

The Lutheran Tradition

Religious Beliefs and Healthcare Decisions

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During the Middle Ages, most of western Europe was united, however tentatively, under the leadership of the Roman Catholic church. In the early sixteenth century, this union fractured, due in part to the work of a German monk named Martin Luther. Luther had striven to guarantee his salvation through ascetic practices but slowly came to believe that salvation can come only through the grace of God, not through any human effort. This fundamental principle of Luther's thought, "salvation by grace through faith alone," diverged from the traditional Roman Catholic belief that both faith and human effort are necessary for salvation. The other fundamental principle of Luther's thought, that the Bible is the sole rule of faith and the only source of authority for doctrine, contrasts with the Roman Catholic reliance on both the Bible and tradition. Luther translated the Bible into German and, thanks to the recent invention of the printing press, it was distributed widely and became a best-seller. The availability of a Bible in the language of the common people, coupled with Luther's idea of the Bible as the sole source of authority, marked the beginning of a significant shift away from Rome as the final source of religious authority for many Christians.

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

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Luther first presented his ideas publicly in 1517, when he nailed to the church door in Wittenberg his Ninety-five Theses protesting the corruption he saw reflected in both the teachings and the practices of the Roman Catholic church. Although Luther was not the first reformer of the church in this era, many cite the posting of his theses as the beginning of the Protestant Reformation, which ultimately resulted in the formation of many non-Roman Catholic, or Protestant, churches in northern and western Europe. In 1530, the German princes who supported Luther presented to the Holy Roman Emperor the Augsburg Confession, an official statement of Lutheran faith; following that event, congregations identified with Luther could formally be called “Lutheran” churches.

Soon thereafter, Lutheranism spread throughout Germany, Sweden, Denmark, Finland, Iceland, and Norway, and in the mid-seventeenth century, to the American colonies. Today, Lutheranism in the United States is divided among two large and seven relatively small denominational groups. The largest, the Evangelical Lutheran Church in America (ELCA), has 5.3 million members in more than 11,000 congregations; approximately 270 hospitals, nursing homes, and other social service organizations are affiliated with the ELCA. The Lutheran Church–Missouri Synod (LCMS), which is more conservative than the ELCA on many theological and moral issues, has 2.6 million members in more than 6,000 congregations. Collectively, the smaller Lutheran churches have about half a million members in 1,700 congregations (Nelson 1991: 123).

FUNDAMENTAL BELIEFS CONCERNING HEALTH CARE

Lutherans as a group do not hold distinctive views on health care or healing. In many respects, including their acceptance of modern medicine, Lutherans blend in with the largely secular culture (Marty 1986: 18). They have

traditionally built hospitals and been open to scientific developments and cures, but those endeavors and attitudes have not retained a specifically Lutheran flavor (Marty 1986: 171, 18–19).

Luther himself respected doctors and promoted close working relationships between them and pastors in caring for the sick. He expected doctors to identify and treat medically the natural causes of sickness, but he believed that more underlay sickness than a doctor could address (Lindberg 1986: 177–78). Luther saw illness as both a result and a sign of that which separates humans from God (Marty 1986: 48) and understood the meaning of suffering, both personal and social, as somehow tied to God’s decision to redeem sinners and the world through the death of Christ on the cross (Lindberg 1986: 176–77).

The first draft of a proposed ELCA social statement understands “healing in terms of God’s work of creating, redeeming, and sustaining humankind” (ELCA 2001b: 4). “Providing good quality health care for all is a social obligation and responsibility compelled by justice” (ELCA 2001b: 9). The proposed statement finds “current forms of health-care resource distribution . . . ethically indefensible” and calls for reforms that would assure “universal access to a comprehensive decent minimum of health care for all persons” (ELCA 2001b: 9–10). The draft does not stipulate particular mechanisms for achieving universal access but encourages ELCA members to participate “vigorously and wisely . . . in the public discussion on how best to fulfill this obligation” (ELCA 2001b: 10). These matters are explored in an ELCA congregational study booklet, *Our Ministry of Healing: Health and Health Care Today*, prepared by the task force that drafted the proposed social statement (ELCA 2001d).

The LCMS, generally leery of an emphasis on “social ministry” lest it obscure the central focus on proclaiming the Gospel and administering the sacraments, nevertheless directs attention to the church’s “communal Christian care.” Parish

nurse programs are identified as one of its possible expressions in a study document titled *Faith Active in Love: Human Care in the Church's Life* (LCMS 1999: 29).

INSTITUTIONAL AUTHORITY AND INDIVIDUAL CONSCIENCE

Issues of institutional authority and individual conscience are rooted in Lutheran ethics, which is inseparable from Lutheran theology. According to Lutheran pastor and writer Edward Schneider, “A basic word in the vocabulary of Lutheran theology is the word ‘and.’ Our theology speaks of law *and* gospel, of the believer as saint *and* sinner. It insists upon faith *and* work. It deals with the kingdom of God *and* the kingdom of the world. The genius of this theology is its ability to dialectically relate aspects of the faith which often tend to be separated and thereby deprived of their full meaning” (Schneider 1990: 15). This “both/and” approach shapes the way Lutherans exercise their conscience in this imperfect world. Lutheran professor of religion Paul Nelson has written, “The sober recognition that we are less than perfect people living in a far from perfect world, along with the conviction that we are, nevertheless, forgiven sinners are the two benchmarks of a Lutheran moral vision. The former precludes self-righteousness and underlies the sense that often we can do little else but choose between greater and lesser evils. The latter makes choice and action possible despite the attendant ambiguities” (Nelson 1993: 151). A statement by the ELCA emphasizes this point when it says that Christians must face complex ethical decisions “in all their ambiguity, knowing we are responsible ultimately to God, whose grace comforts, forgives, and frees us in our dilemmas” (ELCA 1992: 1).

Lutherans, like other Protestants, emphasize the importance of individual conscience over institutional authority, but “Luther makes no claim that one’s natural sense of right and

wrong is uncorrupted” (Schneider 1990: 16); the potential for error within individual conscience is tempered by the Scripture as understood in the Lutheran tradition. The following statement by the American Lutheran Church, one of the bodies that merged to form the ELCA, emphasizes the importance of subjection to God’s law: “One remains subject to God’s law not only for one’s personal good but for the good of the entire body of Christ. A caring community cannot sanction or condone a situation where each member does what appears good, right, and self-satisfying simply in that member’s own eyes. No one can be a law solely to self; each lives in relationship with others” (ALC 1980: 10).

Lutheran church bodies in the United States often issue statements or other documents that reflect internal deliberation on moral and ethical issues of importance to church members. These are normally designed to educate and guide members in developing their own positions on issues. Within a particular church, various documents may differ in the degree to which they reflect the “official teaching” of the church. Sometimes the churches publish works by a single author which are intended to provide information and encourage reflection but do not represent an official position of the church. The history of mergers within the Lutheran church may also complicate the status of various statements. For example, the ELCA was formed in 1988 by the merger of the Lutheran Church in America (LCA), the American Lutheran Church (ALC), and a smaller body, the Association of Evangelical Lutheran Churches (AELC). The ELCA elected to accept and encourage the continued use of the “social statements” issued by the ALC and LCA while it developed its own teachings (Nelson 1991: 123), and continues to use these statements as “part of the basis of ELCA advocacy on health care” (ELCA 2001d: 52). Statements by the ALC and LCA, although those churches no longer exist, will therefore be cited here when the ELCA has not made a statement on a particular topic or when an ALC

or LCA statement adds significantly to the substance of an ELCA statement. Social statements “represent the official policy of the church and are considered binding on staff members and others who may speak on behalf of the church” but are not binding on individual church members (Nelson 1991: 128). A formal statement by the ELCA explains the standing of social statements in this way:

Because they view issues from the perspective of the Church’s faith, social statements are clearly rooted in the biblical and confessional witness of the Evangelical Lutheran Church in America. They are subject again and again to the testing of whether they are faithful to Scriptures as “the authoritative source and norm of [this church’s] proclamation, faith and life” (ELCA, 2.03) and to its creeds and confessions (ELCA, 2.04, 2.05, 2.06). They themselves are not new creeds or confessions. [The parenthetical references are to the ELCA’s constitution.]

Church members are called upon to give social statements serious consideration as they form their own judgments. In their use as teaching documents, their authority is persuasive, not coercive. Their

teaching function builds upon and seeks to nurture the freedom of Christians to decide and act responsibly. Social statements help shape the conscience of Christians by appealing to their faith, moral convictions, and reason. The respect they evoke comes from the truth and wisdom they embody, which has stood the testing of various forums within this church and to which testing they always continue to be subject. Their effective teaching significance will be determined by the intrinsic quality of their contents and by their use in the church. (ELCA 1989: 6)

Within the LCMS, the Commission on Theology and Church Relations has issued a number of reports on medical ethical issues; while they are not themselves the official positions of the synod, they do *reflect* the synod’s positions. Substantive documents that provide information and guidance for synod members and others who are grappling with the issues addressed, they are quoted extensively here. Only synodical conventions have the authority to establish official positions of the church (personal communication, David Mahsman, Director of News and Information, LCMS).

THE INDIVIDUAL AND THE PATIENT-CAREGIVER RELATIONSHIP

Lutherans generally favor open communication between caregiver and patient. “The relationship between patients and providers should be . . . a partnership of trust in pursuit of a shared goal” (ELCA 2001b: 7). Patients have the final authority to decide among their medical options, but they also have an obligation to evaluate those options within a broad context, considering the effects of their decisions on other people. According to the first draft of a proposed ELCA social statement, “our individual autonomy must . . . be understood within the context of our obligation to seek to be obedient to the will of God, because ultimately we belong to God and our exercise of

self-determination should always be understood within that relationship” (ELCA 2001b: 12).

CLINICAL ISSUES

Self-determination and informed consent
Lutherans, consistent with their general respect for medicine and informed decision making, are likely to favor self-determination and informed consent. As a proposed ELCA social statement puts it, “health care professionals and patients deliberate together on the facts and values represented by options for treatments and care, with patients making free and informed consent

to whatever services are to be received” (ELCA 2001b: 7). An earlier statement by the LCA is largely consistent with this view but describes a possible exception: “To treat a patient in violation of his or her deeply held, carefully considered, and clearly expressed preferences is to do violence to that person. . . . At the same time, it must be emphasized that pain and other factors often distort the decision-making process, resulting in expressions of preference that may not represent a person’s true wishes. In such cases, it may be appropriate to administer treatment (by authority of court order, if necessary) if so doing would sustain the life of the patient” (LCA 1982: 5).

The LCMS recognizes that “Christians who have had different specific experiences may at times disagree concerning application of principles to specific cases” but affirms that, within the synod, “agreement exists on the fundamental guiding principles,” including the commitment to care and not to kill. Within the framework of those guiding principles, the LCMS honors individual conscience and self-determination. “Christians have numerous reasons to seek effective ways to assist their loved ones and their health care team in determining their wishes concerning health care” (LCMS 1993: 21–22).

Truth-telling and confidentiality

“Central to [the provider-patient] relationship is respecting patient confidentiality and privacy of medical information” (ELCA 2001b: 7). A companion study guide to the LCA’s 1982 social statement *Death and Dying* discussed truth-telling and confidentiality in this way:

In any community that respects other people and is sensitive and responsive to their needs, truthfulness and faithfulness are crucial. Lying or otherwise resorting to deception is to manipulate others rather than relate to them as persons. It is to view them as adversaries rather than as friends and neighbors. Withholding information from someone—particularly information relating to that

person’s life—is to erect a barrier that gets in the way of the honesty and openness essential to fellowship and human community.

None of this, of course, is to suggest that information should indiscriminately be made available to anyone who wants it. There are many situations, including doctor-patient relationships, in which keeping faith with others means maintaining strict confidentiality about certain matters. . . . However, it is an equally serious breach of faith to withhold from a patient information needed to make decisions about his or her life or to prepare for death. (Lee 1983: 15)

A 1992 statement by the ELCA, which draws upon the LCA statement, states that “truthfulness and faithfulness in our relations with others are essential to the texture of human life” (ELCA 1992: 2). In the same spirit, an early statement from the ALC illustrates the negative effects of failing to tell the truth when a person is dying: “[often] the dying person experiences death as a tragic comedy, supported by a cast of actors and actresses playing deceptive roles in a conspiracy of silence” (ALC 1977: 7).

No official statement by the LCMS was found.

Proxy decision making and advance directives

Lutheran statements tend to support the use of advance directives and the ability of people to make informed decisions about the care of those with whom they have close relationships. According to the ELCA, “Advance directives are welcome means to foster responsible decisions at the end of life” (ELCA 1992: 4). An earlier statement by the LCA addressed at greater length the issue of proxy decision making: “If the situation involves a child under the age of majority, who is therefore legally incompetent, or a person who is mentally impaired and hence unable to participate fully in the decision-making process, a shared decision-making process is preferable. Collective wisdom is likely to result in better decisions, and no one should

be left to bear alone the full burden of deciding. Participants in this decision-making process may include family members, the physician and other health care professionals, the pastor, and others close to the person” (LCA 1982: 3). The statement continued, “A particular responsibility of each individual is making treatment preferences known, after careful consideration, so as to facilitate the decision-making process and relieve the burden on others. Living wills . . . represent one way of doing this” (LCA 1982: 7).

The LCMS concurs in its approval of advance directives and proxy decision making: “It is good ethical procedure for the doctor to request and receive a statement signed by the patient, if competent to consent, or by the nearest of kin,

agreeing to the uselessness of further ‘heroic efforts’ and consenting to termination of treatments” (LCMS 1993: 22). The synod recognizes the complexity of medical decision making and encourages people to seek God’s guidance: “People who know themselves to be redeemed by Christ seek to make the right rather than the wrong decisions for His sake and for the benefit of their neighbor. How else should we seek to bring God’s love and care to our neighbors? Right or wrong ethical decisions, of course, do not make us right or wrong with God—we live by grace—but people who live by grace ponder God’s guidance and seek principled ways to apply that guidance to the complexities of life in a world made difficult by sin” (LCMS 1993: 30).

FAMILY, SEXUALITY, AND PROCREATION

Expressing well the Lutheran view, the LCA has stated that “sex, marriage, and family are gifts of God in which to rejoice. Their essential goodness cannot be obscured by any crisis of our time” (LCA 1970: 1). Contrary to the view that celibacy is preferable to marriage, Luther believed that marriage is a very important vehicle through which to create a sense of community (Lindberg 1986: 181); but he did not believe that marriage is a sacrament, because it does not confer grace (Marty 1986: 130).

The LCA characterized marriage this way: “Christian faith affirms marriage as a covenant of fidelity—a dynamic, lifelong commitment of one man and one woman in a personal and sexual union. . . . Marriage is not simply a legal transaction which can be broken when the conditions under which it was entered no longer exist. It is an unconditional relationship, a total commitment based on faithful trust. This union embodies God’s loving purpose to create and enrich life. As the needs of the partners change, the covenant of fidelity must be renewed by God’s grace and continually reaffirmed by husband and wife” (LCA 1970: 1–2).

Sexuality, when expressed appropriately, is viewed positively in the Lutheran tradition. An LCA statement affirmed that “human sexuality is a gift of God for the expression of love and the generation of life. . . . In the expression of human sexuality, it is the integrity of our relationships which determines the meaning of our actions. We do not merely have sexual relations; we demonstrate our true humanity in personal relationships, the most intimate of which are sexual” (LCA 1970: 1). The ALC stated more directly, “We believe that Scripture sets the standard of a lifelong monogamous marriage of one man and one woman. We believe that sexual intercourse reaches its greatest potential only within the committed trust relationship of marriage” (ALC 1980: 5). The ELCA maintains the positive Lutheran view of sexuality: “We affirm that the goodness of sexual intercourse goes beyond its procreative purpose” (ELCA 1991: 4).

Sexual intimacy outside of marriage is discouraged: “Marriage is the appropriate context for sexual intercourse. This continues to be the position of this church” (ELCA 1991: 4).

The ELCA is nonetheless in the process of debating its traditional position on homosexuality and homosexual practices. While no new official position has been issued, a formal process of study and deliberation is under way.

With respect to procreation, the ALC concluded, “Thus, while ‘be fruitful and multiply’ still expresses the collective human obligation to reproduce and thereby perpetuate the human species, procreation is not an obligation of sexual intercourse. Rather, it is a privilege and gift from God to be used responsibly [and] appropriately” (ALC 1977: 3).

The LCMS takes a similar view on marriage, sexuality, and procreation: “We honor God and the neighbor rightly when we . . . regard marriage as a divine, lifelong institution, ordained by God for the good of man and woman . . . [and] affirm God’s will that sexual intercourse be engaged in only between a man and woman committed to a complete and lifelong sharing of their lives with one another in a marriage covenant not to be broken . . . and affirm that this union of mutual love is the only proper context for human procreation” (LCMS 1981b: 40). “The Biblical injunction to ‘be fruitful and multiply’ is to be understood as a blessing as well as a command. It is one of God’s good gifts to His people, for procreation is an actual sharing in God’s ongoing creative activity” (LCMS 1981b: 17). In 1992, the LCMS reaffirmed its 1973 position “that the synod recognize homophile behavior as intrinsically sinful” (LCMS 1992, Res. 3-12A) and, in support of that position, cited a 1981 report stating that “the homosexual is held accountable to God for homosexual thoughts, words, and deeds” (LCMS 1981b: 35).

In 1996 the Commission on Theology and Church Relations of the LCMS published a study document, *Christians and Procreative Choices: How Do God’s Chosen Choose?* Organized around four case studies involving surrogacy, artificial insemination by a donor, in vitro fertilization, and voluntary childlessness, the document sought to model “biblically disciplined moral reasoning” (LCMS 1996: 5). While it

affirmed the denomination’s previous positions, it recognized that conscientious Christians within and outside the LCMS disagree about the moral justifiability of various reproductive technologies. The document’s specific concerns and judgments are discussed below.

CLINICAL ISSUES

Contraception

Contraception is generally acceptable to Lutherans. The ELCA has said, “Whenever sexual intercourse occurs apart from the intent to conceive, the use of contraceptives is the responsibility of the man and of the woman” (ELCA 1991: 4). In addition, the ELCA “recognize[s] the need for contraceptives to be available . . . and for research [on] and development of new forms of contraception” (ELCA 1991: 8). A more expressive statement was issued by the ALC in 1977: “Effective birth control methods facilitate responsible procreation and greatly enhance the ability to exercise stewardship of genetic resources. Enjoyment of sexual intercourse without fear of unwanted pregnancy is appropriate. Men and women are equally responsible for contraception and procreation. Sexual intercourse is the privilege of mature persons acting responsibly within the context [of] a commitment known in the Christian community as marriage. However, contraceptive information and assistance should also be available to all sexually active persons, regardless of age or marital status” (ALC 1977: 3-4). According to the LCA, “The ethical significance of the use of any medically approved contraceptive method within a covenant of marital fidelity depends upon the motivation of the users. A responsible decision for or against having a child will include evaluation of such factors as the health of the potential mother, a reliable prognosis concerning the health of a possible child, the number and spacing of other children, the family’s economic circumstances, and the rapid growth of population. People have a right not to have children without being accused of

selfishness or a betrayal of the divine plan; and every child has a right to be a wanted child” (LCA 1970: 5).

The LCMS accepts the appropriate use of birth control but cautions against its perpetual use:

In the absence of Scriptural prohibition, there need be no objection to contraception within a marital union which is, as a whole, fruitful. . . . With respect to voluntary childlessness in general, we should say that while there may be special reasons which would persuade a Christian husband and wife to limit the size of their family, they should remember at all times how easy it is for them simply to permit their union to turn inward and refuse to take up the task of sharing in God’s creative activity. Certainly Christians will not give as a reason for childlessness the sorry state of the world and the fear of bringing a child into such a world. We are not to forget the natural promise embedded in the fruitfulness of marriage. To bear and rear children can be done, finally, as an act of faith and hope in the God who has promised to supply us with all that we “need to support this body and life.” (LCMS 1981b: 19–20)

In a more recent study document, the LCMS admits that “in special circumstances there can be reasons for choosing childlessness.” When “pregnancy and childbirth . . . pose a threat to the health of a woman, or when the probability of severe genetic disease afflicting a potential child becomes known,” a Christian couple may conclude that “they will better serve God and their neighbors by choosing not to have children” (LCMS 1996: 32).

Sterilization

Statements about sterilization by the ELCA and its predecessors tend to be tentative but not negative; for example, “We recognize the need . . . for sterilization to be considered” (ELCA 1991: 8) and “In defining the acceptable limits of controlling reproduction, we agree that voluntary sterilization may be an appropriate option” (ALC 1980: 6).

The LCMS view is similar, but the synod is much more explicit about the conditions under which the procedure may be appropriate: “Sterilization may under some circumstances be an acceptable form of contraception. . . . There should be no moral objection to it, especially for couples who already have children and who now seek to devote themselves to the rearing of those children, for those who have been advised by a physician that the birth of another child would be hazardous to the health of the mother, or for those who for reasons of age, physical disability, or illness are not able to care for additional children” (LCMS 1981b: 19–20). The church’s 1996 study document appears to reaffirm this position.

NEW REPRODUCTIVE TECHNOLOGIES

Artificial insemination

Artificial insemination by a husband (AIH) is not problematic among Lutherans; however, artificial insemination by a donor (AID) is cause for moral concern within the ELCA and has been rejected by the LCMS. The ALC stated, “Artificial insemination, . . . in which only one of a couple (the woman in present circumstances) provides genetic material and other genetic material comes from an anonymous donor, becomes a consideration for some married couples. There are, however, such moral, emotional, and legal ambiguities that must be taken into account as to render the procedure suspect for a Christian” (ALC 1980: 6).

According to one critical study, published in a 1986 joint LCA-ALC pamphlet series, Procreation Ethics, “AIH presents few legal, social, or ethical problems” (Schneider 1986: 5). In contrast, “AID is not an ethically acceptable alternative to childlessness in the case of male infertility” because of psychological difficulties and because the donor “exercises his procreative powers apart from any marital bond or commitment. . . . By the introduction of donor semen, AID separates procreation from marriage and thereby violates the marriage covenant”

(Schneider 1986: 11, 12). The author concludes that “a couple who find themselves childless because of male infertility are better advised either to come to terms with their childlessness or to seek children through adoption” (Schneider 1986: 13).

Likewise, the LCMS Commission on Theology and Church Relations has implicitly approved AIH but cautioned that it “may be a way of avoiding underlying psychological problems within a marriage rather than treating them” (LCMS 1981b: 38). It has also rejected AID on the grounds that “the process of fertilization is removed from the personal context of the one-flesh union of husband and wife in a way that not even their consent can allow” (LCMS 1981b: 39). In a 1996 study, the LCMS finds that AID subjects marital partners to “psychological and emotional risks” and puts children “at risk of wondering what significance, if any, is to be found in the hiddenness of their relationship to their biological father” (LCMS 1996: 22). The same considerations apply to human egg and embryo donation. All are to be rejected.

Gamete intrauterine fallopian transfer (GIFT)

No Lutheran statements on gamete intrauterine fallopian transfer were found; presumably, individual synods’ positions would mirror their positions on AIH or AID, depending on whether or not the sperm and egg came from the husband and wife.

In vitro fertilization (IVF)

The Lutheran Council in the USA (LCUSA), formerly a cooperative agency of the LCA, ALC, and LCMS, issued a study document circa 1983 entitled *In-Vitro Fertilization*. The eleven study participants “unanimously concluded that IVF does not *in and of itself* violate the will of God as reflected in the Bible, when the wife’s egg and husband’s sperm are used” (LCUSA n.d.: 31). Representatives from the LCMS, in disagreement with other members of the committee, held that IVF is unobjectionable

only when the sperm and egg come from husband and wife and all of the fertilized eggs are implanted in the womb of the wife. They also objected to “experimentation with, destruction of, or storage of unneeded or defective fertilized eggs” and “interruption of an IVF pregnancy for any reason other than to prevent the death of the mother” (LCUSA n.d.: 31–32).

The LCMS Commission on Theology and Church Relations is “reluctant to locate the problems that arise [in IVF] simply in the medical technique itself and to suggest that Christians could never faithfully use it” (LCMS 1996: 37). Nevertheless, the church is troubled about the potential for abuse. “When embryos explicitly created from within a marriage are denied the possibility of nurture in the womb that God created to receive them, then the unique and sacred expression in the embryo of the one-flesh union of marriage is subject to distortion and diminution” (LCMS 1996: 39).

Surrogate motherhood

In an essay on surrogate motherhood, published as part of the LCA–ALC pamphlet series, the author states that “wholesale condemnation may not be appropriate, but Christian perceptions of the significance of human procreation and its place within the marital relationship are not compatible with the basic premise of surrogate motherhood: that one could deliberately conceive and bear a child with no commitment either to the child or to its father” (McDowell 1986: 10).

LCMS representatives to a pan-Lutheran committee studying in vitro fertilization objected to the use of surrogate wombs in IVF procedures on the grounds that it “involves the intrusion of a third party into this one-flesh union [i.e., marriage] and is contrary to the will of God” (LCUSA n.d.: 31). In its 1996 deliberations on procreative issues, the LCMS recognized the possibility for disagreement within its community of faith. Just as prior documents have allowed for conscientious disagreement, so this discussion of procreative choices presented

reasoned positions against third-party intrusion into the marital relationship but left open the possibility of conscientious dissent. Nevertheless it is clear that the LCMS is worried that surrogacy “may complicate or interfere with the parent-child relationship” and “risks turning a child into a ‘project’ or ‘product’” (LCMS 1996: 17).

Abortion and status of the fetus

Abortion has been an issue of great concern among American Lutherans, as in many Protestant churches, during the past few decades. Delegates to the 1991 biennial Churchwide Assembly of the ELCA approved the following statement that generally discourages abortion but specifically recognizes possible exceptions in cases in which the life of the mother is threatened, the child was conceived during involuntary sexual intercourse, or the fetus has extreme abnormalities:

Because of the Christian presumption to preserve and protect life, this church, in most circumstances, encourages women with unintended pregnancies to continue the pregnancy. . . . This church encourages and seeks to support adoption as a positive option to abortion. . . . This church recognizes that there can be sound reasons for ending a pregnancy through induced abortion. The following provides guidance for those considering such a decision. . . . An abortion is morally responsible in those cases in which continuation of a pregnancy presents a clear threat to the physical life of the woman. . . . A woman should not be morally obligated to carry the resulting pregnancy to term if the pregnancy occurs when both parties do not participate willingly in sexual intercourse. This is especially true in cases of rape and incest. . . . There are circumstances of extreme fetal abnormality, which will result in severe suffering and very early death of an infant. In such cases, after competent medical consultations, the parent(s) may responsibly choose to terminate the pregnancy. Whether they choose to continue or end such pregnancies, this church supports the parent(s) with compassion, recognizing the

struggle involved in the decision. Although abortion raises significant moral issues at any stage of fetal development, the closer the life in the womb comes to full term the more serious such issues become. . . . This church opposes ending intrauterine life when a fetus is developed enough to live outside a uterus with the aid of reasonable and necessary technology. . . . Our biblical and confessional commitments provide the basis for us to continue deliberating together on the moral issues related to these decisions. We have the responsibility to make the best possible decisions in light of the information available to us and our sense of accountability to God, neighbor, and self. In these decisions, we must ultimately rely on the grace of God. (ELCA 1991: 6–7)

The LCMS has consistently taken a strong anti-abortion stance. A 1979 resolution on abortion stated that “the living but unborn are persons in the sight of God from the time of conception . . . and since abortion takes a human life, abortion is not a moral option, except as a tragically unavoidable byproduct of medical procedures necessary to prevent the death of another human being, viz., the mother” (LCMS 1979a: 117). A 1984 statement declared, “Scriptural principles . . . compel us to regard abortion on demand not only as a sin against the Fifth Commandment forbidding the destruction of human life, but also as a grievous offense against the First—that we worship the one true God and cling to Him alone. The act of abortion clearly manifests a refusal to honor God as the Creator and to seek Him above all else in time of need” (LCMS 1984: 32). In 1992, more than 95 percent of the delegates at the triennial convention of the LCMS (Stanich 1992: 734) voted in support of a resolution that restated the church’s 1979 teaching and called for increased activity in support of it (LCMS 1992: 116). The synod again reaffirmed its position and renewed its call to action in 1995 (LCMS 1995: 141).

The 1996 study *Christians and Procreative Choices* affirmed that “the living but unborn are persons in the sight of God from the time of

conception,” while admitting that contrary arguments based on such biological facts as the high incidence of spontaneous miscarriage, the phenomenon of twinning, and the “indeterminate personhood of the embryo in its earliest stages” deserved careful attention (LCMS 1996: 38). However, subsequent actions by the LCMS in convention are unambiguous.

In 1998 the LCMS convention resolved to “uphold and underscore Christian concern for sanctity of life” (Res. 3-13A), “affirm life and oppose abortion on demand” and “willful abortion” (Res. 3-14), and “denounce partial-birth abortion as a barbaric procedure” (Res. 6-02) (LCMS 1998).

The 2001 convention established a standing commission on sanctity of life (Res. 6-01) and directed synodical presidents to write to the President of the United States requesting “a thorough review and reversal of the Food and Drug Administration’s decision to permit the use of the abortifacient drug RU-486” (Res. 6-02A) (LCMS 2001).

Prenatal diagnosis and treatment

The ELCA has not directly addressed the issue of prenatal diagnosis and treatment, although its statement on abortion (above) indicates that in some cases, prenatal diagnosis may lead to a morally acceptable decision to have an abortion; this suggests that prenatal diagnosis is acceptable to the ELCA. The ALC stated that prenatal diagnosis was acceptable under some circumstances:

Evaluation of a pregnancy-in-process by currently imperfect and imprecise methods (mainly amniocentesis) is appropriate under some circumstances. This is the case with families with increased genetic risk or with existing children suffering from metabolic or developmental abnormalities. Amniocentesis will help provide data [with] which to decide for or against abortion, to assuage parental fears, and to facilitate adequate medical treatment. It must, however, be questioned as a routine screening procedure, as a means of assuring the desired sex of the offspring, when

used against the wishes of a parent, or when abortion is the only option offered. (ALC 1977: 4)

The Ethics of Prenatal Diagnosis, a pamphlet in the 1986 LCA-ALC series, encourages caution and medically informed decision making: “Under current conditions amniocentesis, the most fruitful of the diagnostic techniques, involves certain serious risks for the fetus. Is the taking of such risks morally warranted by the concern to prevent possible genetic defect or to prepare a family for the possible birth of a child with genetic disease? . . . Any prudent and morally responsible deliberation about whether amniocentesis should be undertaken will involve a careful assessment of the technique’s possible benefits in relation to these potential costs” (Santurri 1986: 6-7).

No official statement by the LCMS was found.

Care of severely handicapped newborns

The LCA is the only constituent body of the ELCA that has officially addressed the topic of the care of severely handicapped newborns. In 1982, it held that in the case of “a newborn infant with serious birth defects . . . the Christian response . . . must be a strong presumption in favor of treatment. Exceptions might arise in cases of extreme and overwhelming suffering from which death would be a merciful release, or in cases in which the patient has irretrievably lost consciousness” (LCA 1982: 4).

A pamphlet titled *The Nontreatment of Seriously Handicapped Newborns*, published as part of the 1986 LCA-ALC series, advocates equal treatment of all persons regardless of age: “Our reasons for stopping treatment of handicapped newborns must hold across the lifespan and must be compatible with reasons for treating. No one should be treated actively when treatment no longer does any good. That reason, however, does not single out unwanted infants as nonpersons; it does not regard early human life as dispensable or replaceable; and it does not prefer the rights or values of adults to the lives

and needs of these patients” (Tiefel 1986: 11).

The LCMS document *Christian Care at Life’s End* states, “In respect for our relationship with God and with one another, we are required to give and to receive ‘ordinary’ care in which the good effects of the treatment are proportionate to the difficulty and inconvenience involved, care that can be provided without imposing an excessive burden on the patient and on others. We may, and perhaps should, reject ‘extraordinary’ care and in such cases ‘let nature take its course’” (LCMS 1993: 20–21). The document recognizes that people of faith may disagree in their application of these principles, but

nowhere does the document indicate that newborns are to be treated differently from others. In the case of severely handicapped newborns, as in the case of all severely compromised individuals, those involved in making decisions should “ponder God’s guidance and seek principled ways to apply that guidance to the complexities of life in a world made difficult by sin” (LCMS 1993: 30). See “Death and Dying,” below, for additional discussion of LCMS principles.

GENETICS

The ELCA and its predecessor bodies have generally displayed cautious optimism about the possibilities created by new knowledge of genetics. “While we may celebrate the potential of genetic knowledge, its application presents challenges that range from interesting questions to troubling personal crises and social dilemmas” (ELCA 2001a: 5). These matters are explored in a book intended for congregational study, *Genetics! Where Do We Stand as Christians?* which, though not a statement of church policy, assists readers in facing these challenges (ELCA 2001a). The ELCA has also published a book on human cloning, which contains papers presented at a church consultation that brought together persons working in genetics, theology, ethics, and law (ELCA 2001c). This book, too, is intended to foster individual and congregational deliberation rather than provide definite answers or set forth church policy.

The 1998 convention of the LCMS requested its Commission on Theology and Church Relations to prepare a study document on the issues raised by human cloning and directed that special attention be given to issues surrounding the production and harvesting

of human embryos. The resolution stated that the “Synod convention reject[s] without reservation as contrary to God’s Word any technique or method of human cloning that results in the destruction of human embryos or the creation of human embryos for the purpose of harvesting” (Res. 3-15B) (LCMS 1998). The Commission’s study is ongoing at this time.

CLINICAL ISSUES

Genetic screening and counseling

The ELCA has not yet officially addressed the topic of genetic screening and counseling. The ALC was fairly positive about their possibilities: “The benefit of expert genetic counseling is potentially very great. . . . As an endorsement of responsible parenthood, the church has an obligation to foster genetic education of youth and young adults, to assist older mothers, families with a history of genetic defects, and families with abnormal children in obtaining adequate expert genetic counseling” (ALC 1977: 4). Similarly, in 1980 the ALC stated, “Should either partner bear hereditary traits that might impose serious genetic difficulties upon their

child, we encourage them to seek competent genetic counseling” (ALC 1980: 6).

A pamphlet titled *Genetic Screening and Counseling*, published in the 1986 LCA-ALC Procreation Ethics series, emphasizes responsible use of genetic knowledge, which, in the author’s view, may include an obligation not to procreate: “Responsible use of our genetic knowledge in screening and counseling for the prevention of unnecessary suffering is in accord with God’s purposes. However, . . . it is also possible and even likely that sinful human beings will misuse the knowledge they gain or be misguided in their application of that knowledge” (Childs 1986: 7). “Christian couples facing the risk of severe genetic disorders in their children need to consider their obligation to forego the freedom to procreate, and not gamble with the odds in order to prevent unnecessary suffering” (Childs 1986: 9; see also ELCA 2001a: 26-32).

As indicated above (under “Contraception”), the LCMS recognizes that Christian couples may conscientiously choose not to have children when there is a probability of severe genetic disease (LCMS 1996: 32). See also “Prenatal diagnosis and treatment,” above.

Sex selection

A 1977 statement by the ALC asserted that prenatal diagnosis must “be questioned . . . as a means of assuring the desired sex of the offspring” (ALC 1977: 4).

Because of its strong opposition to abortion and its insistence that all eggs fertilized in vitro be implanted in the mother’s womb, the LCMS would almost certainly oppose any efforts to select the sex of a particular child when the destruction of an embryo would result.

Selective abortion

No official statements specifically addressing selective abortion were found. The 1986 pamphlet *The Ethics of Prenatal Diagnosis* states a presumption against abortion but argues that in some cases abortion is a permissible way to “care” for the severely handicapped:

For certain diseases detectable *in utero* [such as Tay-Sachs disease] the prospective symptoms are so harsh that it is meaningful to speak of selective abortion not as the abandonment of parental care, but quite the contrary, as the very manifestation of such care. At the same time, there are other genetic afflictions [such as Down’s syndrome] in relation to which an argument for genetic abortion is not so easily made—if it can be made at all. . . . Finally, there will be borderline cases (neural tube afflictions) where there is enormous variation in degree of severity and where the exact degree in a given case cannot be projected by the appropriate prenatal tests. Given a moral presumption against fetal destruction, perhaps the reasonable choice under such conditions of uncertainty is to forego the abortion option in the hope that a tolerable existence will be achieved. (Santurri 1986: 10; see also ELCA 2001a: 26-32)

The LCMS would strongly disagree with the assertion that abortion could be an acceptable way to “care” for any human fetus; instead, it would argue that “since abortion takes a human life, abortion is not a moral option, except as a tragically unavoidable byproduct of medical procedures necessary to prevent the death of another human being, viz., the mother” (LCMS 1979a: 117).

See also “Prenatal diagnosis and treatment” and “Abortion and the status of the fetus,” above.

Gene therapy

In June 1983, the presiding bishop of the LCA, James R. Crumley, Jr., and 57 other religious leaders issued a resolution asking Congress to forbid genetic engineering of human germline cells. Crumley told reporters, “There are some aspects of genetic therapy [for human diseases] that I would not want to rule out. My concern is that someone would decide what is the most correct human being and begin to engineer the germline with that goal in mind” (as quoted in Nelson 1991: 127-28).

While sharing Crumley’s concerns, the author of the LCA-ALC pamphlet *Genetic Manipulation* expressed much more optimism:

“New tools for dealing with nature may be means by which God is using us to work at bringing back the whole created order into line with God’s own purpose. The Christian is *inclined*, therefore, to underscore the promise rather than the peril of new discoveries. . . . [T]he drive of Christianity toward the future redemption of all things would seem to suggest that those who oppose the procedure be asked to present solid reasons for that opposition” (Burtness 1986: 10).

Although the LCMS has not issued any official statements on gene therapy, the Commission on Theology and Church Relations is currently discussing the issue.

ORGAN AND TISSUE TRANSPLANTATION

Both the LCA and the LCMS have issued statements encouraging organ transplantation under certain circumstances.

CLINICAL ISSUES

Issues concerning recipients

No official statements from any Lutheran churches were found concerning recipients of transplants.

Issues concerning donors

Although the ELCA has not yet addressed this issue, the LCA was very positive about organ and tissue donation: “The Lutheran Church in America recognizes that the donation of renewable tissue (e.g., bone marrow) and live organs (e.g., a kidney) can be an expression of sacrificial love for a neighbor in need [and] encourages its members to consider the possibility of organ donation and to communicate their wishes to family members, physicians and health care institutions” (LCA 1984: 2).

Similarly, in 1981 the LCMS adopted a resolution that encouraged churchwide education about organ and tissue transplants, including informing members of “the opportunity to sign a Universal Donor Card (which is to authorize the

use of our needed organs at the time of death in order to relieve the suffering of individuals requiring organ transplants),” and “encourage[d] family members to become living kidney donors” (LCMS 1981a: 204).

Procurement from cadaveric and living donors

“The Lutheran Church in America regards the donation of cadaver organs as an appropriate means of contributing to the health and well-being of the human family” (LCA 1984: 2).

See “Issues concerning donors,” above, for the LCMS position on the procurement of organs from cadaveric and living donors.

Procurement from anencephalic newborns and human fetuses

No official statement from any Lutheran synod was found. The LCMS would almost certainly object to procurement from anencephalic newborns or human fetuses if death were the result. It has resolved to “reject without reservation . . . any technique or method of human cloning that results in the destruction of human embryos or the creation of human embryos for the purpose of harvesting” tissue or organs for transplantation (Res. 3-15b) (LCMS 1998).

MENTAL HEALTH

Luther believed that mental and physical health are interrelated: “With regard to depression Luther recommended not only Scripture and prayer, but good company, good food and drink, music, laughter, and if necessary, fantasies about the other sex! . . . Thus Luther related physical and mental health, commenting at one point: ‘Our physical health depends in large measure on the thoughts of our minds’” (Lindberg 1986: 182).

The ALC issued a paper calling on the church to be more responsive to people with mental illnesses. It emphasized that Christians should not judge those with mental illnesses or view mental illness as God’s punishment but rather offer care and support to the mentally ill and their families (ALC n.d.). The first draft of a proposed ELCA social statement maintains that “[m]ental health services must be fully incorporated within health care services. The suffering caused by mental illness—to both sufferers and loved ones—is not only debilitating but is intensified by the labeling, isolating, and moral blame

that often accompanies it” (ELCA 2001b: 6).

At its 1995 synod convention, the LCMS adopted a resolution “that the Districts of the Lutheran Church—Missouri Synod identify individuals and/or establish a Task Force on Mental Illness within each District to address the concerns/needs of persons with serious mental illness and the concerns/needs of families” (LCMS 1995: 143).

CLINICAL ISSUES

No official statements from any Lutheran synods were found concerning involuntary commitment, psychotherapy and behavior modification, or psychopharmacology.

Electroshock and stimulation

A statement by the ALC affirmed that electroconvulsive shock therapy could be useful under certain circumstances (ALC n.d.: 3).

MEDICAL EXPERIMENTATION AND RESEARCH

According to the first draft of a proposed ELCA social statement, “Research and [the] development of knowledge and new technologies and practices are an essential part of well-coordinated health care,” and such research is worthy of “substantial financial investment” (ELCA 2001b: 8).

The LCMS Commission on Theology and Church Relations is currently studying medical research involving human cloning. However, the 1998 LCMS convention rejected the creation or destruction of human embryos for

research purposes (Res. 3-15B) (LCMS 1998). Three years later, the convention adopted a resolution on stem cell research. While “not opposed to all stem cell research as a means of seeking alleviation for disease”—the use of umbilical cord and adult stem cells is unobjectionable—the convention found the destruction of human embryos to be “sinful and morally objectionable” and denounced “the utilitarian values that place possible healing of medical diseases over the life of defenseless human embryos” (Res. 6-13) (LCMS 2001).

DEATH AND DYING

In the Lutheran tradition, death is not simply a natural event—it is the ultimate result of sin. One prominent Lutheran thinker has put it this way: “In the tradition, death is not merely the result of natural law. It is a crisis, a decisive event. I am partly responsible for it. I have taken actions against God—even if I have seemed to be ‘saintly’—and am thus an agent of what is ahead of me. Somehow what is happening is also my due. This is a particularly uncomfortable aspect of the Lutheran view of death, but without it the therapy and affirmation this version of faith offers is hollow” (Marty 1986: 165).

Not all Lutheran discussions of death emphasize this point, however. For example, the ALC’s primary statement on death and dying begins with the sentence: “Death is a natural event in the course of human life” (ALC 1977: 7). In a discussion of the LCA’s 1982 statement, *Death and Dying*, author Daniel Lee observes that “being born and dying are part of the dynamic life processes as God has created them” (Lee 1983: 2). But death is not the end of human existence, for “neither life nor death are [*sic*] absolute. We treasure God’s gift of life; we also prepare ourselves for a time when we may let go of our lives, entrusting our future to the crucified and risen Christ who is ‘Lord of both the dead and the living’ (Romans 14:9)” (ELCA 1992: 2). The first draft of a proposed ELCA social statement goes even further. “We should not cling to life at all costs, thereby denying the reality of death in our lives and the promise of salvation and eternal life” (ELCA 2001b: 7).

The LCMS’s 1979 *Report on Euthanasia* reflects well the traditional Lutheran view of death: “God created human beings to live and not to die. Death in any form is inimical to what God originally had in mind for His creation. . . . Dying, therefore, is not just another point in the cosmic process or in the experience of living, as it is sometimes made out to be” (LCMS 1979b: 18). For Christians, death does not have the final victory; through the death

and resurrection of Jesus Christ, God has removed the “sting” of death and continues to envelop believers even outside of their mortal existence (Marty 1986: 159). “Even as the person who awakes from a night’s slumber is the same one who went to sleep in the first place, so the person who lies down to die is the very one to be awakened to his eternal destiny in the resurrection of all people” (LCMS 1979b: 21).

CLINICAL ISSUES

Determining death

In 1977 the ALC affirmed that “definitions of death consist of more than biological facts. They must also consider the personal and the spiritual dimensions of life. Since the dimensions of biology and personhood are present in every instance of life and death, both deserve equal consideration in any serious attempt to render definition” (ALC 1977: 7).

In a companion study guide to the LCA’s 1982 statement *Death and Dying*, Daniel Lee discusses the technical definitions of death: “The whole or total brain definition has the most to recommend it. Unlike the upper or higher brain definition it does not reduce the concept of death to irreversible loss of consciousness. Nor does it violate social sensitivities in the way that the upper or higher brain definition does. Unlike the spontaneous heart-lung definition it does not run the risk of declaring death when consciousness is still possible. And, unlike the more inclusive heart-lung definition, it does not by implication extend the definition of human life beyond the point where integrated functioning of the organism as a whole is possible” (Lee 1983: 51).

The LCMS, consistent with the foregoing statements, has said, “When death, therefore, is described only in terms of the total stoppage of the circulation of blood and the cessation of the animal and vital functions, or even as irre-

versible coma, that may not say enough. For behind such a statement is a view of human life which identifies it solely with that of the animal kingdom. This does not do justice to the biblical revelation. . . . Dying, therefore, is called giving up one's spirit. . . . The use of the criterion of 'brain death' has contributed to a more constructive discussion in depth of the subject at hand" (LCMS 1979b: 18).

Pain control and palliative care

Lutherans generally agree about the importance of pain control, despite its possible risks, and palliative care. "Physicians and other health care professionals also have responsibility to relieve suffering. This responsibility includes the aggressive management of pain, even when it may result in an earlier death" (ELCA 1992: 4). "Every reasonable effort should be made to collaborate with patients to alleviate pain" (ELCA 2001b: 7). "At the same time, adjustments in administering [pain-relieving] drugs should be made so as not to deprive the patient of consciousness prematurely" (LCA 1982: 5). "When artificially-administered nutrition and hydration are withheld or withdrawn, family, friends, health care professionals, and pastor should continue to care for the person. They are to provide relief from suffering, physical comfort, and assurance of God's enduring love" (ELCA 1992: 3).

The LCMS takes a very similar stance: "Administering pain-killing medications, even at the risk of shortening life, is permissible, since this does not entail the choice of death as either a means or an end" (LCMS 1993: 5). Death as a "solution" to suffering is never an option in the LCMS; instead, suffering gives Christians the opportunity to practice their faith through caring: "In Christ we discover that we need not flee from the sufferer whose suffering resists alleviation and explanation. Our baptism concretely witnesses to Christ's presence with us and gives us strength in the presence of suffering" (LCMS 1993: 25).

Forgoing life-sustaining treatment

The first draft of an ELCA social statement indicates that "when death is likely or imminent, a peaceful death should become the goal of a health care system, sought as confidently and competently as other goals through adequate palliative care and services such as hospice. Our health care services should not abandon those who are dying" (ELCA 2001b: 7). The ELCA and its predecessor bodies support the right of persons to forgo life-sustaining treatment, including nutrition and hydration: "Food and water are part of basic human care. Artificially-administered nutrition and hydration move beyond basic care to become medical treatment. Health care professionals are not required to use all available medical treatment in all circumstances. Medical treatment may be limited in some instances, and death allowed to occur. Patients have a right to refuse unduly burdensome treatments which are disproportionate to the expected benefits" (ELCA 1992: 3). In such cases, the patient should be the primary decision maker, but all decisions should be made in consultation with others who are directly involved: "We consider . . . [advance directive] legislation [to be] consistent with the principle that 'respect for that person [who is capable of participating] mandates that he or she be recognized as the prime decision-maker' in treatment. The patient is a person in relationship, not an isolated individual. Her or his decisions should take others into account and be made in supportive consultation with family members, close friends, pastor, and health care professionals" (ELCA 1992: 1).

A 1993 report issued by the LCMS stated that "when the God-given powers of the body to sustain its own life can no longer function and doctors in their professional judgment conclude that there is no real hope for recovery even with life-support instruments, a Christian may in good conscience 'let nature take its course'" (LCMS 1993: 5). Likewise, a 1995 resolution opposing legalization of assisted suicide said,

“We respect the individual’s right to refuse treatment or to forbid life-support systems by a prior directive and to be allowed to die” (LCMS 1995: 141). Disagreement exists within the synod over whether artificially administered nutrition and hydration constitute “ordinary” (necessary) or extraordinary care for someone in a persistent vegetative state. The validity of both positions can be demonstrated given the guiding principles articulated by the LCMS. In such an instance, individual conscience is respected.

Suicide, assisted suicide, and euthanasia

Both the ELCA and the LCMS maintain a strong stand against assisted suicide. The ELCA has stated, “As a church we affirm that deliberately destroying life created in the image of God is contrary to our Christian conscience. . . . We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased” (ELCA 1992: 4).

The LCMS, consistent with its strong pro-life stance, has condemned death as a means to end suffering. “To the dismay and fear of many, the advocates of euthanasia, as well as of assisted suicide, have sought to justify the taking of human life on moral grounds by describing it as a truly compassionate act aimed at the relief of human suffering. In light of what the Scriptures say about the kind of care God wills that we provide to those who suffer and are facing death, we reject such claims as neither compassionate nor caring. Christians aim *always to care, never to kill*” (LCMS 1993: 3).

The LCMS holds that euthanasia and assisted suicide are contrary to God’s law (LCMS 1993: 5) and that “any attempt to legalize assisted suicide

is an affront to the Lord, who gives life, and opens the door for abuse and future legislation that would deny the freedom of many” (LCMS 1995: 143). The synod also maintains that “Christians are obligated to make their position known, by whatever means possible, as a way of helping to shape public opinion on the question of euthanasia” (LCMS 1993: 31). In 1998 the LCMS convention reaffirmed its rejection of assisted suicide (Res. 6-02A) (LCMS 1998).

Autopsy and postmortem care

A 1982 statement by the LCA encouraged members to consider authorizing an autopsy or donating a body for scientific purposes (LCA 1982: 7).

The LCMS regards the practice of donating one’s body for medical research as “a matter of individual conscience” (Nelson 1991: 139).

Last rites, burial, and mourning customs

Although cremation has become increasingly acceptable among Lutherans, it is still a minority practice; most Lutherans are buried after death. Burial from a church, rather than from a funeral home, is the traditional practice of Lutheranism, and one that is once again on the ascendancy after a period of decline. Lutheran graveside services reflect widely held Christian beliefs and emphasize both the reality of death and the hope of resurrection (Marty 1986: 163–64).

Stillbirths

The historical Lutheran teaching and practice is to baptize only living persons (LCA 1970: 5); if the possibility of life exists in a stillborn, baptism would be appropriate (Marty 1986: 143).

SPECIAL CONCERNS

ATTITUDES TOWARD DIET AND THE USE OF DRUGS

One author representing the LCA wrote that stewardship of the gift of life “includes eating balanced diets, exercising regularly and otherwise doing those things that contribute to good health” (Lee 1983: 12). According to the first draft of a proposed ELCA social statement, stewardship of our own health includes “taking reasonable steps to prevent illness and disease” and “engaging in healthy behaviors.” The statement recognizes, however, that “[d]isability, disease, and illness do happen . . . even to those who are good stewards” (ELCA 2001b: 10).

A 1971 LCMS resolution stated, “We encourage all people to avoid perverting God’s will by resorting to indiscriminate termination of life, either directly through such acts as abortion or euthanasia or indirectly through the improper use of drugs, tobacco, and alcohol” (Resolution 9-07, as quoted in Larue 1985: 63).

RELIGIOUS OBSERVANCES

Baptism and Eucharist

Baptism and Eucharist are the two sacraments in the Lutheran church; most Lutherans are baptized in infancy.

Blessing of the sick

Although Lutheranism is a liturgical tradition, “there is less recourse here than in some other traditions to the notion of a separate supernatural sphere to which the believer seeks access through the use of anointing oils, the laying on of hands, or special prayers of healing designed to induce miracles” (Marty 1986: 84).

Nevertheless, Lutheran interest in liturgies of healing has increased in recent years. The 1982 edition of *Occasional Services: A Companion to Lutheran Book of Worship*, published jointly by

the LCA and ALC, includes two services entitled “Service of the Word for Healing” and “Laying on of Hands and Anointing the Sick.” Although anointing the sick is not a sacrament in the Lutheran church as it is in the Catholic churches, these services do display a sacramental quality (Ballard 1987: 20). The use of liturgies for healing is encouraged in the first draft of a proposed ELCA social statement (ELCA 2001b: 13).

Holy days

Like many Christians, Lutherans observe liturgical festivals and designate certain days in commemoration of saints, martyrs, and other notable Christians. Unlike the Roman Catholic church, the Lutheran church does not consider these occasions “holy days,” nor does it recognize “feasts of obligation.” Each Sunday is the Lord’s Day.

Polity, scripture, and doctrine

The ELCA is “the most liberal of Lutheran church bodies in North America. . . . The church is divided into 65 synods, each headed by a bishop. During the final merger process [in 1987], headquarters for the new church were established in Chicago. Administratively, the churchwide organization is divided into units with particular program responsibilities,” and the whole church is headed by a presiding bishop (Melton 1993: 320). The ELCA accepts the Bible as the inspired word of God, the three great ecumenical creeds (the Apostle’s, Nicene, and Athanasian) as declarations of faith, the Unaltered Augsburg Confession as a witness to the gospel, and the other confessional writings of the *Book of Concord* as valid interpretations of the faith.

The LCMS is relatively conservative. It maintains that the Bible is the inerrant Word of God and it operates with modified congregational polity. “The members’ responsibility for congre-

gational leadership is a distinctive characteristic of the synod. Power is vested in voters' assemblies, generally comprised of adults of voting age. Synod decision making is given to the delegates at national and regional conventions, where the franchise is equally divided between lay and pastoral representatives" (Bedell 1994: 96). In addition to the Bible, the synod accepts all the writings in the *Book of Concord* as "a true and unadulterated statement and exposition of the Word of God" (LCMS Constitution II); the *Book of Concord* includes the three great ecumenical creeds, the Augsburg Confession, Luther's *Small Catechism*, his *Large Catechism*, and four other sixteenth-century statements (Nafzger 1994: 7).

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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 first-hand 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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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.

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