The United Methodist Tradition

Religious Beliefs and Healthcare Decisions

Edited by Edwin R. DuBose

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The Methodist tradition dates back to the late 1720s, when John and Charles Wesley and a number of other students at Oxford formed a Holy Club meant to recapture the piety and intensity of the early church. In North America, Methodism separated from American Episcopalianism and was established as an ecclesiastical organization in 1784.[1] The United Methodist Church, the largest church within Methodism, resulted from the 1968 merger of the Methodist Church (itself formed by an earlier union of three bodies) and the Evangelical United Brethren. In 1999 the United Methodist Church had approximately 8.3 million members.[2]

As represented by the United Methodist Church, Methodism is a highly organized religious body. The quadrennial General Conference is composed of clergy and lay delegates, elected through their Annual and Central Conferences, and is the policy-making body of the church. Proposals adopted by the General Conference become United Methodist law and social policy and are recorded in two books. The United Methodist Church's law book, *The Book of Discipline*, holds the higher status because it contains the laws of the church as well as the "Social Principles," the highest social policy of the church. *The Book of Resolutions* contains the social policy resolutions that are passed in a democratic process by the General Conference. These resolutions hold until they are overturned or repealed by a future assembly. Generally, reflection on the moral nature of specific medical interventions is done by

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theologians, though the number of churchwide investigations and judgments with respect to particular technologies and procedures is likely to increase.[3] Moreover, official positions taken or resolutions passed at the General Conference are not necessarily accepted by all Methodists. Implementation of policy is carried out by a variety of boards and agencies.

Within Methodism great stress is placed upon moral decision making carried out with mature Christian judgment, thoughtful and prayerful consideration, and informed clergy counseling and support. The general tradition of Methodism is characterized by concerns for personal spiritual growth and social welfare.[4]

The following discussion is based on reference to documents and specific resolutions of the United Methodist Church. Several clinical procedures have as yet received no attention but may well be reviewed at future conferences.

THE INDIVIDUAL AND THE PATIENT-CAREGIVER RELATIONSHIP

According to the church, health is something beyond, but does not exclude, biological well-being. In this view, health care is inadequate when it attends solely to the body and its physiological functions. Part of the task of Methodists is to enable people to care for themselves, to take responsibility for their own health, and to receive care that allows them to live a full life. This task demands spiritual, political, ethical, economic, social, and medical decisions that maintain the highest regard for the condition of society, the environment, and the total life of each person.[5] These views have implications for the patient-caregiver relationship.

Clinical issues

Self-determination and informed consent

The patient is an active participant in medical treatment decisions.[6] Inasmuch as people are created in the image of God, a person's autonomy and self-determination are highly valued. The right of persons to accept or reject treatment is protected in a just society by norms and procedures that involve the patient as an active participant in medical decisions.[7]

Informed consent, therefore, requires that the patient be given all information that would be useful to a reasonable person in the same circumstance, including the benefits, risks, and harm of the proposed treatment, of its alternatives, and of no treatment at all. Patients must show that they understand what has been communicated to them. If a patient does not have decision-making capacity, consent is to be obtained from the guardian or others who are legally permitted to give such consent.[8]

Although no statement was found on the issue of medical experimentation, Methodist views on self-determination and informed consent would correspond to accepted standards for informed consent in that area.

Truth-telling and confidentiality

Confidentiality is affirmed in several resolutions adopted by the United Methodist Church in 1976 and 1988. Expectation of confidentiality covers treatment for alcohol and drug dependency, venereal disease, abortion, contraception, psychiatric care, and HIV testing and counseling.[9]

No specific resolution regarding truth-telling was found. Given the church's strong emphasis on concern for individual and social well-being, and its insistence on the importance of counseling and informed consent, it would follow that truth-telling in medical care is valued.

Proxy decision making and advance directives

Methodists are encouraged to make advance directives, which provide for proxy, power of attorney, or "living will" arrangements to protect one's desires and consent in medical treatment.[10]

FAMILY, SEXUALITY, AND PROCREATION

Family is an important entity within Methodism and is seen as the primary locus for the nurture and protection of children and youth.[11]

The bonds of family define the acceptable limits of sexuality and procreation. For example, sexuality is regarded as an integral part of human wholeness. The 1988 *Book of Resolutions* acknowledges and affirms sex as "God's good gift." The only fully acceptable sexual relationship, however, is within heterosexual marriage. If not informed by an intention of lasting care and commitment, sexual intercourse may become an instrument of exploitation.[12] At the same time, recent Methodist statements regarding the family have been broadening to include single parents and "those who choose to be single."[13]

In regard to child abuse, the *Book of Discipline* calls for strict enforcement of laws prohibiting the sexual exploitation or use of children by adults, and the establishment of adequate protective services, guidance, and counseling opportunities for children thus abused.[14] Moreover, children have rights to food, shelter, clothing, health care, and emotional well-being, as do adults. These rights are affirmed regardless of parents' or guardians' actions or inaction. Children must be protected from economic and sexual exploitation.[15]

Every child has the right to be regarded as a person and the right to receive appropriate medical care and treatment. The church's policy on medical rights for children is not to be construed as a bypassing of the family's right to personal privacy; it becomes operative when parental rights and the child's rights are in direct conflict and it becomes necessary to act in the best interests of the child. The church urges the development of policies that encourage inclusion of youth and young adults in health care decision-making processes.[16]

Clinical issues

Contraception

Recognizing that the relational and procreative levels of sexual union overlap, Methodists endorse the use of contraceptive devices. The use of contraception must be acceptable to both husband and wife and must reflect a relational commitment. Methodists also have recognized, however, that responsible care for the neighbor and for the unborn child requires facing the reality that sexual intercourse occurs outside of marriage and among persons who lack relational commitment or the ability to care for children. Therefore, the General Conference in 1976 concluded that every person, regardless of age, shall have the right to seek and to receive information concerning medically accepted contraceptive devices and birth-control services in doctor-patient confidentiality.[17] The right, however, is clearly subordinated to the responsibility to refrain from harming another person, including an unborn child.[18]

Sterilization

Sterilization is ultimately the decision of the person.[19]

Abortion and the status of the fetus

Although belief in the sanctity of unborn human life makes the church reluctant to approve abortion, the United Methodist Church does uphold abortion rights:

> Our belief in the sanctity of unborn life makes us reluctant to approve abortion. But we are equally bound to respect the sacredness of the life and well-being of the mother, for whom devastating damage may result from an unacceptable pregnancy. In continuity with past Christian teaching, we recognize tragic conflicts of life with life that may justify abortion.[20]

Abortion is permitted if the mother's life is in danger, if the fetus is severely deformed, or if the conception was due to rape or incest. Social, economic, and familial concerns and the "mental capability of the child to be" are also legitimate reasons to consider abortion.[21] The United Methodist Church opposes abortion, however, as a means of birth control or gender selection.[22] The church has stated that the fetus is at least a potential person, embodying divine intention. It is on the way to full personhood, and as such it is a creature worthy of care and respect. For the Methodist, moral decision making has to do with acting responsibly. Therefore, those considering abortion must weigh their obligation to respect the fetus against any other responsibilities they may have. In this calculus, while recognizing "the tragic conflict of life with life," the church supports the above stated concerns of the mother and other existing persons over the concerns of the fetus.

Minors who are pregnant should be treated as adults and should not be subjected by law to parental approval for treatment and abortion.[23]

Prenatal diagnosis and treatment

Although no specific resolution was found, it can be inferred that prenatal diagnostic and treatment procedures are permitted with the informed consent of the parents-to-be. No position was found bearing on the treatment of pregnant women.

Care of severely handicapped newborns

A 1976 resolution supports care for handicapped newborns, stating that "every child . . . has the right to be regarded as a person and shall have the right to receive appropriate medical care and treatment."[24] There is an expectation that considerate and respectful care should be provided to a handicapped newborn, regardless of the severity of his or her condition.[25]

New reproductive technologies

No official positions were found on artifical insemination by husband (AIH) or donor (AID), on in vitro fertilization, or on surrogate motherhood.

GENETICS

Between 1989 and 1992, members of the Genetic Science Task Force reviewed insights, questions, and concerns about genetics and biotechnology based on genetic research and drafted a report for the 1992 Annual Conference. In its report, the task force affirmed the inherent value of all individuals as children of God regardless of genetic or medical conditions and supported a universal right to health care education. It also urged greater public funding and greater public control of genetic research. The report opposed the use of genetic information by insurers for the purpose of rating or denying insurance coverage, as well as the use of such information by employers in ways detrimental to present and potential employees.[26] The 1992 General Conference adopted the report as official United Methodist policy.

Because humankind has the responsibility of stewardship for the whole of creation, Methodists generally approve genetic research and technology relating to improvement of the food supply and efforts to heal diseases. However, concern has been expressed about the possible economic, political, and military abuses of genetic research and its application. A position opposing animal, plant, and human patenting was adopted by the 1992 General Conference. The Genetic Science Task Force urged the United Methodist Church and its appropriate boards and agencies to educate laity and clergy to deal constructively with these issues. It also recommended further discussion in future General Conferences.[27]

Clinical issues

Genetic screening and counseling
Techniques of screening for therapeutic purposes are approved, and equal access to genetic testing is supported. Informed, objective counseling should be available to individuals. Knowledge of any individual's chromosomes must not be used to his or her disadvantage, and strict standards of confidentiality must be upheld concerning such knowledge. Exceptions may be made, however, in cases where an adopted person has a medical need to know about a biological parent's genetic make-up, where the life of a relative is threatened, or where such genetic information is the only means to identify a deceased person.[28]

Sex selection
Although no direct reference to sex selection was found, it seems clear that the church would reject the use of genetic manipulation for the purpose of sex selection.

Selective abortion
Although no direct reference to selective abortion was found, the church's limited approval of abortion suggests that evidence of possible genetic disorders or damage might be grounds for abortion. The church unconditionally rejects abortion as a means of gender selection.[29]

Gene therapy
Changes in human chromosomes are justified only for therapeutic reasons and only if they do not include experiments that produce waste embryos, genetic enhancements, or changes in germ cells. All kinds of positive eugenics, cell-cloning, and hybridization must be prevented.[30] The United Methodist Church thus supports somatic gene therapy but at this time opposes germ-line gene therapy.

ORGAN AND TISSUE TRANSPLANTATION

As long as the practice does not hasten death and is carried out using reliable criteria, the United Methodist Church supports the donation of organs and tissue for transplantation.[31] Donation is encouraged as an expression of the Christian ethic of "selfless consideration for the health and welfare of others," as a "life-giving" practice, and as a source of comfort for survivors, a positive outcome of what might otherwise seem a senseless death. Requests for organ donation and the procedure itself should be "conducted with respect and with the highest regard for maintaining the dignity of the deceased and his/her family."[32]

Clinical issues

Denominational members are encouraged to become prospective organ and tissue donors.[33] No positions on transplantation issues relating to living-donor donations, anencephalic newborns, fetuses, or the use of human fetal tissue were found.

MENTAL HEALTH

The United Methodist Church considers mental health to be a part of physical and spiritual health. In a 1988 resolution on mental health, the General Conference specifically called upon churches to help their communities expand counseling and crisis intervention services; to conduct public awareness campaigns to combat the stigma of mental illness; to promote community and congregational involvement with mentally ill patients; to support individuals and families caring for mentally ill family members; and to promote better interaction among systems involved with the care of the mentally ill—courts, employers, housing offices, and so on.[34]

Confidentiality is important in psychiatric care and counseling and in work with those who are dependent on drugs or alcohol.[35]

Clinical issues

In its official statements the United Methodist Church appears to accept the existence of physical and genetic bases for most serious mental illnesses, but it makes no specific statements on matters of psychotherapy and behavior modification, involuntary commitment, psychopharmacology, or electroshock treatment.

MEDICAL EXPERIMENTATION AND RESEARCH

Physical and mental health has been improved through discoveries in medical science. While such research and experimentation must continue, it is imperative that governments and the medical profession enforce prevailing medical research requirements, standards, and controls in testing new technologies and drugs on human subjects. These standards require that those engaged in research shall use human beings as research subjects only after obtaining full, rational, and uncoerced consent.[36]

Clinical issues

No positions were found on therapeutic and nontherapeutic medical experimentation or research on fetuses, children, and adults, but genetic experiments that produce "waste embryos" or changes in germ cells were deplored.[37]

DEATH AND DYING

The Methodist tradition offers no binding rule that governs every painful decision regarding such topics as suicide, euthanasia, death with dignity, cessation of life-maintaining medical support systems, and palliative care. Applauding medical science for efforts to extend the meaningful life of humans, the church also recognizes the agonizing personal and moral decisions faced by the dying and their physicians, families, and friends. It asserts the right of every person to die in dignity, with loving personal care and without efforts to prolong terminal illness merely because the technology to do so is available.[38] One criterion of death with dignity is the ability to participate in "cognitive and affective activities that enable conscious, loving relationships with

others in community." To the extent that medical technology supports the preservation of this dignity, its use is encouraged. "However, when technology becomes an end in itself, unduly prolonging the dying process," human dignity may be undermined.[39]

Clinical issues

Determining death

No statement defining death was found in any resolution or document of the Methodist church. In an *amicus curiae* brief to the United States Supreme Court in the Cruzan case, the General Board of Church and Society of the United Methodist Church cited a Presbyterian statement relating death to the irretrievable loss of the capacity for human relationship, regardless of any biological function that can be sustained. "In medical terms, that means when brain function ceases and when a flat electroencephalogram occurs, cardiovascular activity ceases, or other tests of responsiveness have been conducted and found to be negative."[40]

Pain control and palliative care

The proper application of medical science, as demonstrated by hospice care, can in most cases enable patients to live and die without extreme physical suffering. Such methods of controlling pain, even when they risk or shorten life, can be used for terminally ill patients, provided the intention is not to kill. The law should facilitate the use of drugs to relieve pain in such cases.[41]

Forgoing life-sustaining treatment

When a person's suffering is unbearable or irreversible, or when the burdens of living outweigh the benefits for a person suffering from a terminal illness, the cessation of life may be a relative good. For the United Methodist Church, theological and ethical reflection leads to the conclusion that the obligations to use life-sustaining treatments cease when the physical, emotional, financial, or social burdens exceed the benefits for the dying patient and the caregiver.[42]

Patients have the right to protection from the extremes of premature or delayed termination of treatment. When a person is dying and medical intervention can at best prolong a minimal level of life, the objective of medical care should be to give comfort and maximize the individual's capacity for awareness, feeling, and relationships with others. In cases when patients are undoubtedly in an irreversibly comatose state, and when cognitive functions and conscious relationships are no longer possible, decisions to withhold or withdraw mechanical devices that continue respiration and circulation may justly be made by family members or guardians, physicians, hospital ethics committees, and chaplains.[43]

The family is the proper context for decision making regarding "how best to cope with the natural ending of a life"; government should not intrude in even a surrogate role.[44]

There are no official statements about forgoing care of severely handicapped newborns, but "considered and respectful care" should be provided, regardless of the child's condition.[45]

Suicide, assisted suicide, and euthanasia

"Suicide: A Challenge to Ministry," a resolution adopted at the 1988 General Conference of the United Methodist Church, encouraged initiatives to prevent suicide by cultivating a caring attitude toward all persons within society. The appropriate pastoral response for patients contemplating suicide is to assist them in understanding God's gift of life, the human stewardship of life, and the responsibilities of the person in relation to the community and the exercise and limits of human freedom.[46] Pastoral caregivers should respond to those contemplating suicide with theological and pastoral understanding and presence. Survivors of those who choose suicide need the support of others who do not pass judgment on the suicide or stigmatize the survivors.

"Understanding Living and Dying as Faithful Christians," a resolution adopted at the 1992 General Conference, addresses the hastening of

death by terminally ill persons. Some persons, when confronted with a terminal illness that threatens to prolong suffering and anguish for them and for loved ones, may consider suicide as a means to hasten death. Some may ask caregivers for assistance in taking their lives. No statement pertaining to assisted suicide was found, although it appears that the church supports controlling pain, even when such methods shorten life, provided the intention is to relieve pain and not to kill.[47]

The United Methodist Church has no official position on active euthanasia.[48] "Understanding Living and Dying as Faithful Christians" contains ambiguous language regarding active voluntary euthanasia.[49] Under certain circumstances, euthanasia might be an ethically permissible action, but United Methodists generally encourage alternatives to euthanasia. Through hospice care and pain management, patients can die without extreme suffering.

"Understanding Living and Dying as Faithful Christians" makes several recommendations to health care institutions regarding care for the dying.[50] Institutions should encourage the formation of institutional ethics committees for policy advising, discussion of issues, and educational leadership; encourage the establishment of policies and procedures that support alternatives in terminal care; and ensure the presence and availability of persons and programs to assist in the resolution of doubt and conflict associated with the use of life-sustaining technologies and support those who must make and implement the decisions that arise at the end of life.

No specific resolutions were found on autopsy, postmortem care, last rites, or burial and mourning traditions. However, the assumption of the importance of human dignity would seem to carry over into these areas.

SPECIAL CONCERNS

Attitudes toward the use of drugs

The 1992 *Book of Discipline* calls for abstinence from alcohol and from the misuse of drugs. Moreover, the church encourages wise policies regarding the availability of beneficial or potentially damaging prescription and over-the-counter drugs. The misuse of drugs should be viewed as a symptom of underlying disorders for which remedies should be sought. Included in this statement is a recommendation to discourage the use of tobacco.[51]

Religious observances

Special religious observances or holy days include Sundays and the traditional holy days and seasons associated with Christianity.

NOTES

1. For a general discussion of Methodism, see Vanderpool, "The Wesleyan-Methodist Tradition," 330.
2. Figures taken from the official website of the United Methodist Church. <http://www.umc.org/abouttheumc/organization/factsandfigures.htm>. Accessed April 2, 2002.
3. For example, one United Methodist doctrinal statement affirms that "new issues continually arise that summon us to fresh theological inquiry. Daily we are presented with an array of concerns that challenge our proclamation of God's reign over all of human existence." *The Book of Discipline* (hereafter *BD*) 1988, para. 69.
4. Shelton, "Recent Developments," 45.
5. *Health and Wholeness*, 3–4.
6. *Health and Wholeness*, 3–4.
7. "Understanding Living and Dying as Faithful Christians," 1992 resolution, in *Health and Wholeness*, 39; hereafter cited as "Understanding Living and Dying."
8. "Medical Rights for Children and Youth," 1976 resolution, in *Health and Wholeness*, 45; hereafter cited as "Medical Rights."
9. *The Book of Records*, hereafter cited as *BR*, 101–6, 265–68.
10. Shelton, "Recent Developments," 150.
11. "Medical Rights," 42.
12. Holifield, *Health and Medicine*, 19.
13. Shelton, "Recent Developments," 146.
14. *BD*, 95.
15. *BD*, 98.
16. "Medical Rights," 43.
17. *BR*, 266.
18. Holifield, *Health and Medicine*, 147.
19. *BD*, 99–100.
20. "Social Principles," *BR*, 20.
21. *BR*, 110–11.
22. *BR*, 20.
23. *BR*, 112.
24. "Medical Rights," 43.
25. *Holy Living and Holy Dying*, n.d.:19–20; hereafter cited as *Holy Living*. Although it is not an official document, *Holy Living and Holy Dying* reflects a number of views held by the United Methodist Church.
26. Carder et al, "Genetic Science Report."
27. *BR*, 213–16.
28. Carder et al, "Genetic Science Report," 20.
29. *BD*, 96.
30. *BD*, 101.
31. *Holy Living*, 9.
32. Ranck, "The Gift of Life," 33.
33. *BR*, 108.
34. *BR*, 270.
35. *BR*, 265–68.
36. *BD*, 101.
37. *BD*, 101.
38. *BD*, 97.
39. *Holy Living*, 11.
40. Shelton, "Recent Developments," 157.
41. "Understanding Living and Dying," 39.
42. Ibid., 33.
43. Ibid., 38.
44. Shelton, "Recent Developments," 155.
45. "Medical Rights," 43.
46. *Health and Wholeness*, 35–36.
47. "Understanding Living and Dying," 39.
48. Interestingly, the Pacific Northwest Conference of the United Methodist Church endorsed Washington State Initiative 119 to legalize physician-assisted suicide and voluntary euthanasia. See Campbell, "Religious Ethics and Active Euthanasia," 61.
49. "Understanding Living and Dying," 33.
50. Ibid., 41–42.

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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, 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.

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