *Lawes*, V.73.7.
39. Donne, *Sermons*, II:340.
40. D120, *JGC* 1988; B020, D049, *JGC* 1991; D006, *JGC* 1994; A071, *JGC* 1997; C042, *JGC* 2000.
41. A104, *JGC* 1991.
42. B101, B012, *JGC* 1994.
43. C043, *JGC* 2000.
44. C008, D039, *JGC* 2000.
45. D039, *JGC* 2000.
46. A009, *JGC* 2000.
47. Sedgwick, "Transformation of Sexuality."
48. *Book of Common Prayer*, 423.
49. O'Donovan, *Begotten or Made?*
50. Taylor, *Holy Living*, 103.
51. D016, *JGC* 1982; D009, *JGC* 1994.
52. Smith, *Health and Medicine*, 79–80.
53. Board for Social Responsibility, *Sterilization*.
54. Committee on Medical Ethics, *Genes and Choices*, 67–73.
55. Smith, *Health and Medicine*, 79–80.
56. D091, *JGC* 1994.
57. Board for Social Responsibility, *Sterilization*, 40–41.
58. Smith, *Health and Medicine*, 81.
59. A067, *JGC* 1982.
60. A101, *JGC* 1991.
61. *Blue Book*, 1988, 159.
62. *Blue Book*, 1988.
63. Ibid.
64. *Blue Book*, 1982, 1988.
65. *Blue Book*, 1988.
66. Ibid.
67. O'Donovan, *Begotten or Made?*; Banner, *Christian Ethics*.
68. Dyson, "At Heaven's Command?"; Dunstan, "The Embryo"; Dunstan, "Moral Status of the Human Embryo"; Habgood, *Being a Person*, 249–252, 277–281.
69. *Blue Book*, 1988.
70. A054, *JGC* 1994; C047a, *JGC* 1988; A065, *JGC* 1982.
71. C047a, *JGC* 1988.
72. Scott, "Changing Teachings on Abortion."

73. C037s, *JGC* 1991.

74. Committee on Medical Ethics, *Genes and Choices*, 15–18; Board for Social Responsibility, *Personal Origins*, 24–26.

75. Committee on Medical Ethics, *Genes and Choices*, 15–18.

76. Board for Social Responsibility, *Personal Origins*, 29–30.

77. A090, *JGC* 1985.

78. *Blue Book*, 1988.

79. A095, *JGC* 1991.

80. Ibid.

81. Smith, "Creation, Preservation."

82. Committee on Medical Ethics, *Genes and Choices*, 17.

83. A095, *JGC* 1991.

84. Committee on Medical Ethics, *Genes and Choices*, 36–40.

85. Ibid., 26–30.

86. Ibid., 102–104.

87. A097, *JGC* 1991; C024, *JGC* 1982.

88. *Blue Book*, 1988, 161.

89. A097, *JGC* 1991.

90. *Blue Book*, 1988.

91. A096, *JGC* 1991.

92. D127, *JGC* 1985.

93. D088, *JGC* 1991.

94. C032, *JGC* 2000.

95. *Book of Common Prayer*, 1559:76.

96. Taylor, *Holy Dying*.

97. *Book of Common Prayer*, 459.

98. Booty, "The Anglican Tradition," 259.

99. Cohen et al, *Faithful Living*, 16.

100. A093, *JGC* 1991.

101. Cohen et al, *Faithful Living*, 39–42; Committee on Medical Ethics, *Christian Death*, 31–40.

102. Cohen et al, *Faithful Living*, 65; Committee on Medical Ethics, *Christian Death*, 18–19.

103. Cohen et al, *Faithful Living*, 44; Committee on Medical Ethics, *Christian Death*, 42, 49–50, 115–117; Lambeth Conference, *Official Report*; A093a, *JGC* 1991.

104. Smith, *Health and Medicine*, 48–54.

105. Cohen et al, *Faithful Living*, 156–161; Committee on Medical Ethics, *Advance Directives*, 31–39.

106. Cohen et al, *Faithful Living*, 51–58; Lambeth Conference, *Official Report*, 101–106; Committee on Medical Ethics, *Christian Death*, 73–84; Board for Social Responsibility, *On Dying Well*, 20–25; A056, *JGC* 1994; A093a, *JGC* 1991.

107. Board for Social Responsibility, *On Dying Well*, 23.

108. Cohen et al, *Faithful Living*, 57.

109. Board for Social Responsibility, *On Dying Well*, 22.

110. Committee on Medical Ethics, *Christian Death*, 81.

111. Cohen et al, *Faithful Living*, 65–69; Committee on Medical Ethics, *Christian Death*, 21–23; C008, *JGC* 1991; C002a, *JGC* 1982.

112. Committee on Medical Ethics, *Advance Directives*.

113. Cohen et al, *Faithful Living*, 45–51; Board for Social Responsibility, *On Dying Well*; Lambeth Conference, *Official Report*; Committee on Medical Ethics, *Christian Death*, 61–72; A056, *JGC* 1994; C008, *JGC* 1991; C002a, *JGC* 1982.

114. A056, *JGC* 1994.

115. Cohen et al, *Faithful Living*, 49–50.

116. A078, *JGC* 2000; A056, *JGC* 1994; C008, *JGC* 1991; C002a, *JGC* 1982.

117. A078, *JGC* 2000.

118. Board for Social Responsibility, *On Dying Well*.

119. Cohen et al, *Faithful Living*, 45–48; Committee on Medical Ethics, *Christian Death*, 86–91.

120. A078, *JGC* 2000.

121. Booty, "The Anglican Tradition," 255.

122. A088, *JGC* 1985.

123. B009, *JGC* 1988.

124. A099, *JGC* 1991.

125. A057, *JGC* 1991.

126. A010, *JGC* 1991.

127. A055, *JGC* 1994.

128. A079, *JGC* 2000.

129. D062, *JGC* 1985.

130. D062, *JGC* 1985; A086, B007, D101, D104, D109, *JGC* 1988; A002–A006, A008, A009, B025, D096, *JGC* 1991; A002, A003, A006, A007, B028, *JGC* 1994; A047, A048, D099, *JGC* 1997; A050-A052, D049, *JGC* 2000.

131. A128, *JGC* 1994.

132. A046, *JGC* 1997.

133. A007, *JGC* 1991.

134. A005, *JGC* 1994.

135. D110, *JGC* 1988; A004, *JGC* 1994.

136. A083, *JGC* 1985.

137. Ibid.

138. A100, *JGC* 1991.

139. A083, *JGC* 1985.

BIBLIOGRAPHY

Avis, Paul. "What Is Anglicanism?" In *The Study of Anglicanism*, ed. Stephen Sykes, John Booty, and Jonathan Knight, 459–476. Minneapolis, Minn.: Fortress, 1999.

Banner, Michael. *Christian Ethics and Contemporary Moral Problems*. London: Cambridge University, 1999: 86–135.

The Blue Book: Reports of the Committees, Commissions, Boards, and Agencies of the General Convention of the Episcopal Church. New York: Episcopal Church Center, multiple years.

Board for Social Responsibility, Church of England. *On Dying Well: A Contribution to the Euthanasia Debate*. Second edition. London: Church House Publishing, 2000.

———. *Personal Origins*. Second revised edition. London: Church Publishing House, 1996.

———. *Sterilization: An Ethical Inquiry*. London: Church Information Office, 1961.

The Book of Common Prayer and Administration of the Sacraments and Other Rites and Ceremonies of the Church Together with the Psalter or Psalms of David According to the Use of the Episcopal Church. New York: Church Hymnal Corporation, 1979.

Booty, John E. "Anglicanism." In vol. 1 of *Oxford Encyclopedia of the Reformation*, ed. Hans J. Hillerbrand, 38–44. New York: Oxford, 1996.

———. "The Anglican Tradition." In *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen, 240–70. New York: Macmillan, 1986.

Butler, Joseph. *Fifteen Sermons Preached at the Rolls Chapel*, ed. T. A. Roberts. London: SPCK, 1970.

Butler, Perry. "From the Early Eighteenth Century to the Present Day." In *The Study of Anglicanism*, ed. Stephen Sykes, John Booty, and Jonathan Knight, 30–51. Minneapolis, Minn.: Fortress, 1999.

Chadwick, Henry. "Tradition, Fathers and Councils." In *The Study of Anglicanism*, ed. Stephen Sykes, John Booty, and Jonathan Knight, 100–114. Minneapolis, Minn.: Fortress, 1999.

Cohen, Cynthia B., Jan C. Heller, Bruce Jennings, E. F. Michael Morgan, David A. Scott, Timothy F. Sedgwick, and David H. Smith. *Faithful Living, Faithful Dying: Anglican Reflections on End of Life Care*. Harrisburg, Pa.: Morehouse, 2000.

Committee on Medical Ethics, Episcopal Diocese of Washington. *Assisted Suicide and Euthanasia: Christian Moral Perspectives*. Harrisburg, Pa.: Morehouse, 1997.

Committee on Medical Ethics, Episcopal Diocese of Washington. *Before You Need Them: Advance Directives for Health Care, Living Wills and Durable Powers of Attorney* Cincinnati, Ohio: Forward Movement, 1995.

Committee on Medical Ethics, Episcopal Diocese of Washington. *Toward a Good Christian Death: Crucial Treatment Choices*. Harrisburg, Pa.: Morehouse, 1999.

Committee on Medical Ethics, Episcopal Diocese of Washington. *Wrestling with the Future: Our Genes and Our Choices*. Harrisburg, Pa.: Morehouse, 1998.

Donne, John. *The Sermons of John Donne*, ed. G. R. Potter and E. M. Simpson, 10 vols. Berkeley: University of California Press, 1955.

Dunstan, G. R. "The Embryo, from Aristotle to Alton." *Cross Currents* 38, no. 47 (1988): 6–8.

———. "The Moral Status of the Human Embryo." *Journal of Medical Ethics* 1 (1984): 38–44.

Dyson, Antony. "At Heaven's Command?: The Churches, Theology, and Experiments on Embryos." In *Experiments on Embryos*, ed. A. Dyson and J. Harris, 82–105. London: Routledge, 1992.

Fletcher, Joseph. *Situation Ethics*. Philadelphia, Pa.: Westminster, 1966.

Habgood, John. *Being a Person: Where Faith and Science Meet*. London: Hodder and Stoughton, 1998.

Haugaard, William P. "From the Reformation to the Eighteenth Century." In *The Study of Anglicanism*, ed. Stephen Sykes, John Booty, and Jonathan Knight, 3–29. Minneapolis, Minn.: Fortress, 1999.

Hooker, Richard. *Of the Lawes of Ecclesiastical Politie*. Folger Library Edition, ed. W. S. Hill. Cambridge, Mass.: Harvard University, 1977–1981.

Journal of the General Convention of the Episcopal Church. New York: General Convention, multiple years.

Kirk, Kenneth. *Conscience and Its Problems: An Introduction to Casuistry*. With an introduction by David H. Smith. Louisville, Ky.: Westminster John Knox, 1999.

Lambeth Conference. *The Official Report of the Lambeth Conference 1998*. Harrisburg, Pa.: Morehouse, 1999.

O'Donovan, Oliver. *Begotten or Made? Human Procreation and Medical Technique*. London: Oxford University, 1984, 49–66.

Pritchard, Robert. *A History of the Episcopal Church*. Revised edition. Harrisburg, Pa.: Morehouse, 1999.

Scott, David A. "Changing Teachings on Abortion." In *The Crisis in Moral Teaching in the Episcopal Church*, ed. Timothy Sedgwick and Philip Turner, 56–73. Harrisburg, Pa.: Morehouse Publishing, 1992.

Sedgwick, Timothy F. *The Christian Moral Life*. Grand Rapids, Mich.: Eerdmans, 1999.

———. "The Transformation of Sexuality and the Challenge of Conscience." In *Our Selves, Our Souls and Bodies: Sexuality and the Household of God*, ed. Charles Hefling, 27–42. Cambridge, Mass.: Cowley Publications, 1996.

Smith, David H. "Creation, Preservation, and All the Blessings . . ." *Anglican Theological Review* 81, no. 4 (Fall 1999): 567–588.

———. *Health and Medicine in the Anglican Tradition: Conscience, Community, and Compromise*. New York: Crossroad, 1986.

Tanner, Mary. "The Ecumenical Future." In *The Study of Anglicanism*, ed. Stephen Sykes, John Booty, and Jonathan Knight, 427–446. Minneapolis, Minn.: Fortress, 1999.

Taylor, Jeremy. *Holy Living* and *Holy Dying*. 2 vols., ed. P.G. Stanwood. Oxford: Clarendon, 1989.

Taylor, Jeremy. *Doctor Dubitantium*. London: J. O. Luke Meredith, 1696.

Temple. William. *Christus Veritas: An Essay*. London: Clarendon, 1949.

Wood, Thomas. "Anglican Moral Theology/Ethics." In *Westminster Dictionary of Christian Ethics*, ed. James F. Childress and John Macquarrie, 22–28. Philadelphia, Pa.: Westminster, 1986.

Wright, J. Robert. "Anglicanism, *Ecclesia Anglicana*, and Anglican: An Essay on Terminology." In *The Study of Anglicanism*, ed. Stephen Sykes, John Booty, and Jonathan Knight, 477–482. Minneapolis, Minn.: Fortress, 1999.

Introduction to the series

Religious beliefs provide meaning for people confronting illness and seeking health, particularly during times of crisis. Increasingly, health care 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.

THE PARK RIDGE CENTER
FOR THE STUDY OF HEALTH, FAITH, AND ETHICS

211 E. Ontario • Suite 800 • Chicago, Illinois 60611-3215
http://www.parkridgecenter.org

The Park Ridge Center explores and enhances the interaction of health, faith, and ethics through research, education, and consultation to improve the lives of individuals and communities.