Homosexuality: Revolution in Ruins

James L. Fletcher, Jr., M.D.

Dr. Fletcher is a graduate of Vanderbilt University School of Medicine and completed a residency in Family Medicine at the University of Connecticut School of Medicine. After practicing in Sparta, Tennessee and Atlanta, Georgia, he became assistant professor of medicine at The Medical College of Georgia in Augusta.

"There is a way which seems right to a man, but its end is the way of death" (Proverbs 14:12).

(Editor's note: In general, in this paper, the term homosexual refers to male homosexuals. All Scripture references are from the New American Standard Bible. La Habra CA: Foundation Press, Publications, 1972.)

Where Is Homosexuality in 1987?

The 1960's were a period of tremendous social ferment in the United States of America. One of the offspring of those turbulent years was the so-called "gay revolution." Prominent in and drawing strength from coastal enclaves, the revolutionaries enjoined the battle across the land. The war is still being waged on our soil. It is a war over the place of homosexuality in our society.

"Homosexual rights" have become a major issue of the 1980's, much as abortion rose to prominence in the 1970's. The antagonists in the fray are those on the one hand who assert that homosexuality and heterosexuality should be on equal footing as sexual alternatives; hence, homosexual individuals are just another minority group seeking to establish their place in the social/political arena. On the other hand, there are those, whether in crude or articulate fashions, who persist in assessing homosexual behavior as unnatural, abnormal.

Some would date the advent of the homosexual revolution to an incident at the Stonewall Inn in New York in 1969.[1] Since then, it is remarkable just how much territory the pro-homosexual camp has conquered. Successes have been both small and large, local and national. They have successes, to a large extent, in removing the term "homosexual" from our social parlance, substituting "gay" with its pleasant connotations. A major victory was won in 1974 when the American Psychiatric Association succumbed to pressure and expunged homosexuality as an illness entity from their diagnostic rubric. This added concrete to the homosexual beachhead, reiterating that they are not abnormal but rather "alternative." Many homosexuals view this as "the greatest of gay victories," since it has effectively transformed into official "dissidents" any

psychiatrists who would persist in assessing homosexuality as a serious psychosexual condition.[2]

The battle has been waged by both biologic sexes, although the lesbians and their associated feminism have perhaps not been quite as strident about homosexual "rights" as have the males. The latter also seem to have a tighter grip upon the media's attention, probably because of the acquired immunodeficiency syndrome (AIDS).

Indeed, had it not been for AIDS, one wonders how much more definitive might have been legislative, judicial and popular security at this time. AIDS has definitely hurt the homosexual cause and has given pause for many possibly sympathetic heterosexual individuals to think about the homosexual revolution.

Etiology of Homosexuality

It is customary, when considering a pathologic entity, to discuss its etiology. When considering homosexuality, such considerations bring one around to the ongoing debate between the "biologic" camp and the "environmental" camp. Apart from considerations of space, such a discussion is not judged helpful to the present paper as the Bible has nothing to say about homosexual etiology, other than with reference to man's basic rebellion against God.

The Bible classifies any misguided attempt to meet human needs, outside of God's plan, as sinful. In his helpful book, Colin Cook has described homosexuality as a "counterfeit intimacy."[3] As the homosexual first ignores, then suppresses God's design for him/her as a heterosexual creature in His image, a state of the "darkened mind" develops, as described in the first chapter of Romans. Such a darkened state leads to further sin as such a one is "given over" by God to depravity and to the lusts and passions of the heart.

Once a hidden practice in our society, homosexuality has experienced a recent trend among activists promoting a "gay lifestyle" emphasizing random, repeated and anonymous sexual contact (at least prior to AIDS). Although there is a broad spectrum of homosexual practice, from basically heterosexual/occasional homosexual to exclusively homosexual, seriously homosexual men generally find long-lasting "monogamous" relationships nearly impossible, and thus

such activist encouragements have fostered runaway promiscuity. Precise sexual contact statistics are hard to come by. Alfred Kinsey estimated the average male homosexual to have about 1,000 partners in a lifetime. The *Village Voice* has estimated 1,600 partners. One homosexual activist has stated that 10,000 partners in the lifetime of a "very active" homosexual would not be extraordinary. Such unbridled vigor, occurring in bathhouses, gay bars, public rest rooms, interstate highway rest areas, urban parks, and various other locations, boggles the mind of most heterosexuals and renders very understandable public health concern about the serious threat of homosexually

transmitted diseases currently facing our society.

The Homosexual's Destructive Effects Upon Society

In a penetrating paper, Paul Cameron has written:

No known human society has ever granted equal status to homo- and heterosexuality. What information do those who desire social equivalence for these two sexual orientations possess that assures them that this new venture in human social organization is called for at this time? Have cultures of the past practiced discrimination against homosexuality out of mere prejudice, or was there substance to their bias?[4]

Cameron goes on to argue that the weight of tradition, both social and religious, is preponderately on the side of discrimination against homosexual practice. He challenges those who would "reverse" such discrimination to prove, by weight of scientific evidence, the worth of their plan, to derive more logically sound arguments than the one often implied: People ought not to be discriminated against; homosexuals are people; therefore homosexuals ought not be discriminated against.[5]

It is estimated from two fairly recent surveys that the incidence of "serious" homosexuality in our nation is less than 8% (1-2% bisexual males/0.5-2% females; 1-2% mainly or totally homosexual males/0.5-2% females).[6] Yet, the influence of this small minority is writ disproportionately large. The media have fostered this influence; it is estimated that today's populace is experiencing a 50-fold increase to exposure to homosexuality compared to those living 50 years ago. It can also be shown that current exposures are of a pro-homosexual tilt.[7] Despite this relative barrage, only about one-third of 1520 individuals interviewed in 1976-78 favored social acceptance of homosexuality, whereas nearly half of those interview indicated they would discriminate against homosexual practice in some way.[8]

Cameron argues persuasively that certain psychosocial elements favor homosexuality. If one believes that sexuality is learned, homosexuality receives several developmental "boosts" beginning with the fact that early childhood is marked by "homophyllous" relationships ("I like those who are liked me"; boys play with boys, girls with girls) which leads to "homosociality (same-sex friendships). Without the proper heterosexually oriented influences occurring at the right developmental times, homosociality may lead to homosexuality. Some would argue that these heterosexual developmental influences have been weakened in a society populated by so many broken families. Also, as our society has become more self-oriented, homosexuality, with its "sex-for-sex's-sake" impersonal encounters, becomes more attractive. In its egocentric (selfish) orientation, homosexuality appeals to the adolescent who is naturally egocentric.[9] Homosexual

gratification, often anonymous, requires much less work than heterosexual gratification which, at its best, is quite interpersonally intense and energy-requiring across gender lines.

Cameron also concludes that homosexuality is a significant threat to our social fabric. If the massive traditional cultural support for heterosexual practice were replaced (by means of pro-homosexual campaign aimed at the young) with a true choice of sexual orientation, a significant increase in homosexual incidence could be expected.[10] Heterosexuality would then diminish in its effectiveness as "social glue." It can be argued that since heterosexual relationships generate human offspring, heterosexuality tends to produce others who care about one. It also provides a living example of social cohesion in that the families and multi-generational kinships it spawns provide unparalleled opportunity for humans to overcome their xenophobia ("I don't like people who are not like me").[11] Cameron writes therefore that "heterosexuality and its fallout provides one of, if not the most, potent socially cohesive forces in our society."[12] Homosexuality, by contrast, is a potent force for social fragmentation. While the one has the potential to produce collective social betterment, the other tends toward social individualism.

From his experience and that of other therapists, Cameron also suggests a "disproportionate loading" among homosexuals of undesirable traits such as egocentricity, superciliousness, narcissism, hostility and irresponsibility.[13] He notes a "personal lethality" among homosexuals, and that on the whole, far from being "gay," they are not as happy as Americans in general.[14] Homosexuals have a disproportionately large incidence of suicide.

The lethality theme may be connected with one's progeny. For although homosexual practice avoids "messy pregnancies," it also bears no children. The desire to remain alive and care for and nurture one's children has been described as a powerful antidote to suicidal desires among men.[15] Society must have an interest in the bearing and nurturing of children if there is to be a future. Alternatively, homosexuality fits well with "lethal complex" social policies of those intent upon population trimming.[16]

Medical Consequences of Homosexual Behavior

Quite apart from psychological and social consequences of homosexuality, there are many more tangible resultant problems. Several years before the outbreak of AIDS, it had been recognized that male homosexuals suffered from increased vulnerability to a number of medical problems and diseases.[17] The utilization of the mouth and the rectum as sexual functionaries poses hazards for the contraction of certain diseases. These include infections with amebas, giardia (a protozoan), and bacteria (such as shigella species). A new term, "gay bowel syndrome," has been invented to describe

these types of intestinal infections in homosexuals who are often infected not with just one but with several different microorganisms simultaneously.[18] A small Swedish study demonstrated that nearly 60% of homosexual subjects without symptoms (not to mention those with symptoms) harbored intestinal parasites.[19] Hepatitis B can also be sexually transmitted, and it appears at a much higher rate among homosexual males; a German study has shown an incredible 81.7% rate of blood test positive for hepatitis in one group of 200 homosexuals studied.[20] Other infections found at higher rates in homosexual men include those of the cytomegalovirus and Epstein-Barr virus.

Moreover, the more common sexually transmitted diseases (STD's) are rampant in the homosexual population. Homosexual men are infected with gonorrhea more often than heterosexual men,[21] and they tend toward multiple simultaneous sites of infection (eg, throat, rectum) Throat and rectal infections frequently cause no symptoms, making their discovery and eradication difficult. Syphilis is currently at such a low prevalence (rate of infection) among the general U.S. population that a positive pre-marital blood test is more likely to represent a laboratory error than a true case of syphilis. By contrast, the homosexual population now harbors about 50% of total infectious syphilis among males in this country (in contrast to their small numbers among the general population).[22] Making these figures more concrete, in 1979 it was estimated that a homosexual man living in Denver, Colorado, had over 28 times the risk of early syphilis than a heterosexual Denver male.[23] An other unusual syphilis-like infection of the intestines has also been reported among homosexuals.[24] Lymphogranuloma venereum (usually occurring on the groin of heterosexuals) may occur in homosexuals as proctitis (inflammation of the rectum). The herpes virus can likewise cause severe infection of the homosexual's rectum and anus (opening of the rectum). Other infections more commonly seen in homosexuals include syphilitic warts and molluscum contagiosum (a bumpy skin disorder caused by a virus).

Considering non-infectious health problems, some homosexuals also suffer from an unusual type of thrombocytopenia (low concentrating of a blood clotting element called platelets).[25] Physical problems seen in increased numbers among homosexuals include hemorrhoids, fissures (cracks) of the anus, and various injuries resulting from insertion into the anus and rectum (for purposes of sexual stimulation) of fists, entire forearms, and a variety of foreign objects (eg, vibrators, balls, dildos). Cancer of the anus is being found in increasing incidence among male homosexuals. To be sure, some of the diseases and problems listed above are also found among heterosexual individuals, but the point is that their representation within the homosexual community is disproportionately large. And all of these predated and/or have existed in addition to AIDS.

AIDS

AIDS may well be the "New Plague." It is an epidemic that has driven fear into stolid, scientific hearts. It has stricken the wealthy and well-known as well as the poor and unknown. It has stricken the wealthy and well-known as well as the poor and unknown. In the U.S., we "discovered" the disease in 1981 when reports of unusual infections and cancers began to accumulate from major urban medical centers. AIDS is now said to be the leading cause of death among single American men aged 15 to 50.[26] AIDS has captured the media's and public's attention in what is perhaps an unprecedented fashion. Many wonder if our nation can cope with this disease and its victims who already strain the health care system in certain cities.

Just how bad it? As of December 12, 1986, there were over 28,000 cases (74% of whom were homosexual/bisexual: 66% homosexual/bisexual men plus 8% homosexual/bisexual men who have also used IV drugs) diagnosed in the U.S., according to the criteria of the Centers for Disease Control in Atlanta.[27] Cases have been reported from many countries world-wide and from all 50 states. The death rate of the disease is in the neighborhood of 50-60% of existing cases at any given time; to date, no one has ever been known to recover from AIDS.[27]

One of the worst features of AIDS is its "latency period," that is, the period of time between an individual's being inoculated with the causative agent and later being recognized as having the actual disease. This latency period can be in excess of 5 years, perhaps as long as 10 years. Hence, many individuals currently infected with the disease are completely unaware of their perilous status and so may pass on their affliction to others who are similarly unaware.

It has been estimated that 1 1/2-2 million Americans have been infected with AIDS. Some apparently will never come down with the full-blown disorder. Exactly what proportion of those infected will ultimately develop the overt disease is unknown, but it has been estimated that the total cases of AIDS will exceed 270,000 in the U.S. in the next five years.[28]

The initial causative virus of AIDS was jointly discovered by American scientists (and called human T-cell lymphotropic virus, HTLV-3) and a French team (who called it lymphadenopathy-associated virus, LAV). This virus has recently begun to be referred to as the human immunodeficiency virus (HIV); it is one of a group of "retroviruses," which include HTLV-1 (which causes one type of adult leukemia in areas where the virus is endemic), HTLV-2 (which has not been related to any particular human disease), and HTLV-3.[29] Of further chilling interests is the recent report of a "new" retrovirus from several West African patients with AIDS; this virus has been called HIV-2.[30] Perhaps even more AIDS-causing viruses await discovery.

AIDS is a complex disease process

initiated, we now believe, when HIV invades the body and infects certain lymphocytes ("T-cells"), a type of white blood cells. Thereafter, the virus may go into hiding for months to years, but, in individuals destined to have full-blown AIDS, ultimately induces a breakdown in the body's immune defense system. This breakdown, which affects the very lymphocytes that the HIV invaded, allows certain bacteria, parasites, and fungi which often otherwise live peacefully within the human body to proliferate rapidly. Without the normal impedance to their growth, rampant infections develop. Similarly, certain cancers (eg, Kaposi's sarcoma), also normally destroyed by the affected lymphocytes, flourish. The hapless victim, assaulted by recurrent infections and also perhaps suffering from chronic diarrhea and other health problems such as weight loss, gradually weakens and dies. The virus is though to have arisen in Central Africa; how it first came to North America remains speculative.

The HIV has been isolated from lymphocytes, blood, bone marrow cells, spinal fluid, brain tissue, lymph nodes, semen, saliva and tears, so that multiple body tissues and fluids must be regarded as potentially infective. Yet, HIV, is apparently not spread casually, but rather by intimate contact, usually by sexual intercourse with one who has the disease (or contact with his/her infected body fluids--such as blood and semen) or by sharing dirty needles. These modes of transmission of the disease correlate with those who have been shown in study after study to be at highest risk of contracting AIDS. Thus far, roughly 70-75% of cases have occurred among male homosexuals (or bisexuals) and about 10-15% of remaining cases are among intravenous drug abusers. Others affected have included hemophiliacs (who have received blood products infected with HIV for treatment of their blood clotting disorder), heterosexual (especially female) sexual contacts of those with AIDS, babies born to mothers with AIDS, and a few health care workers. Thus, although homosexual activists point to cases of AIDS involving heterosexual transmission of the disease, nonetheless it seems an inescapable conclusion that there is something about the specific sexual practices of male homosexuals that predisposes of this dread affliction. Sobering, also, is the fact that extensive abnormalities of the immune system have been found among "well" homosexual men who did not have AIDS, whereas no similar abnormalities were documented among a comparison group.[31] If homosexual practice apart from AIDS is healthy, why do these laboratory abnormalities exist?

Some would explain high risk status among male homosexuals strictly as a function of their high level of promiscuity (even as promiscuity also increases heterosexual individuals' risk for the disease). Others speculate about possible "co-factors" found in male homosexuals and that may be necessary for HIV invasion. Whatever the truth is discovered to be, there appears to be something obviously distinctive about male homosexuals as a high risk group for AIDS.

ETHICAL DILEMMAS

The treatment of AIDS may be summed up in one word: dismal. Treatment of the complications of AIDS (eg, unusual infections) is difficult enough. Even more difficult has been the pursuit of an effective treatment to stop the HIV from ever establishing a beachhead in the lymphocytes, or else to destroy it once it's there. A vaccine to prevent AIDS is being sought, but experts admit that an effective vaccine, if it can be formulated at all, will be forthcoming only in the indefinite future. A number of experimental virus-killing drugs have been tried and others await a trial. Such trials stimulate consideration of some of the ethical issues surrounding AIDS in particular and homosexuality in general.

Drug trials for AIDS have been difficult to perform because of the tremendous media awareness of the disease and the understandable terror among those afflicted with it. Who should get the treatment? Who is in-eligible? How should the National Institutes of Health respond to the pleas for therapy that tie up its switchboard when a new treatment protocol is announced? What should be done about unproven or dangerous "treatments" that circulate in underground fashion among victims?

And what about the care of those who don't respond to treatment and are dying? What about the appalling numbers of cases predicted by the end of this century? Will individuals with other health problems be able to find a hospital bed in the urban areas where thousands of AIDS patients will reside? How shall we care for all of these terminal AIDS patients who are often otherwise "too young to die"? How much treatment is "enough" for a disease that has proved 100% fatal so far? Where shall we obtain the health care personnel (who report their own depression in caring for these dying young), the hospital facilities, the dollars? And who is responsible for the bill? It is the private health insurance companies who have responsibilities of financial solvency to their other, healthy patrons? Is it the federal government with its already massive financial deficit and its many demands from other quarters for the succor of its resources?[32] Then there is the ethics of confidentiality. Confidentiality has been one of the buzz words of homosexual activist groups who apparently wish to "go public" and yet remain undistributed in their practices. In 1985 a laboratory test became available to test blood for the presence of HIV shortly thereafter, screening of all blood donations for the presence of HIV began in the U.S. Some homosexuals became very concerned lest those who were discovered to have a positive AIDS blood test might be "found out," with consequences possibly involving employment and insurance. There seems to have been much more in print documenting homosexual concern over confidentiality of blood test results than concern over the public health. And although there has been much said and written regarding results of screening tests and regarding school children with AIDS that is neither compassionate nor helpful, there are legitimate questions raised. What are the proper limits of confidentiality where a

lethal disease threatens the public health? What does one tell the individual who tests positive where a positive test does not necessarily mean he will ever contract full-blown AIDS, but for whom the precise likelihood of such an outcome cannot be calculated? What about the unsuspecting citizen with no risk factor for AIDS who tests positive when he seeks to fulfill his community duty by giving blood? Is his test truly or falsely positive? How much agony will he endure as he awaits the answer? And who should be told about positive test results? Individuals tested? Their families? Their physicians? Their dentists? Their insurance companies? Should an insurance carrier be legally forced to regard, just as any other subscriber, a homosexual who has just found out he;s positive?

An what about the ethics of public information regarding AIDS? There has been perhaps an unprecedented attempt to prevent public panic about this disease. "Education" has been a key word from the lips of politicians and public health officials alike. It has been said that the public must be educated with the truth about AIDS. On the other hand, there are those who speculate that the public has not been told the truth, or at least the whole truth. Gene Antonio has asserted in an alarming and cogent fashion that despite assurances by officials to the contrary, there are many disturbing facts about the AIDS virus itself, its possible transmission, and the public health ramifications of AIDS that are either not known or perhaps have been suppressed.[33] In view of this extensive, documented research, such allegations are quite disturbing.

Homosexuality, and especially homosexuality, and especially homosexuality-since-AIDS, presents a sobering ethical challenge to the medical profession. In view of the impression of many that AIDS is America's premier public health problem today, one is impressed with the paucity of writing in medical literature concerning an essential element of the AIDS conundrum: Is the group from whom the majority of cases have come to be assessed just as any other risk group? Put another way, is there something about homosexual males as a high risk group for AIDS (and other diseases) that the medical community should comment upon?

To be sure, paralleling the swirl of writings in the lay press on AIDS, there has been much, much descriptive material in medical journals concerning AIDS: case tallies, new treatments, virologic studies, unusual manifestations, etc. There have even been a few articles advancing value judgments, yet these have tended toward topics such as necessity of screening blood donors, confidentiality of test results, guidelines in caring for AIDS patients, the need for more research funding, and education of high risk groups.

Education of high risk groups has focused on "safe sex" with fewer partners. Such educational efforts, of course, seem tacitly to assume that homosexual activity is basically acceptable. The message is that there is no need for radical change of sexual behavior as long as you practice "safely." To wit, if America can just get "condomized," we'll be O.K.

This is a distinctly unusual posture for the medical profession. It is difficult to imagine today;s physicians counseling smoking patients to "safe-smoke," or their alcoholic patients to "safe-drink," or their drug abusing patients to "safe-shoot" (although, interestingly, some physicians faced with large populations of drug abusers at risk for AIDS have recently advocated selling sterile needles to addicts). In all of these cases, if forced to do so, a physician might grudgingly accept a reduced level of engaging in the specific pathologic behavior. Yet, given a choice, he or she advises total abstinence for cigarettes, alcohol (for alcoholics) and drug abuse. Why not with homosexual behavior? Why haven't health professionals risen up in professional outrage against homosexual behavior? We do not speak here of "gay-bashing" or of with-holding compassionate care from those afflicted with AIDS. Nonetheless, the truth is injured and society damaged when the medical profession, whether actively or passively, places its imprimatur upon homosexual practice as healthy. (And, when public voices within the visible church urge acceptance of homosexual practice as morally fit, one might add.)

But here it may be objected that it is not homosexuality that's the problem, but rather promiscuity. If a homosexual will only have fewer partners, he'll be safe and AIDS will ultimately decline. Promiscuity is the real problem.

This argument is superficially enticing. And yet, practically speaking, no one has proven that reducing numbers of partners or even using condoms will definitely reduce the occurrence of AIDS. The efficacy of condoms as a heterosexual contraceptive device gives little encouragement; there is a significant rate of failure. How then will they perform in the physically vigorous practices of male homosexuals? Furthermore, it has been noted how difficult it is for male homosexuals to cease promiscuous behavior. The promiscuity argument loses even further persuasion when we consider the increase in the overall percentage of homosexuals infected with HIV. Consider a study of nearly 500 homosexual men begun in San Francisco in 1978; in that year the rate of positive blood tests for HIV among these men was 4.5%; by Augusta 1985 the rate of positives had risen to 73.1%, a 16-fold increase.[34] If rates of presumed HIV infectivity in other areas of the nation even approach these stunning figures, one must ask:What is "safe sex"? Is using a condom or restriction to 5(10?20?) partners adequate protection against contracting AIDS?

It has also already been noted, even setting AIDS aside, that homosexuals get more than their proportionate share of several other serious and unusual disease. The medical evidence argues persuasively that homosexuality, in and of itself, is basically a pathologic behavior. Promiscuity aside, homosexual behavior is no more an "O.K. alternative" than smoking two packs of cigarettes per day. How many smokers, alcoholics or drug abusers would seriously claim that their addiction is healthy? Yet homosexuals and their sympathizers stand boldly to proclaim that pathology equals

health. What is the social and medical precedent for such deception? It is a tribute to the exponential growth of homosexual social and political power that they go about their deeds and ways with so little public and professional outcry.

The lack of an outcry is also a tribute to the lack of effective opposition. Although a few physicians have pointed to root moral issues surrounding the prevention of AIDS,[35] and a few doctors in Texas have banded together in political opposition to the spread of AIDS,[36] since AIDS and therefore homosexual behavior are such serious public health issues in the 1980's, why haven't many more physicians and health officials called for true metamorphosis of lifestyle in the highest risk group? Some, to be sure, have been apathetic. Others have been fearful of making waves. Some are themselves homosexual.[37] Others, often the influential experts, apparently believe homosexuality is an acceptable alternative and hence have no philosophical opposition.

As for the response from the general public, that which has occurred has been characterized by inconsistency, inarticulate frenzy, apathy or, above all, confusion. The public is confused. What's right? What's wrong? How can we know without a standard?

The Christian's Response and the Biblical Perspective

When we look at the United States and other countries today, we see increases in homosexuality, support for abortion on demand, disobedience to authority, people who do not want to work, pornography, the abandonment of marriage and modest clothing, to name but a few examples. What has occurred in society to bring about this change? Why is it that many people today just scoff when we talk about Christ and the doctrines of the Gospel?

It wasn't long ago that creationism was the basis of our society. A creation basis means there are absolutes. If you accept a belief in God as Creator, then you accept that there are laws as He is the lawgiver...[38]

There is a standard by which to assess homosexual behavior, even as there is to assess the whole of life. In our culture in the latter 20th century, the Bible is the lost standard. It has been replaced by humanism philosophically and by relativism ethically. Man is the center of the universe, and anything goes. As alluded to by Mr. Ham, homosexuality is but one example of this shift and its effects upon our societal values. Medicine has been certainly affected. Following the lead of the American Psychiatric Association, national medical organizations publish "neutral" positions that offer little if any resistance to contemporary homosexual activism.[39] Other physicians have taken a more stridently affirmative stance.[40]

What is the biblical perspective on homosexuality? Although abandoned by most of the modern medical community as having nothing relevant to say to 20th century men and women, the Bible is

neither silent nor ambiguous about homosexual practice. and while it does not make direct, specific statements about the causation of homosexuality (except man's basic rebellion against God), neither does it suggest that homosexuality is an illness nor just another alternative sexual lifestyle. The Table is a comprehensive list of Scripture references to homosexuality.

Reference Comment

1.Genesis 1:27 God creates human in His image, **male** and 2:21-24 **female**. His pattern for conjugal relations: 4:1 one man and one woman, Adam and Eve -- not Adam and Steve or Eve and Genevieve.

2.Genesis 19:1-29 Sodom and sodomites. Only 19 chapters into Scripture mankind has perverted God's plan.

3.Leviticus 18:22-30 Homosexuality/bestiality are abominations, defilements. Death penalty to be imposed.

4.Leviticus 20:13 Death penalty for both homosexual (male) partners.

5.Judges 19:20-26 "Bisexual" sin in the tribe of Benjamin.

6.Judges 20:13 Israel makes war against tribe of Benjamin for sheltering homosexuals.

7.I Kings 22:46 Jehoshaphat drives homosexual prostitutes (sodomites) out of Judah.

8.Romans 1:18, 24-28 Homosexuality unnatural, an indicator of severe depravity.

9.I Corinth. 6:9-10 Homosexuals unrighteous and will not inherit the Kingdom of God.

10.I Tim 1:8-11 Homosexuality lawless, rebellious, ungodly, sinful, unholy, profane, contrary to sound teaching.

There is nothing anywhere in Scripture that affirms homosexuality. It is declared to be an error, a departure from God's sovereign plan for man, a sinful practice, and it is condemned.

Many evangelical Christians are familiar with and subscribe to this position. Why, then, bother citing Scripture references, or with exegesis which is straight-forward? The reason is the culture in which we find our selves and which is succinctly characterized by the bible itself: "in those days...every man did what was right in his own eyes."[41] For years homosexuality was not even considered a topic for polite conversation. Yet today we have "gay pride" marches and a national political party that, during the last presidential election campaign, placed its official stamp of approval upon homosexual practice. Even clergymen from major U.S. denominations are becoming increasingly outspoken as homosexual advocates, and reports are surfacing that substantial numbers of clergymen are themselves practicing homosexuals,[42,43] In our culture today, where secular humanism is not only preached by elitist intellectuals but has seeped down into the minds of the

common folk as well, it is unfortunately necessary to restate what should be obvious: God still means what He has had written in Scripture about homosexuality aside, God does not change.

God hates sexual immorality, be it heterosexual or homosexual. His solutions for the prevention of sexual immorality are heterosexual marriage or chaste celibacy; for the act of sexual immorality committed, He demands confession and repentance. He does not excuse sexual immorality even if we label it "alternative." The Bible clearly states that man's sexual immorality will bring forth God's judgement.

Such judgement has entered into many recent discussions of AIDS. This writer formerly believed that AIDS represented God's judgement on homosexuals and possibly upon our culture. Others have said the same. However, after further reflection upon judgement as presented in Scripture, the writer now sees AiDS in a different light.

In many places in the Old Testament, God's judgement upon man is said to have three components: famine (starvation), the sword (war), and pestilence (disease). Thus judgement can come in the guise of health problems. And yet, when judgement fell, as in the instances of Sodom and Gomorrah, the plagues of Egypt, the Assyrian and Babylonian conquests of Israel, and the destruction of Babylon, it was widespread and unmistakable. god describes His judgements as "the chalice of My wrath",[44] and those who "drink" it are said to "stagger" as if drunk. Their dysfunction is severe and visible to all observers. This is why when severe calamity struck western culture in earlier ages, those with a Biblical heritage were ready to attribute their misfortunes to God's judgement (eg, the Black Death in the Middle Ages).

Therefore, applying a similar interpretation to AIDS, America is probably not yet judges, since the pestilence is not yet ubiquitous and is not yet of staggering proportion. Rather, what we see in certain high-risk groups is that God is not mocked; whatever an individual sows, he reaps. Scripture, describing homosexuals, declares that they "receive in their own persons the due penalty of their error."[45] God has so ordered His universe that we may choose to sin if we wish; however, such choices are inevitably followed by consequences. Thus we currently observe in AIDS not judgment so much as wages. Why such wages appear at this particular juncture in history is an intriguing question. Professor Brown has proposed one of two possible explanation. In HIV, we may be seeing what was previously an animal virus which has recently begun to infect humans. Alternatively, perhaps HIV was previously a "minor" human virus causing unimportant human illness, and either the virus has changed in some way or else the behavior of the human host has altered.[46]

Unfortunately, the consequences of the wilfully sinful often spill over upon the (relatively) innocent. And so hemophiliacs (who must receive blood products to live) and transfused babies contract and die of AIDS as a result of blood donations from

infected high-risk individuals. Thus, all cases of AIDS are certainly not matters of choice-consequence.

We should be warned by the judgments of the past recorded in Scripture. In view of growing evidence of spread of AIDS into the general public (many of whom are guilty of heterosexual immorality), it might be argued that AiDS will yet prove to be God's judgement upon America if projections regarding AIDS and its economic consequences become reality.

THE COMPLETED BIBLICAL PERSPECTIVE

God's wrath against sin and his judgments notwithstanding, he is also a God of mercy and loving kindness. Some Christians have neglected this aspect of God's nature to the extent that homosexual activists have lumped them with those depicted in unfavorable media pieces.[47] Those with anti-homosexual convictions are often maligned as "homophobics," implying that they fear homosexuals or latent homosexual impulses within themselves. Such charges are generally only a pro-homosexual smoke screen (similar to those employed by pro-abortion activists); such anti-homosexual convictions might better be analyzed not as fear but as a revulsion - a God-given abhorrence for that which is perverted and morally repugnant.

Nonetheless, Christians cannot escape the teaching of Scripture regarding compassion to the sinful. Need we be reminded that we are all sinners before a holy God? Forgiveness is preferred to those who truly repent. Scripture is clear: where there is sin, there is a means of avoiding or escaping it. Christ provides the way out for the homosexual as for all sinners.

TREATING THE HOMOSEXUAL

"Treatment" for homosexuals has been problematic and discouraging for many health professionals, and yet treatment is possible. Treatment must be Biblical, not as some well-intentioned counselors have rendered it in affirmation of the homosexuals' "alternative" lifestyle; rather, it must be compassionate deliverance from his lifestyle; rather, it must be compassionate deliverance from his lifestyle: HE must stop. A prerequisite for cessation of any sin in regeneration. There is always hope in the Savior, for in Christ we are "a new creature; the old things (are) passed away; behold, new things have come."[48] After regeneration, the key is a homosexual motivated to change his orientation and behavior. For a homosexual claiming a saving relationship with Christ, a serious look at the Bible passages pertaining to homosexuality should provide ample initial motivation.

Various methods of homosexual treatment have been employed including individual psychotherapy, aversion therapy (associating unpleasant stimuli with homosexual activity), and behavior modification. Group therapy can be most helpful. One Christian psychiatrist has noted how effective a group of homosexuals similarly motivated to change and pray for one another can be; fifteen of seventeen individuals in one group he

supervised were healed (ie, had their sexual lifestyle transformed); all were Christians who wanted to change.[49] Another therapist has written about the efficacy of a Christian community committed to helping homosexuals.[50] Cook has written ably about the help Christian former homosexuals may be to other homosexuals seeking help.[51] Father John Harvey has founded Courage, a Roman Catholic spiritual support group for homosexuals, and has been successful in teaching Christian celibacy.[52]

Is treatment difficult? Many with experience have attested that it can be. And yet is the possibility of failure justification for condemnation of all treatment efforts? Obviously not. And how can we not cry out for what would be preventive therapy for AIDS in the group at highest risk? We would not be so naive as to expect all homosexuals to turn away from their practice. Nevertheless, for those individuals who would change, Christians may offer true hope and compassion. And all the while, especially in this age of AIDS, let us call upon our culture to have done with the promotion of perversion, the flames of whose temple fires already lick voraciously at our society.

CONCLUSIONS

Homosexuality is pathologic as can be seen by the physical problems that those who practice it have in abundance. It is clearly immoral and sin before God; it is"exchanging the truth of God for a lie". IT brings the wrath of God upon those who practice it and is therefore a spiritual problem. IT is both a personal problem for many individuals and a health problem for our nation. Two further things need to be said.

First although innately repugnant to most Christians, homosexuality is no more sinful than adultery, murder, theft, lying, drunkenness, fornication, or any other sin. We must never forget that God hates all sin, and without Christ's atonement, all sinners will suffer the same judgement and penalty.

So why single out homosexuality for specific consideration? Indeed, in our contemporary culture, evangelical Christians may often feel they have taken on the hydra of Hercules' twelve labors. If we're not opposing homosexuality, it's broken marriages, or the drug problem, or pornography, or teenage pregnancy, or abortion. The list seems nearly endless: for every head of social evil we lop off, two more seem to sprout from the severed stump. We do not need to be told that the days and men's deeds are evil. As we grow weary of the warfare, it is ever more apparent that what our culture requires is sweeping, penetrating revival so that we return to a consensus Judeo-Christian worldview. The hydra monster's central anatomy requires a lethal blow (revival) so that we may cease our struggle with peripheral heads (homosexuality, etc). The disease must have a radical cure rather than symptomatic treatment.

And yet, some symptoms are of such arresting severity that they must be dealt

with immediately before a comprehensive diagnosis is determined. IF a child presents to the hospital emergency room with seizures and a fever of 107@ Fahrenheit, the physician seeks effective anticonvulsant and antipyretic therapy as his first, immediate concerns. HE then seeks an underlying diagnosis and an indicated treatment.

And so it is with homosexuality. It is a pernicious symptom in our culture. Just how pernicious may be seen from its health effects coupled with the acquiescence of significant segments of religious and medical communities that it is healthy and to be left alone (or promoted) rather than pathologic and to be treated. Similarly, the power of pathology may be assessed by the social gains garnered in just a few years by militant activism on the part of those who practice homosexuality and those who encourage it (eg, our judicial system, in many cases).

Thus, the truth which sets men and women free must be told, for God has called Christians to be watchmen[53] and agents for cultural moral correction,[54,55] where individuals within the culture will listen. AIDS and related issues of homosexuality, with the significant public attention accorded them, may even serve to focus the thoughts of some individuals upon eternal values and hence provide an entry point for the gospel. But truth, by its nature, is confrontational. Thus conflict with our culture should not be unexpected.

Notwithstanding, the second thing that needs to be said is that confrontation and compassion are not contradictory. Despite the commonly circulated myth that one may not be both confrontational and compassionate, we must remember that the most poignant refutation of this deception was our Saviour's earthly life. AS someone has said, Christ's purpose for His Church is to comfort the afflicted and to afflict the comfortable. God has clearly communicated that He hates sin and that sin spawns consequences, but just as clearly has He said that He takes no pleasure in the death of the wicked. Rather should they repent and live. The Christian message is one of hope to all who will receive it; judgment is reserved for those who spurn the offer. The choice is real.

Drawing an example for the issue of abortion, as we confront homosexual behavior, we might look at one of the most effective recent Christian responses to a social evil: crisis pregnancy centers. Here, women are confronted with the truth of what abortion is, and yet are simultaneously offered compassionate support and care during their pregnancies.

Although homosexual activists have achieved a number of their political and social goals, their influence may soon wane (indeed may become negative) as the onus of AIDS grows heavier and heavier in our society. Thus, as we might expect, based upon the truth in Scripture, their pseudo-revolution seems to be faltering, perhaps beginning to grind to a halt. Yet while it is clear that homosexuality is no true revolution at all but rather a pathologic lifestyle, it is likewise clear that help and healing for homosexual individuals are

indeed possible. Possible in Christ, the consummate revolutionary.

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BROPHY vs. NEW ENGLAND SINAI HOSPITAL: Ethical Dilemmas in Discontinuing Artificial Nutrition and Hydration for Comatose Patients

By John Jefferson Davis, PhD.

Dr. Davis is Associate Professor of Systematic Theology and Ethics at Gordon-Conwell Theological Seminary, author of numerous articles and several books, including Evangelical Ethics, Abortion and The Christian, and Your Wealth in God's World.

On October 11, 1986, in a bitterly divided 4-3 decision, the Supreme Judicial Court of Massachusetts authorized the removal of the feeding tube which was sustaining Paul Brophy's life. Twelve days later, on October 23rd, Paul Brophy died, becoming the first American to die after court-authorized discontinuation of artificial nutrition and hydration to a comatose patient.[1]

The case of Paul Brophy may be destined to play as momentous a role in the medical ethics of the 1980s as that of Karen Ann Quinlan in the 1970s. Since on any given day in the United States, there may be as many as 10,000 patients who are in a similar condition to that of Paul Brophy,[2] the facts of his case the moral principles involved in such decisions deserve the most careful scrutiny by all those who are concerned about the sanctity of life, the integrity of the medical profession, and the medical and moral trends in our society.

BACKGROUND OF THE BROPHY CASE

On the evening of March 22, 1983, Paul Brophy, then aged 46 and employed as a fireman and emergency medical technician in the town of Easton, Massachusetts, suffered an aneurysm, a ruptured blood vessel in his brain. Brophy became unconscious, and never regained consciousness, being in a condition described as a "persistent vegetative state." On June 18, 1983, Brophy was transferred to the New England Sinai Hospital, where he remained as a patient.[3] He was unable to chew or swallow and was maintained by nutrition and hydration received through a gastrostomy tube (G-tube) surgically inserted through the abdominal wall on December 22, 1983.

On February 6, 1985, Mrs. Brophy, after consulting with her children and a priest, requested a probate court in Massachusetts to authorize discontinuation of all life-sustaining treatment for her husband, including hydration and nutrition. On October 21, 1985, the probate judge denied Mrs. Brophy's petition. On September 11, 1986, the Supreme Judicial Court of Massachusetts reversed the lower

court in a 4-3 split decision. The ruling was appealed to the U.S. Supreme Court, but jurisdiction to hear the appeal was not granted.[4]

The justices in the majority in the Brophy case held that Brophy's sentiments, expressed prior to his illness, that his life not be maintained in a vegetative state by artificial means, if he were ever placed in such a circumstance, should be honored. The three dissenting judges protested that the majority view authorized suicide and a form of euthanasia, and that the state was being asked to allow a man to starve himself to death. After eight days without food Mr. Brophy died of pneumonia. His death was said to be "extremely peaceful."[5]

BROPHY: A DANGEROUS PRECEDENT

While one can only have the deepest sympathy and compassion for Patrician Brophy and the family who suffered much mental anguish during this lengthy ordeal, a care observer will surely have serious misgivings about the dangerous precedent set by the Supreme judicial Court of Massachusetts in this case. The medical facts of the case itself, basic normative principles of medical ethics, and the possible long-term consequences all raise serious questions about the wisdom of the decision.

Paul Brophy was not terminally ill; his organs functioned, and he did not need a respirator.[6] He had suffered serious and irreversible damage to his brain, but was not brain dead, according to the widely accepted Harvard committee's 1968 definition.[7] Brophy's cerebral cortex was largely intact, though damage to the thalamus, which conducts impulses to the cortex, and damage to other parts of the brain, seriously impaired brain function.[8]

After the insertion of the G-tube, Brophy appeared to be comfortable, and on the occasions when he showed signs of discomfort, medication was able to alleviate the discomfort. Brophy was not in danger of imminent death from any other medical cause. During a period of approximately eighteen months he had experienced no adverse side effects from the pressure of the G-tube. The probate judge found that the G-tube was not "painful, uncomfortable, burdensome, unusual, hazardous, invasive, or intrusive" in Brophy's case.[9]

Given the facts of the case, it appears that the majority justices in Brophy violated one of the basic normative principles of medical ethics: the moral obligation to use ordinary means to preserve life. Relevant here is the frequently quoted statement of Pope Pius XII in 1957:

Natural reason and Christian morals say that man (and whoever is entrusted with taking care of his fellowman) has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health ... But normally one is held to use only ordinary means - according to the circumstances of persons, places, time and culture--that is to

say, means that do not involve any grave burden for oneself or another.[10]

In the case of Brophy, the G-tube was not unduly invasive or burdensome, was essential to maintaining his life, and, in these circumstances, as an ordinary means was ethically obligatory. Such a principle is presupposed in a classic expression of the Reformed theological tradition, the Westminster Larger Catechism. Question 136 asks, "What are the sins forbidden in the sixth commandment?" ("Thou shalt do no murder.") The answer given is as follows:

The sins forbidden in the sixth commandment are: all taking away the life of ourselves, or of others, except in case of public justice, lawful war, or necessary defense; the lawful or necessary means of preservation of life (Emphasis added) . . . and whatsoever else tends to the destruction of life of any.[11]

The Scripture text cited in connection with the emphasized part is Matt. 25:42. "I was hungry and you gave me no food, I was thirsty and you gave me no drink." This basic principle of the moral obligation to use ordinary means for the preservation of life has been articulated on a number of occasions by authoritative teachers of Roman Catholic doctrine. A 1980 Vatican declaration on the subject of euthanasia stated:

> *When death is imminent and cannot be prevented by the remedies used, it is licit in conscience to renounce treatments that can only yield a precarious and painful prolongation of life. At the same time, however, ordinary treatment that is due to the sick in such cases may not be interrupted. (Emphasis added)*[12]

On November 25, 1985, Pope John Paul II, speaking to a Conference on "Pre-Leukaemia," stated:

> *The principle ... while it discourages from employment of purely experimental or completely ineffectual operations, does not dispense from the valid therapeutic task of sustaining life nor from the administration of the normal means of vital support. Science, even when it is unable to health, can and should care for and assist the sick.*[13]

In June of 1986 the National Conference of Catholic Bishops in the United States, through its Committee for Pro-Life Activities, issued a statement dealing directly with the issue of nutrition and hydration:

Because human life has inherent value and dignity regardless of its condition, every patient should be provided with measures which can effectively preserve life without involving too grave a burden. Since food and water are necessities of life for all

human beings, and can generally be provided without the risks and burdens of more aggressive means for sustaining life, the law should establish a strong presumption in favor of their use.[14]

This and the foregoing statements presuppose that human life has an inherent value in God's sight,. a value that is not exclusively a function of brain states. This presupposition is justified biblically in terms of perceptive in which the value of human life is not measured in merely psychological, economic, or sociological terms, but rather from the perspective of God who is the Creator of all life. God valued the life of David long prior to the development of full brain function (Ps. 139:13-16), and the implication is that God continues to value human life made in the image of God even when full brain function may no longer be present.

The Brophy decision can be seen to be a bad decision not only in terms of a normative or rule-oriented perspective, but also in terms of consequentialist ethic. It can be argued that such a decision is likely to have negative consequences both in the medical profession and on other patients whose circumstances are similar to Brophy's.

Discontinuing food and water for comatose patients could undercut the physician's image as a caring professional. According to Dr. Mark Siegler and Alan J. Weisbard, "The dedication of the profession to the welfare of patients might be severely undermined in the eyes of the public even by the apparent complicity of physicians in the deaths of the very ill, the permanently unconscious, or the pleasantly senile."[15]

Dr. Siegler, who is director of the Center for Clinical Medical Ethics, University of Chicago Hospitals and Clinics, noted that it would be "sadly ironic" if the movement for "death with dignity" served to undercut the image of nurses and physicians as caring and nurturing servants.[16]

There is also a significant danger that the circle of candidates for non-treatment might be substantially widened under pressure from a variety of social forces. This concern for the danger of the "slipper slope" is not merely hypothetical, in light of both the history of the German euthanasia experience and current pronouncements in the medical literature.

It should be recalled that the German euthanasia movement, which ultimately took some 275,000 lives, did not originate with the Nazis, but with Dr. Alfred Hoche, a professor of psychiatry at Freiburg, and Dr. Karl Binding, a professor of jurisprudence at Leipzig, who in their 1920 book The Release of the Destruction of Life Unworthy of Life, popularized the concept of a "life not worth living."[17] Hitler and his followers were able to pursue a euthanasia program because the decadent and permissive moral climate of Weimar Germany had already paved the way for it.

Dr. Leo Alexander, a medical consultant at the Nuremburg Trials, pointed out in his famous article, "Medical Science, Under Dictatorship," that the euthanasia movement had its genesis in a shift in

attitude of the German medical profession toward the non-rehabilitable sick.[18] A change in attitude toward patients in circumstances similar to Brophy's (and less severe circumstances as well) opened the floodgate to later abuses.

The relevance of the German experience to the American situation becomes all the more striking in the face of recently published statement in the medical literature. Dr. S.H. Wanzer and his associates have advocated the withholding of fluids and nutrition from irreversibly demented patients, and at times, even from a group of elderly patients they refer to as the "pleasantly senile."[19]

Sentiments such as those of Wanzer, in the current climate of concerns for "cost-containment" in medicine, could place in jeopardy the lives of large numbers of helpless patients. According to Dr. Edmund Pellegrino, "The growing conflict between economics and ethics may be the most serious challenge to medicine's future as a genuine profession."[20] And as Siegler and Weisbard have pointed out, in the current climate it may well be all too easy to move from recognition of an individual's "right to die" to a climate enforcing a "duty to die."[21] The price in human lives for exchanging a "sanctity of life" ethic for a "cost-benefit" ethic may be high indeed.

SOME NARROWLY DEFINED EXCEPTIONS

The general position taken in this paper is that under most circumstances artificial nutrition and hydration are ordinary means and hence morally obligatory. As any practicing physician will recognized, however, general principles must always be applied in the light of the specific medical facts of each individual case. There are a number of narrowly defined circumstances in which it may be morally appropriate to discontinue artificial feeding and hydration for a comatose patient, e.g.: (a) in the case of brain death; (b) when death is imminent, whatever course of treatment may be prescribed; and (c) when artificial nutrition and hydration would be unduly invasive, painful, or burdensome to the patient.

In the case of brain death, where this is understood according to the Harvard criteria, artificial means are clearly not morally obligatory, since in such a case the procedure constitutes useless treatment that neither preserves life, provides reasonable hop of cure, nor even provides care and comfort. While the moral obligation to provide care and comfort to dying patients still obtains, in the case of patients already dead this is no longer so. There is no ethical obligation to employ useless or futile treatments.

When death is imminent, i.e., reasonably certain within hours or days irrespective of the course of treatment,, artificial means may not be morally obligatory. In some cases patients who die without artificial feeding and hydration may die more comfortably than those who receive such treatment. Terminal pulmonary edema, nausea, and mental confusion may be more likely in some instances where the patient

has been treated to maintain fluid and nutrition until close to time of death.[22]

In some circumstances the use of artificial means may be unduly invasive or burdensome for the patient, and hence not morally obligatory. In the case of a patient with a nearly total body burn and serious clotting deficiency, for example, nasogastric tube placement may be quite painful, and there may be no skin to suture the stomach for a gastrostomy tube. In other cases a nasogastric tube may lead to pneumonia, cause irritation or discomfort, or require arm restraints for an incompetent patient. The volume of fluid needed to deliver nutrients, itself may in some instances be harmful.[23]

It should be carefully noted that decisions to discontinue treatment in such instances are made on the basis of best medical judgments as to what means are most likely to benefit the patient--not on the basis of some "quality of life" ethic or subjective judgments concerning the "worth" of a patient's life. The proper question is not, "How worthwhile is the patient's life?", but rather, "What means can provide medical benefits to this patient in these circumstances?" Such a distinction, while not always easy to discern in practice, is in principle essential to the integrity of the practice of good medicine.

CONCLUSION

While in certain narrowly defined instances, artificial feeding and hydration may be legitimately withdrawn from a comatose patient, in most circumstances such procedures would constitute ordinary means, and hence would be morally obligatory. The case of Brophy vs. New England Sinai Hospital sets a dangerous precedent which places at risk the lives of a large class of incompetent patients, and which also could erode the ethical integrity of the medical profession. Christian physicians are urged to guide their practice not on the basis of "quality of life" judgments, but rather on the basis of a "sanctity of life" ethic that seeks to provide appropriate medical benefits to the patient whatever the circumstances. 'To cure, when possible; to care and comfort when cure is not possible; always, to do no harm."

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Counterpoint to Dr. Davis on the Brophy Case

Franklin E. Payne, Jr., M.D.

Dr. Payne is Associate Professor in The Department of Family Practice at The Medical College of Georgia, author of Biblical/Medical Ethics, and an elder in First Presbyterian Church of Augusta.

INTRODUCTION:

It is with reluctance that I write the following counterpoint. Dr. Davis ranks near the top of my list of theologians and ethicists (he is both). His books have been invaluable to help structure and confirm my thinking in many areas. Any disagreement we may have is clearly one within the inerrant and authoritative Biblical system because we are both fully committed to it. Unfortunately, even with that commitment, on this side of heaven we will not all agree. Further, I believe that as Dr. Davis and I dialogue we will come closer in our relative positions. The goal of the Journal is to present both sides for the reader to arrive at his own Biblical position and even to contribute areas of omission or disagreement with either of our positions with their letters.

WHAT IS HEALTH?

The problem with Dr. Davis' approach seems to be an elevation of the sanctity of human life above all other Biblical considerations. Now, I certainly agree that this sanctity is extremely important and have been active in writing and in other ways to move against what has been a degradation of human life in American society. The sanctity of human life, however, is only one of Ten Commandments. Further, other Biblical principles give us a more complete understanding of each commandment, especially in their application to specific situations. To raise one commandment above all others is to distort the unity of the whole and to lead to actions that are detrimental for God's people.

The necessary starting point is that health (and therefor, medicine as the preservative and restorative process of health) is fundamentally determined by one's worldview. For example, the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease." Christians recognize two states where this definition applies: the garden of Eden before the Fall (Gen. 1-2) and heaven (Rev. 21-22). Thus, the WHO definition could be used as a Biblical definition of health in these two realms.

Clearly, however, that definition of health is not applicable to the time between the first and last two chapters of the Bible. Thus, a Biblical application of the definition must

be made to the time of man's earthly existence. In general, man suffers from his own sins and the sinus of others (Mark 7:21-23, Gal. 5:19-21). Thus, he can only experience relative health during his lifetime.

Man's nature is also different from what WHO would say that it is. Man is both body and soul.[1] Because of the Fall, both body and soul are sinfully conditioned. Man is bent on self-destruction and the destruction of others because he is in rebellion against God (Rom. 5:10). The fact that he does some charitable acts and is not fully as evil as he could be is due to God's common grace (Mt. 5:45). But, for man's sin God has provided a remedy in Jesus Christ. Because of His sacrificial death and the regeneration of the Holy Spirit, some men are given a new heart (II Cor. 5:17, Titus 3:5). This transformation causes a two-fold division of the human race: the saved and the unsaved. This division has profound implications for health and medical concerns. First, this regenerate state is a prerequisite for health. Without being at peace with God, one can hardly be considered "healthy." Second, obedience is a prerequisite to maximal health even for the Christian. The New Testament is clear that some Christians are more obedient than others. Certainly, those who are more obedient will generally be more health.[2] Thus, Biblical health consists of obedience to God's instructions to us through His Word.

Most simply, obedience is a life consistent with the Ten Commandments. From the Sixth Commandment comes the principle of the sanctity of life about which we are particularly concerned. Biblical obedience, that is Biblical ethics, however, concerns all the Commandments and one is not to be elevated above the others. Together, they form a whole, a unity that reflects the unity of God Himself (Dt. 6:4). In philosophical terms they perfectly "correspond" to each other and to Him. Then, all other biblical principles illumine and explain these commandments within that unity. It is within this system that medical ethics must be examined. This system as a whole is absolute, not any one commandment or principle.

THE EIGHTH COMMANDMENT

The negative side of this commandment is, "You shall not steal (Ex. 20:15)." The positive side of this commandment is, to "labor, performing with his own hands what is good, in order that he may have something to share with him who has need" (Eph. 4:28b). The Parable of the Good Samaritan is an example of one who shared with another who had medical need (Luke 10:25-37). The Bible also limits those in "need." "...if anyone will not work, neither let him eat" (II Thess. 3:10b).

A text that concerns widows and the church further explains financial responsibility and giving (I Tim. 5:3-16). First, the principle of primary responsibility for needs lies with the person's family, if he or she has one (v. 8, 15). Second, like the passage above, "need" is not automatically the responsibility of others. A widow is not a responsibility of the church if she has

family. She must be a "widow, indeed," that is she must be living a godly life (v. 5,10). If she gives herself to "wanton pleasure," she is not a responsibility of the church. She must be sixty years old (v.9). Younger widows are to marry (v. 11-15). Thus, "need" is not unconditional. Discernment is necessary in its distribution in all situations.

With this long introduction we can turn to the case of Paul Brophy. Who is financially responsible for his medical care? As we have seen, his family is primarily responsible, followed by his church or other voluntary, charitable organizations or people. From Dr. Davis' article and other information we do not know who was paying for his care. If his family was paying for it, then the situation would be consistent with biblical responsibility. More likely, his care was being paid for by Medicaid, a system of joint payment by the particular state of the patient's residence and the federal government because Medicare and private insurance will only pay for a few days of nursing home care. Thus, we must answer the question of whether government at any level is responsible to pay for the medical care of its citizens.

First, no texts in the entire Bible give the role of medical care (or welfare in general) to the government. Second, the explicit role of the state is to punish evil and reward good (Rom. 13:1-7). By extension the reward of good might apply to medical care, except that the government's application of medical payments nowhere considers right (what is good) and wrong as criteria for payment. It pays for the primary treatment and secondary complications of sexually transmitted diseases as readily as conditions unrelated to morality. Thus, even if this verse could justify government payment of medical care, (and I do not think that it comes close to doing so) then current practice is clearly unbiblical.

John Frame, a notable Biblical ethicist on the faculty of Westminster Seminary (West), believes that "society" does have the obligation to provide medical care for others, based upon both Old and New Testament principles, that is, to be charitable and to share what we have with those in need. But, "that is not to say that such benevolence is to be administered by the state; the tests don't say that."[3] Later, he says, "I believe that the state has no role in welfare."[4]

Third, the government gives little consideration to fiscal responsibility. The federal deficit has exceeded two trillion dollars. State deficits also exist. A large portion of these deficits are related to medical care. For example, from 1970 to 1983 the expenditures for national defense increased a total of 9.9 percent while the expenditures for Medicare and Human Resources (of which the largest portion is for medical care) increased 236 percent and 142 percent respectively. (All figures are based upon 1983 dollars to factor out inflation.)[5]

The usual response to these numbers is that medical need justifies these expenditures. We have seen, however, that

the government fails to determine Biblical need. Further, this irresponsibility of the government should be placed in its proper light. Is one Biblically justified to steal from your next door neighbor to feed your family, if they are starving? Further, is one Biblically justified to make counterfeit money in the same situation? I know of no Biblical ethicist that would begin to justify either means to this right end. So, one avenue that the government uses to provide for medical care, the creation of "new" money, is a form of theft because the money was not earned and the inflation that it causes, steals value from others.[6] Further, taxation for programs that are not Biblically the responsibility of the government is theft, also.

An analogy may be helpful to understand this situation. A person who inherits several million dollars may begin to spend it for a large house, expensive cars, servants and other amenities consistent with his means. Initially, it seems that the money is almost inexhaustible. Sooner or later, however, he realizes that the implementation and maintenance of this lifestyle has consumed his resources. Now, who is responsible to pay for the maintenance of his lifestyle? Everyone would say that the responsibility is his own and no one else's. But, he would say, "I get such benefits from this lifestyle." You would say, "Such benefits are excessive and not essential to the basics of life."

This analogy is accurate for medical care. We have spent what we did not have (both in taxes and in "new" money). Now, because of the benefits of medicine, many clamor for its maintenance and continued expansion. But, the benefits are not clear (see above), and medicine fosters a lifestyle that ignores Biblical principles. Can we continue to subsidize ineffectiveness and immorality? An horrific example is the current AIDS threat. Medicine has supported homosexuality almost without hesitation. The advocacy of an "Alternate" (read healthy) lifestyle alone amy kill more than any plague in history and make the threat of nuclear war seem tame by comparison.

This "new" money has increased the overall cost of health care as well. New procedures and medications have been developed with this money. Anything "new" in medicine is almost always considerable more expensive. Again, theft does not justify the good that it may do. Further, as government ad private insurance restrict their payments (and they are doing so because of the rapid increase in medical costs), families are faced with a level of medical care that they cannot afford or that they too will go bankrupt or borrow heavily to finance the "latest and the best."

I am aware of the dangers of an approach that is solely concerned with economics. I am not arguing for cost as the only consideration. The Bible, however, clearly does not direct a blind fulfillment of the "needs" of others. Further, one cannot violate one Biblical standard in order to fulfill another. Payment of medical care by the government is wrong for at least the three reasons that we have stated. To justify this payment, a Christian must

clearly violate the Eighth Commandment, as well as the explicit responsibilities stated in the Bible for the role of government. Evangelical Christians rightly proclaim and defend the sanctity of human life on the basis of the Sixth Commandment. But, in cases such as Mr. Brophy they violate another commandment. In so doing, they have elevated the sanctity of life above all other considerations.

We live in a world of limited resources.[7] Decision must be made about the distribution of these resources, preferably according to Biblical criteria. God has delegated this primary responsibility to the family. Daily, all families make financial decisions that have life and death consequences for its members. Although they are usually less dramatic than these we are considering, they are no less life and death. As we have seen, the church is to supplement its own members under certain conditions. Further, Christians and others are to share and be charitable toward others. Thus, I advocate for medical care only what already is both Biblical and practical for families already.

Knowing the heart of man, I am aware of the potential "slippery slope" that a distortion of these principles can cause. It is possible for termination of life support and even less medical care to become based solely upon financial considerations. In fact, that scenario is likely, considering that the government now provides almost solely on the basis of financial need, rather than true medical need. They could deny for the same reason. This "slippery slope," however, does not negate the Biblical commandments and principles that we have examined. Rebellious man always stands ready to distort God's Word for his own fiendish needs. Biblical Christians, however, must apply the "whole counsel" of God's Word to situations.

ORDINARY AND EXTRAORDINARY

The categories of ordinary and extraordinary (p.3) are misleading and impractical. What is extraordinary today is ordinary tomorrow. For example, plastic feeding tubes were unknown prior to a few decades ago. Further, the initiative to insert and to maintain a G-tube without undue complications was extraordinary until even more recently. These categories are exactly the problems of "ordinary" air, food and water. Dr. Davis quotes the Larger Catechism of the Westminster Confession of Faith (to which I also subscribe) concerning the "lawful or necessary means of preservation of life."

To place air, food and water without further definition as "lawful and necessary means" is to conflict with his categories or ordinary and extraordinary. The artificial deliverance of any one of these means is extraordinary. Rarely can a respirator or feeding tube (whether through the nose or into the stomach) or simply intravenous fluids be maintained outside a hospital or nursing home. The former is a minimum of $400 per day and the latter is a minimum of $60 per day. Neither figures includes physicians fees or the cost of "tests." The latter amounts to $22,000 per year, a figure that is hardly ordinary for the budget

of most families.

Further, there is now the availability of hyperalimentation by which complete nutrition can be maintained intravenously. This technology has only been available for the last few years. Prior to that time, a patient could not be given complete nutrition through a vein. The cost of hyperalimentation is $125-150 per day in addition to the $300-1000 per day for hospital costs, depending upon whether they are in a regular hospital bed or in the intensive care unit. If air, food and water are ordinary and obligatory, then hyperalimentation must be included for everyone, also. Thus, all patients can be kept alive a few days or weeks longer and the cost of medical care will be increased markedly.

The situation must be fully understood before artificial support is discontinued. The motive is all-important. Simply "unplugging" a respirator can be murder, if one's intent is to kill the patient. An example is the classical "plot" of the inheritor who does something to cause a "natural death." Further, with the intense emotions that can accompany these situations, motives can become blurred. I believe, however, that enough current safeguards exist with the routine oversight of nurses, other physicians, and family members as well as the medical-legal climate, that it would be extremely difficult to manipulate the system for one's personal motives.

THE GOLDEN RULE

And just as you want men to treat you, treat them in the same way. Luke 6:31

And a second (commandment) is like it, "You shall love your neighbor as yourself." Mt. 22:39

The Bible was written to give principles for every area of life, but it was not written to give complete casuistry, that is, to cover every possible situation that actually occurs or occurs in the imaginations of men. Also, Christians differ in their understanding, their reasoning, and in other ways that causes different decisions in similar circumstances. These two verses give more specific direction than might at first be apparent in the situation that we are considering. It seems that few people want "life-support" when recovery is very unlikely.

A recent Gallup survey supports this observation.[8] Seventy percent of the respondents said that they would be "very willing" to have life-support disconnected and only six percent said that they would be "very unwilling." Also, supporting mine and others' observations, that when the same situation presents for a family member, decisions are much more likely to favor "everything" being done. Forty-six percent, however, said that they would be "very willing" to stop life-support for a relative, while twenty six percent said that they would be "somewhat willing" to stop life-support for a relative. This difference in application to self and to others is consistent with observations of patient care. When someone's relative is the one on life support, the family is more likely to ask that "everything" be done.

Other surveys and observations of patients generally fails to find people, especially the elderly, who want "everything" done for themselves. The Golden Rule states that the application of one's own desires is sometimes appropriate for decisions concerning others. In this situation the Golden Rule supports an almost universal consensus. Even though this application can be made apart from economic factors, financial limitations could further support a decision not to initiate or to discontinue life support.

Certainly the Golden Rule has a degree of subjectivity that could be abused. It is inconsistent with the unity of the Bible, however, to apply one Biblical principle to the exclusion of all others. Concerning terminally ill patients we find a distinct difference between Christians and non-Christians. The latter see no difference between discontinuing life-support and the injection of the patient with a lethal drug to end his life. In fact they support the latter as a means to relieve the patient's suffering. The Sixth Commandment, however, makes these two acts totally separate. Letting die in these situations has no necessary relationship to killing. John Frame makes the excellent point that for this reason the term passive euthanasia is totally inappropriate.[9] The word euthanasia should never be applied to the decision not to implement or to stop life-support since euthanasia is an act where the primary intention is the death of the patient.

An analogy can be made with the situation (rarely necessary) in which a baby must be taken from its mother before it is able to survive outside her womb. Technically, this procedure falls into the general category of abortion. The intent, however, is not to kill the infant, but to save the life of the mother rather than lose both lives. With the terminally ill or otherwise severely debilitated patient the intent is not the death of the patient, but an acceptance that nothing effective can be done medically and either that the patient has expressed a prior desire not to have such life support or that the Golden Rule is applied by the person who has Biblical authority over the patient.

INITIATION vs. WITHDRAWAL OF LIFE SUPPORT

An important question in these issues is whether any moral difference exists between the initiation of life support and its withdrawal. At first glance there seems to be a major difference. Failure to initiate allows an immediate situation to continue its course to the death of the patient. Withdrawal seems to cause the death of the patient. This distinction, however, is artificial.

In either case the disease process causes the death of the patient. The confusing factor is that life-support frequently is started in an emergency situation. Decisions must be made quickly, often before further studies can be made. The observation of the patient over time, however, gives information that could not otherwise be obtained and that is unavailable at the time of emergency decisions. Thus, the major difference

between the failure to initiate and the withdrawal of life support is the extent of information available. The condition of the patient is often unchanged This latter fact is perhaps the most important in answering the dilemma. The patient has not changed, only his technical assistance and the knowledge concerning his prognosis. Thus, all concerned are better able to understand that the recovery of the patient is highly unlikely.

SUMMARY

What might a scenario have been if these additional Biblical principles had been applied to Mr. Brophy's case? First, his wife has the responsibility and the authority to make medical decisions for her husband. She may (and probably should) consult her husband's physicians and other health care workers, other family members and the leaders of her church before making her decision. Second, the responsibility for payment falls first to her and the patient's family, second to her church and finally to other voluntary charity. The responsibility of her husband prior to his death would have included medical insurance to the extent that he and his wife wanted to be covered. We have seen that government payment systems are thoroughly immoral in their structure, even to encouraging sinful behavior.

Third, what would Mrs. Brophy want done for her (the Golden Rule)? Or, what were Mr. Brophy's desires about life-support systems? All husbands, wives and other relatives ought to discuss this matter at their earliest convenience. These decisions arise all too suddenly and unexpectedly.

Fourth, the withdrawal of life support has no moral principles that are different from those that govern initiation of life-support.

We not know Mrs. Brophy's motives, but from outward considerations her decision to stop treatment was consistent with Biblical principles. She may have desired to act upon her husband's prior wishes or the Golden Rule. She may not have had the financial resources to continue his required level of medical care and did not have the voluntary assistance of a church or other charity. Thus, there is considerable Biblical justification for her behavior, but not necessarily her motives because we do not know them.

References

1 Here, I skip over an area of debate with Christendom: whether man is dichotomous or trichotomous. I personally believe that the soul and spirit are one and the same. The two names denote its relationship to the body.

2 God calls some to unhealthy situations, for example, missionaries to backward countries where they are exposed to various diseases and other unhealthy situations. Generally, however, the obedient life will produce the maximal health available to use in this life.

3 Frame, John, Medical Ethics: Principles, Persons and Problems, manuscript being prepared for publication, p. 20.

4 Ibid., p. 39.

5 Carr, Albert C., "An Attack on Physician Services," The Journal of the Medical Association of Georgia, 74:142-52, 1985.

6 The tax money is also theft, but the government does have a right to tax (Rom. 13:6-7) and the refutation of that right is this land other instances is too long for this article. Also, I do not advocate tax avoidance for such immoral taxation, but we should strive to have it repealed and made consistent with Biblically legitimate taxation.

7 The earth' resources are far more abundant than the population planners consider that it is. The earth is capable of supporting several times its current population with a diet as generous as that of Americans. Nevertheless, on a day-to-day basis each family makes choices concerning its own limited resources.

8 "Survey Shows Most Americans Favor Ending Life Support," American Medical News, March 27, 1987.

9 Frame, Medical Ethics, pg. 54.

Concepts of Christian Health Development: Implications for Short-Term Medical Missions

Cynthia D. Calla, M.D.

Dr. Calla is a family physician working in the Indian Health Service on the White Earth Indian Reservation in northwest Minnesota. She has participated in short-term medical missions in Haiti, Dominican Republic and Ecuador.

Healing was an important part of Christ's ministry as described in Matthew 9:35 where He went through towns and villages healing along with preaching the gospel and teaching. Following His example, much medical mission work has been administered on a short-term medical basis to relieve present ills. In the short-term medical missions I've participated in, including Medical Group Missions of the Christian Medical Society, we engaged in this type of ministry, treating for the most part acute conditions in the name of Christ and as an example of His compassion and love. While the immediate rewards of this approach are evident, the long-term benefits are less clear. The purpose of this article is to examine how short-term missions might be expanded beyond immediate relief by employing concepts of Christian health development to achieve longer-term effects.

What is Christian development and, more specifically, Christian health development? Christian development may be viewed as a process in which man, in becoming liberated from slavery to Satan by entering into a relationship with God through Christ and being empowered by Him, transforms and develops forces in his environment, bent in the fall and used by Satan to oppress him, into those in subjection to God. Thereby man works out a new condition wherein he may progressively realize his dignity and potential in Christ. Christian health development helps liberate and heal man from forces of disease and allows him to achieve his potential in wellness and health.

After creation, man was given the commission and authority to develop the earth. However, man disobeyed God and, after the fall, he faced development problems of thorns and thistles, toil, and scarcity of resources over which he was granted stewardship. Sickness appeared after the fall: Eve experienced pain in childbirth; Adam suffered physical exhaustion in work. There are several principles of Christian health development seen in creation and the fall:

1. Health development should take place in the context of other ongoing types of development:

Human 'malaise' is not viewed in Scripture in isolation from other afflictions of man as

a result of the fallen state. As sickness is part of the greater affliction of man, health development should take place in the context of other ongoing types of development, including economic and educational. Not only do these other areas of development have far-reaching implications for health in improvement of nutrition, housing, sanitation and hygiene, but there is some concern over health development in isolation from other areas of development; medical relief and development separate from development in other areas may result in a greater population burden than an already-compromised economic system can support.

Of course, the introduction of Christianity, per se, into a community will likely produce improved quality of life in general and therefore have an indirect effect on all areas of development. This bring us to the second principle of development, that

2. Health development should take place in conjunction with evangelism:

Sickness and physical illness are linked in the Scripture to individual sin and spiritual illness. The relationship between individual sickness and sin is seen in Matthew 9 where Jesus forgave the paralytic's sin before He healed his disease. Peter says Jesus "went around doing good and healing all who were under the power of the devil" (Acts 10:38). In James 5, the prayer of faith offered on behalf of the sick person will make him well, and if he has sinned, he will be forgiven. Jesus "took up our infirmities and carried our diseases" (Isaiah 53:4) on the cross. Ultimate triumph over individual sin and, therefore, sickness, is through the cross and Christ, hence the importance of health development in conjunction with evangelism. Indigenous folk therapy often addresses broader issues in society beyond physical healing by providing explanation and meaning. We create a void if we introduce scientific medicine and method in isolation. For the most part such an approach does not address these broader issues. Through evangelism, we may introduce and alternative theology to help relieve the often-underlying spiritual sickness.

3. Health development should take place in a context of establishing just social systems:

Sickness and physical illness are also linked in Scripture to corporate sin and spiritual illness. Corporate sickness and sin are seen in certain instances where sickness of a whole group of people is a result of punishment from God, e.g., the infliction of plagues on Egypt. Isaiah described ailing Israel using physical symptoms to describe the inward sinful state of the nation (Isaiah 1:5). Old Testament prophets proclaimed social righteousness in the corporate political and economic order and prophesied against institutional sins and warned of God's judgment. Corporate sin is as important to God as individual sin: Amos condemns legalized oppression of the poor in the same passage as adultery (Amos 2:6-7).

Health development in the larger context of development should therefore take place

with some understanding of the political/social milieu with an eye toward helping to health corporate sin and sickness. This is not to say that Christian missionaries should get involved in politics in their host countries. It is only to say that they should have some understanding of the cultural system and its barriers to development in order to creatively work within the system. For instance, as regards health, they should be aware of the existing health facilities, public health programs, and health insurance programs. By knowing these things, they can more knowledgeably serve and encourage individuals in the society to work toward change in their own society, ultimately helping to heal corporate sin and sickness.

4. Health development should take place along with prevention of illness:

Man exists in a fallen world where sickness is part of his general affliction. Even in a fallen world, however, God demonstrated His great mercy for those people He considered His own by providing deliverance from sickness through laws of prevention given to the Israelites, the benefits of which are still timely. Examples include: not eating the fat or blood of the animal (Lev.7:23,26); quarantining those with infectious skin diseases (Num. 5:2); burying excrement outside the community (Deut. 23:12,13); not having incestuous or promiscuous sexual relations (Num. 18). In extrapolating this principle, medical care should be administered with preventive health education as demonstration of God's providence to His people in a fallen world.

In creation, "God commissioned man to develop the earth as his obedient and responsible vice-regent. Man chose a way of independence, became responsible only to himself ... if there had been only that one commission and that one opportunity, there would be no more hope. But God has acted a second time; there is a new initiative. God acted first in creation, again he acts in redemption."[1] Christ gave the great commission to go into the world and preach the gospel of redemption. In Mark 1:15, Christ binds the gospel to the coming of the Kingdom of God. Despite the fall, the created order is capable of restoration as man is redeemed and the kingdom is established. The picture of the ultimate kingdom in Heaven is one in which there is no sickness, pain, or death (Rev. 21:4), where the eyes of the blind are opened, the ears of the deaf unstopped, and the lame leap like the deer (Isaiah 35:5,6). Our task in fulfilling the redemption commission is that we work enabled by God toward establishing this Kingdom.

Another principle of Christian health development seen in redemption and the Kingdom is that:

5. Health development should take place in the context of community:

The idea of community is implicit in development if we are to help establish the Kingdom. We need to establish new communities of believers where relationships in every area, including social, economic, and spiritual, are in the process of being redeemed. These "counter-culture" communities become a witness to

the community's neighbors as pockets of freedom in the midst of oppression. These local church communities are linked to churches in richer nations working to invest money, resources, and expertise in the world body of Christ.

Community involves using ideas of natives. This ensures that the idea survives after the short-term sources leaves and avoids the pitfall of imposing foreign culture as the community tests Biblical concepts of development in its own culture. Community means an attitude of going into the society as learners (as well as teachers) and working alongside members of the community to reach a common goal, which precludes paternalism. Where everything is done by outsiders to and for people, what is developed is dependency rather than self-sufficiency.

Community involves consulting the local health specialists and using traditional medicine in conjunction with modern medicine whenever possible and when not in conflict with Christian values. Some anthropologists argue that modern short-term medicine often leaves people worse off in alienating them from their own cultural expertise and relationships with local healers, losing the local healer's friendship who refuses to treat them when the missionaries depart. Community involves developing new lay leadership, for example, training village health workers who will then become responsible for the health programs of the community after the missionaries leave.

Considering the Biblical mandate of these five concepts of Christian health development, how might we improve and expand short-term medical missions? They must be done in conjunction with formalized evangelism to help heal individual sin as well as sickness. While immediate aid coupled with evangelism is important to help heal individual sin as well as sickness. While immediate aid couple with evangelism is important to help heal individual sickness, we also need to consider the social realities of the culture and the underlying structural "sicknesses." Hence, health relief and development should be performed in conjunction with other types of development and with some broader anthropological understanding of existing systems in order to work creatively within these systems to maximize development on an individual and corporate basis. Even on a short-term basis,. preventive medicine might be emphasized with educational teaching regarding nutrition, hygiene, and sanitation. The community aspect could be strengthened in fostering ongoing associations with local churches and in using resources to train village health workers who may remain after the group departs.

Hopefully, in strengthening the "development" aspects of short-term medical missions as well as continuing the "relief" aspects, we will help usher in the Kingdom, now partial, in a fuller sense as it approaches completeness in the new heaven and new earth.

Reference

1 Sinclair, Maurice. Green Finger of God. Exeter, UK: The Paternoster Press, 1980, p. 23.

BOOK REVIEW

Reviewed by Ed Payne, M.D.

The Aids Cover-up? The Real and Alarming Facts About AIDS

by Gene Antonio

Published by Ignatius Press and available from Plymouth Foundation, P.O. Box 425, Marlborough, NH 03455, $7.70 (postpaid).

I fully expected this book to be reactionary and thus to present a distorted view of the AIDS (Acquired Immunodeficiency Syndrome) in a manner that supported the author's biases. My expectation was erroneous. The author does have his biases, as well all do, but the book is quite objective for such an emotionally-charged issue.

The book is almost entirely based upon a review of the medical literature with numerous direct quotes. Not only does the author present the expected statistics and possibilities of the spread of AIDS, he presents a sound case for the pathophysiology of the disease and its probable epidemiological development. For example, the vagina is well-designed to prevent infection during intercourse with its multi-layered epithelium and lubricating fluids. The rectum, however, used for intercourse by homosexuals, has only a single lining of cells that readily allows the transmission of infectious agents. It is also easily damaged, making infections even more likely. This fact confirms the greater prevalence of sexually transmitted diseases among homosexuals, as compared to immoral heterosexual activity.

The book is useful for both physicians and laymen for a thorough overview of the AIDS epidemic from its beginning to the present situation. So far, the number of AIDS cases has doubled every year since the disease was recognized. We cannot know whether those numbers will continue, but they are the only statistics thus far available! The projection of those numbers means a possible 15-64 million people infected with the AIDS virus by the end of 1990. Since 20 percent go on to develop the disease (the others remain carriers) over the next 5-10 years, the possible number of cases is awesome.

The danger is not only acquiring the infection from carriers and those with the disease, but an overwhelming of the medical and hospital system and third-part payments by both private insurance and government. With this economic burden and the loss of productivity of those with

the disease, even total economic collapse is a possible consequence.

Mr. Antonio goes on to describe how AIDS has been a socially and politically "protected" disease. In the history of mankind no society has intentionally threatened its own destruction by failing to take comprehensive action to prevent the spread of such a plague according to the medical understanding of the times. Further, he describes specific actions that people should take to push the government toward containment of AIDS. In fact, had the recommended public health response been made at the point that AIDS was recognized to be an epidemic, then the incidence of infection and new cases would probably already be on the decline. This limitation of AIDS is still possible with these same measures (for example, immediately close all known gathering places for homosexuals.)

This epidemic is not limited to the United States, but is prevalent throughout the world. So far, those who are faithful to their marriage vows have little to fear. With increasing numbers of cases and the possible mutation of the virus, that safety may not continue. At the present time, however, infection with AIDS is virtually impossible for those faithful to God's design for sexual intimacy, aside from accidental exposure through blood transfusions, needle sticks, etc.

Mr. Antonio has given us the information upon which we can plan for our families and for government action. He has enabled every Christian needs to be aware of the enormous potential impact of this disease.