MEDICAL EXPERIMENTATION AND RESEARCH

Southern Baptists have no objections to competent medical experimentation that involves human subjects who can provide informed consent. (Strong objections are expressed, however, to any research or experimentation involving fetal tissue, as noted above.)

Notions of soul competency and freedom of conscience, combined with an ethic of service and love for fellow human beings, often prompt volunteers to enter experimental medical protocols. The volunteer may do so for the benefit of others, rather than for personal therapeutic benefit. As long as the protections required by law and medical ethics are provided and careful attention is given to informed consent, there is no moral reason to prohibit a person from entering a research study. Experimental devices, such as the artificial heart, will also need volunteer subjects if researchers are to discover whether the technology is sufficiently advanced for routine use with human patients.

CLINICAL ISSUES

Genetic engineering and experimentation

Genetic engineering is supported by Southern Baptists because it promises new avenues of therapy and new possibilities of cure. Now that genetic markers have been found for such dread diseases as cystic fibrosis, ALS, Huntington's disease, neurofibromatosis, retinoblastoma, certain leukemias, diabetes, and Wilms's tumor, such findings seem to promise new treatment approaches and cures for hundreds of lethal illnesses. The SBC holds, therefore, that scientists should be encouraged in the battle against genetic illnesses.

While the SBC supports genetic therapy, its materials also caution that “we must be careful not to violate the sanctity of human life.” Research that could support genetic enhancement is strongly resisted. The fear is that eugenics efforts like “those in Nazi Germany” might surface again with proposals for sterilization, abortion, or infanticide to prevent birth defects or eliminate the genetically damaged.

Patenting new life forms produced by genetic engineering is also opposed when the patent involves mixing human genes with animal genes. Such research, declared Richard Land, is “a particularly egregious abuse of genetic technology,” since the researchers violate the God-given limits of nature and science. Each species should retain its own integrity: “Animals and humans are pre-owned beings. We belong to the Creator God . . . [but] patents . . . represent the usurpation of the ownership rights of the Sovereign of the universe.” Further, “transgenic experimentation—introducing animal genetic material into human genetic material—devalues human life and, in our view, represents a form of genetic bestiality.” Thus, Land continued, “[p]atenting human life ‘commodifies’ human beings, body parts, tissues, and gene sequences . . . [and is] a form of genetic slavery . . . That the U.S. Patent Office would grant such applications is absolutely chilling.”

Not all Baptists share such strong reservations. Some would argue that the absolute distinction between human and animal biology is hard to maintain. The difference lies in the complexity of the human genetic code, but some basic gene sequences can be found in both plant and animal life. Further, some would add, it is difficult, if not impossible, to show that the Bible supports the notion of forbidden knowledge. Human sin and limitation may well distort human capacities for curiosity and innovation, but sin attends every human endeavor without rendering the venture itself sinful or forbidden. Some contend that to call the mixing of human and animal tissue a form of “bestiality” is surely an exaggeration, even a misuse of language for political effect. If to own a patent on a life form is by definition to enslave it, is a life form or virus designed to do a certain job (e.g., clean up oil spills) really a victim of enslavement? Clearly, this aspect of genetic research and engineering represents another area in which Baptists are not of one mind.
MENTAL HEALTH

Southern Baptists have made few formal statements regarding mental health. Discussions about healthcare reform have not been a priority for convention leaders, and thus the topic has received little attention as a public policy matter during annual conventions. At the personal and professional level, however, Southern Baptists have contributed a great deal to the field of mental health. SBC seminaries provide training in pastoral care that combines the insights of psychiatry with those of theological and biblical studies. Baptist chaplains serving in prisons, hospitals, and the military have brought insight and healing to persons facing mental health crises. Jesus’ miracles of healing and the biblical portrayal of God’s concern for human health and wholeness have provided inspiration and direction to such ministries.

The Wayne E. Oates Institute, located in Louisville, provides materials for ministers engaged in mental health services (and in other health-related aspects of ministry). The Institute offers monthly presentations and discussions, on-line conversations, an on-line journal, individual articles that can be downloaded, and other materials to ministers and laypersons who seek assistance.

DEATH AND DYING

Baptists nurture a strong belief in the afterlife, and this belief affects decisions regarding aggressive treatment during the dying process. Some support is given for choosing to forgo treatment for lethal illnesses based upon the belief that “whether we live or whether we die, we are the Lord’s” (Rom. 14:8). Death is not seen as an ultimate enemy but as a transition to eternal life.

CLINICAL ISSUES

Forgoing life-sustaining treatment

Withholding or withdrawing treatment from a dying patient is morally acceptable to most Southern Baptists. Their strong theology of the afterlife provides support for this approach in situations when death is imminent. The distinction between “allowing to die” and intentionally or willfully killing a patient is still vitally important.

The Supreme Court’s decision in Cruzan (1990) included nutrition and hydration among those invasive treatments that might be refused or withdrawn. Trustees of the CLC, however, directed staff to “discourage any designation of food and/or water as ‘extraordinary’ medical care for some patients.” Thus, providing nutrition and fluids by medical means was also to be viewed as “compassionate and ordinary care.” The trustee dictum left the CLC able to provide only limited guidance to Southern Baptists on various options for refusal of treatments.

The same problem emerges in CLC guidance regarding living wills and advance directives. Without elaborating, the CLC says it “supports living wills in most cases.” But a CLC pamphlet on living wills never mentions the fact that the Patient Self-Determination Act (PSDA) of 1991 specifically includes the right to refuse even life-prolonging treatments. This information does not appear in the CLC pamphlet even though it was published nearly three years after the PSDA became effective.

Again, the declarations of SBC agencies are not binding on individual conscience. Southern Baptists embrace a personal theology that stresses the presence and power of God available to the dying for comfort and consolation, as well as
for wisdom, strength, and courage in dying. Death is the gift of God for the relief of suffering and serves as a transition to eternal life. Baptists also believe in and pray for miracles on behalf of the sick and dying, but tend to have strong reservations about faith-healing rituals or evangelists who exploit hopes for a miracle. Notions of personal salvation and the divine presence provide a religious frame of reference for persons confronting death. One can die in peace knowing that life everlasting in the presence of God is assured.

Beliefs in heaven and hell as the eternal habitations of the righteous and unrighteous, respectively, dominate Southern Baptist thought. Such religious beliefs serve as incentives to the life of morality and piety and provide an orientation for life beyond death. Southern Baptists have been inspired to sacrificial service by such beliefs, even to the point of martyrdom.

Believing in the afterlife also serves to mitigate efforts to prolong the dying process. Aggressive end-of-life measures may be seen as contradictory to the desirability of death under circumstances of intractable pain and incurable illness. Refusing treatment or withdrawing aggressive care would be acceptable on religious and moral grounds. Quality-of-life considerations can also figure prominently in Baptist patient preferences. An accident or debilitating illness may leave a person so severely impaired that death may seem preferable to living under such conditions. Baptists recognize that persons might well grow spiritually through suffering or during the dying process. But few would suggest that this possibility justifies imposing further suffering on the dying by using aggressive treatments.

**Suicide, assisted suicide, and active euthanasia**

Convention statements and literature draw the line at decisions intended to hasten or invite death. Suicide, physician assisted suicide, and euthanasia are condemned as violations of the sanctity of human life. Suicide is often condemned as a sign of weakened if not inadequate faith. The distinction between “allowing to die” and intentionally or willfully killing the patient is therefore treated as vitally important. Because God decides when death comes, all human efforts to alter the divine time frame are labeled “playing God” or condemned as unethical. God’s providence guides, if it does not determine, the course of the disease, whether and when one is healed, and the moment of death.

Euthanasia and assisted suicide are condemned since “they are direct, intentional acts of killing.” Such practices are said to violate “the biblical prohibition” against the taking of innocent human life, whether by another person or by oneself. A resolution in 2001 condemned the Netherlands for legalizing active euthanasia, whether with or without the patient’s consent. The practice of infanticide, even if the neonate is born with lethal deficits, was equally condemned. Messengers expressed fear of a growing “quality of life” ethic as opposed to the sanctity-of-life ethic they embraced. Better pain management and keeping dying patients comfortable were supported.

A CLC pamphlet calls upon governments at all levels to prosecute physicians or others who practice euthanasia or assist patients to commit suicide. The reason given is that there are sufficient pain management techniques to relieve pain without the intentional killing of the patient. Hospice is thus implicitly commended. The 2001 resolution affirms that “every human life, including the life of the terminally ill, disabled or clinically depressed patient, is sacred and ought to be protected against unnecessary harm.” Legalized euthanasia is condemned as “immoral ethically, unnecessary medically and unconscionable socially.”

Nonetheless, some Baptists believe that under certain conditions it is more humane and moral to help a patient die more quickly when the alternative is enduring a slow and ugly death. Further, it is reasonable to believe that there are and have been Southern Baptist physicians and
others who have assisted persons to die. It can also be argued that, from a Baptist perspective, suicide is not an unforgivable sin, especially when a person is terminally ill. Even in cases in which no terminal condition exists, many would concede that any “moral failure” involved in suicide is mitigated by depression or mental illness. Believing, as Baptists do, that salvation is by God’s grace means that the final determination of one’s destiny is, in every case, up to God.

A Texas CLC brochure recognizes the moral dilemma in end-of-life care. The writer counsels open dialogue and constant care as persons face death. Euthanasia, understood as the active killing of the comatose or unconscious, is not condoned. The brochure says nothing, however, about those who are in unremitting pain and request assistance.

The moral and legal rule of “double effect” (or indirect effect), commonly associated with the Roman Catholic tradition, allows the use of medication to alleviate pain even if death occurs as an unintended result. Such an action is supportable on Baptist theological and ethical grounds, as well. The patient who sees death as a gift of God for the relief of suffering and as a transition to eternal life will not fear death so much as dying an ugly death. Baptists will support comfort measures, assure patients of the presence of loved ones and caregivers, and pray that God’s mercy will be experienced with a gentle death.

**SPECIAL CONCERNS**

**ATTITUDES TOWARD DRUG AND ALCOHOL ABUSE**

A Drug Task Force, composed of the leaders of the twelve SBC agencies, was established by Southern Baptists in 1998. It reported to the annual convention in 2001. Targeting alcohol abuse and street drugs, as well as abuse of prescription drugs, the report charged that the abuse of drugs is “ravaging our families.” Churches were challenged to establish halfway houses for community ministry to the abuser and the addicted. Among Baptists, injurious habits related to drug abuse, nicotine, or alcoholic beverages are condemned on moral grounds because of their adverse effects, both on health and on society: the body is a “temple of the Holy Spirit” (I Cor. 6:19), and “you are not your own; you were bought with a price” (I Cor. 6:19-20; cf. 7:23). On the problem of drug abuse and addiction, Southern Baptists are in near-unanimous agreement.

Additional insight into the meaning of Baptist beliefs about the freedom of conscience emerges from Baptist attitudes toward abusive habits. Southern Baptists believe strongly in free will, and this belief underscores personal responsibility for one’s actions. So strong is this conviction that it can be difficult for Baptists to recognize the implications of studies suggesting a genetic basis for alcoholism. In ethics, “ought implies can,” and this maxim points to the diminished capacity that people may have to control their addictive behavior. At the same time, an emphasis on free will and individual responsibility is often a source of hope and determination for those struggling with substance abuse. With God as helper, a support group for companionship, and the interventions of skilled therapists, unhealthy and indeed life-defeating patterns of behavior can be broken and positive, healthy patterns developed.

The emphasis on personal responsibility also implies certain boundaries around the liberties of conscience that Baptists claim so strongly. The classic text for Christian freedom is Galatians 5:1, which is an open declaration that freedom from bondage to the law is the gift of Christ. But Chris-
tian liberties are both defined and limited in certain ways. One is not free to do whatever one pleases just because the human spirit has been liberated by the work of Christ. Rather, three freedoms are made possible: one is enabled by grace to choose appropriate behavior (1 Cor. 10:23); one is free to contribute to the general well-being (1 Cor. 10:23b); and one is free not to be enslaved by legalistic religion or injurious habits (1 Cor. 6:12; 10:23).

Baptists have thus been strong advocates of abstinence from alcoholic beverages. Some go so far as to say that Jesus and the disciples drank only grape juice, not wine. On the other hand, numerous Baptists work in distilleries, many drink alcoholic beverages, and some churches actually require wine for the Lord’s Supper on the basis of the New Testament pattern. Strong prohibitionist factions still exist within Baptist ranks, however, and they can often keep a town or county “dry” in a local referendum.

Even so, a larger proportion of Baptists tend to become abusers of alcohol than is the case, for example, among Jews, who use wine on a regular basis. A major factor in the Baptist pattern may be that the ostracism and judgmentalism directed toward those who drink tend to drive them into private spaces in order to hide the habit. Social and religious disapproval creates guilt and shame, which, in turn, cause persons to drink in order to escape their problems or feel better about themselves—a sure formula for abusive behavior.¹⁰⁵

For those who have problems with drink or drugs, Baptists strongly advise therapeutic interventions. Medicines are now available to facilitate withdrawal and therapy is available to help establish new ways of thinking and acting. Alcoholics Anonymous and other assisting groups are provided and supported by hospitals, churches, businesses, and government agencies.

**VIOLENCE AND SEXUALITY**

Southern Baptist responses to violence and sexuality in the media and on the internet have reflected the national concern about outbreaks of violence among teens and in society generally. Fervent preaching often takes up moral issues, and issues associated with drugs, violence, and sexual exploitation are frequent targets for Baptist preachers. A resolution by the SBC addressed “a despair-soaked culture fixated on death replete with horrifically realistic and vicious computer games, new music genres such as death metal and shock rock, and Internet web sites with malignant content offering the means for the acting out of hate-filled behavior and destruction.”¹⁰⁶ At issue is the extensive exposure of America’s youth to violence through music, movies, television, videotapes, on-line interactive games, and other media. According to the resolution, violence and sexuality pervade the national consciousness and have a pernicious effect on youth. Thus Baptists called for better parenting, heightened attention to moral values, and stronger family commitments to nurture young people. The entertainment industry was challenged to “exercise restraint” in the “depiction of violence, immoral sexual conduct, [and] the use of offensive language and lyrics,” and to create products that are “morally wholesome.”

Southern Baptists also make available materials for sex education of various age groups, from pre-school children through young adults.¹⁰⁷ The first educational series was launched in 1973. A revised series, launched in 1993, advocates a much more conservative posture than prior books. For example, no mention is made either of homosexuality or of abortion in the book currently used with early teens.

“True Love Waits” is a religious and educational campaign that aims to persuade teens to commit themselves explicitly to abstinence prior to marriage. A variety of videotapes, books, and manuals, along with a pledge sheet, are available as part of the campaign.¹⁰⁸ So strong is the SBC’s commitment to sexual abstinence as the only possible approach to unmarried sexuality that the executive director of the Ethics and Religious Liberty Commission (ERLC) publicly criticized the U.S. Secretary of State for suggesting that sexually active teens should use condoms.¹⁰⁹
HIV/AIDS

Southern Baptist attitudes toward and approaches to HIV/AIDS have typically been linked to beliefs about homosexuality, which is regarded as a “perverted lifestyle.” The AIDS epidemic has been viewed as the judgment of God, and it has been claimed that “toleration” of homosexuality (as well as abortion) leads to God’s punishment of a nation. A 1987 resolution viewed AIDS as “a major health threat” resulting from a rejection of “biblical standards of decency and morality.” Opposition to the distribution of condoms and the notion of “safe sex” was expressed. Still another resolution viewed homosexuality as the cause of AIDS, linked suffering to God’s punishment, and called on gays to seek forgiveness for their “abomination.”

The Bible is said to teach that homosexuality is an abomination to God on the basis of such passages as Genesis 19:1-5, Leviticus 18-22, and Leviticus 20:13 (which calls for the capital punishment of males engaged in homosexual activity). A 1992 recommendation from the Executive Committee of the SBC condemned two churches for “accommodating homosexuality” and called for their exclusion from the SBC. One had blessed the union of a gay couple and the other had ordained an openly gay man as a deacon. Convention resolutions express “abhorrence of homosexuality” because “God regards homosexuality as a gross perversion and unquestioned sin” and “unrepentant homosexuality is repeatedly condemned in Scripture.”

SBC literature has tended to dwell on certain fears associated with AIDS. The CLC, for instance, expressed a fear that the AIDS epidemic would be so costly as to “force the country to adopt active euthanasia out of economic necessity.”

Even so, an ethic of “Christlike compassion” for the “victims of AIDS and their families” informs the responses of most Baptists. Open acceptance of homosexuality is not often found, but nearly all Baptists advocate a caring ministry to those with AIDS. Educational material is available to facilitate discussions by study groups in local churches and calls are made for ministry to those who are homosexual.

Southern Baptist churches have begun to recognize the inevitable presence of persons living with AIDS (PLWAs) in both church and society. Because AIDS is a disease that affects actual human beings, a highly personal theology and ethical orientation has led many Baptists to engage in caring ministries for people regardless of their circumstances. A number of effective ministries, such as the Baptist AIDS Partnership of North Carolina, have been developed. Other ministries have been instituted in Houston, San Francisco, and Knoxville.

Educational materials have also been created to assist concerned individuals and churches in developing ministries and countering fears and prejudices that often accompany encounters with PLWAs. A resource and study guide published by the Cooperative Baptist Fellowship suggests that moral judgment be suspended in the interest of truthful understandings and compassionate ministries. It aims to provide accurate information about HIV/AIDS, dispel myths, diminish fears based on false rumor, encourage churches to be open to PLWAs, deal with ethical issues emerging in the AIDS crisis, and provide ministries to families dealing with grief and other issues.

The tragic story of a prominent Southern Baptist minister’s family and its struggle with AIDS brought national attention to their experience. It has proven to be a case study in how biblical-theological beliefs and traditional approaches to homosexuality influence attitudes toward those living with AIDS. The minister now works with the AIDS Interfaith Network and served for three years on the President’s Commission on AIDS.
Effective responses to healthcare needs often emerge in creative ways among Southern Baptists through individual and church ministries. These ministries are part of a movement emphasizing the relation of faith to health care that seems to be gaining recognition and momentum throughout the country.

A foot care clinic, headed by a retired nurse who recognized the need for such care among diabetic patients, has opened at a church in Fort Smith, Arkansas. The ministry serves older adults who find it difficult to care for their feet and toes because of physical limitations. The service combines the biblical story of Jesus' washing the disciples' feet with meeting the health needs of this particular population.124

Parish nurses and congregational health ministries often connect area churches with a hospital, thus making these ministries a source of ecumenical cooperation as well as resources for people with health-related needs.125 Support groups for home and family caregivers are also gaining recognition for the vital ministry they provide. Further, there is an emerging recognition that caregiving professionals—pastors, physicians, nurses, social workers, and other providers—are also among those who need support groups. These groups provide resources for the family or professional, relationships with other caregivers, assistance in dealing with fears and myths, and counsel on how to work through complex decisions.126
NOTES

1. At least two other views of their origins can be found among Baptists. Some claim that Baptists descended from 16th century Anabaptists centered in Westphalia, Germany. But the General Baptist Confessions of 1611 and 1666 and the Particular Baptist Confession of 1644 rejected any association with Anabaptists. Others, called Landmark Baptists, claim an unbroken succession through various dissenters, whom they trace all the way back to John the Baptist. This claim has been thoroughly refuted. An occasional similarity of views is hardly sufficient to establish organic connections with those claimed as ancestors. See W. M. Patterson, Baptist Successionism: A Critical View (Valley Forge: Judson Press, 1969); B. Hays and J. Steely, The Baptist Way of Life (Englewood Cliffs, N.J.: Prentice-Hall, 1963); and P. A. Duncan, Our Baptist Story (Nashville: Convention Press, 1958).


4. See H. L. McBeth, A Sourcebook for Baptist Heritage (Nashville: Broadman Press, 1990), 443-542. McBeth discusses the major controversies that contributed to significant changes and divisions among Southern Baptists in the twentieth century. The Baptist Faith and Message statements of 1925 and 1963 are found at 503-518.

5. See ibid., 521-522, for statements regarding the priesthood of the believer. These show differences of opinion between the SBC and the Baptist General Convention of Texas that reflect a major controversy within the SBC.


10. The Cooperative Baptist Fellowship (CBF), Atlanta; Mainstream Baptists, Norman, Okla.; and the Baptist General Convention of Texas, Dallas, have distanced themselves without openly separating from the SBC.

11. For instance, the Alliance of Baptists, with offices in Washington, D.C.

12. The CBF supports the work of the Baptist Center for Ethics in Nashville (on the web at: baptist4ethics.com); the Baptist General Convention of Texas has its own Christian Life Commission, which produces materials on various issues and conducts conferences; Mainstream Baptists also produce and distribute pamphlets that challenge materials from the SBC (on the web at: mainstreambaptists.org).


15. Southern Baptists distinguish “messengers” from “delegates.” The local church appoints a “messenger” but cannot dictate how the messenger is to vote at the annual convention. Further, the “convention” is not a church or ecclesiastical body, as such. It is an annual gathering of messengers from local churches for the purpose of conducting business and encouraging one another in missions and evangelism.


17. Messengers at the Kentucky Baptist Convention approved a report affirming the authority of Scripture in all matters of faith and practice, and recommending that churches study various Baptist confessions of faith for education and edification. See Western Recorder, September 18, 2001, p. 6.


30. See ibid., 58, for Stassen’s interesting and helpful synergistic model.

31. J. W. McClendon, Jr., *Ethics*, vol. 1 of *Systematic Theology* (Nashville: Abingdon, 1986). Despite his criticism of excessive reliance on reason, McLendon identifies three “spheres” or strands basic to Christian thought: the organic, which takes account of bodily needs, and for which love is the central norm; the communal, which deals with life in society and the assistance the church can provide for ethical living; and the anastatic, which accounts for resurrection and the work of the Holy Spirit in the life of the believer. McLendon’s focus is on peacemaking and nonviolence, and he does not address healthcare issues. His approach thus has limited value for medical or clinical ethics, but an attempt to devise a decision-making model based on his three spheres could be intriguing.


33. Ibid., 105.

34. Ibid., 106.


36. 1999 *Annual*, 199.


38. 2000 BF&M, Article VI: “The Church.”


42. See 1971, 1974, and 1977 *Annuals*.

43. See *Christianity Today*, February 16, 1973, p. 48 [516], which quotes Criswell as saying, in response to the *Roe v. Wade* decision, “I have always felt that it was only after a child was born and had life separate from its mother that it became an individual person, and it has always, therefore, seemed to me that what is best for the mother, and for the future should be allowed.”


45. Ibid. Pressure to assure such conformity to the convention mandate led to the termination of the teaching contract of Dr. Robert Adams by Southwestern Seminary in Fort Worth. Adams, a former missionary, had most recently taught at the seminary under a spe-
cial presidential appointment. The seminary president acted when a conservative trustee discovered that Adams had signed "A Call to Commitment."

47. Resolution 4, 2000 Annual, 80.


49. The Christian Life Committee of the SBC became the Ethics and Religious Liberty Commission on June 19, 1997. References to materials from this agency refer to its name at the time of the publication cited.

51. Ibid., p. 9.
52. Resolution 4, 1993 Annual, 100.


54. D. Hughes, "Paying Our Respect to Life," in Global Discipleship: A Guide for Local Churches Paying Profound Respect to Human Life (Nashville: Baptist Center for Ethics, 1992), 1. Hughes also advocates a "seamless garment" position in the pamphlet, and asserts that being "pro-life" requires concern for "those in poverty, the family, the rights of women and children, racism, tobacco, alcohol and drug abuse, handgun control and the environment."


57. Ibid., p. 9.
58. Ibid.


60. J. Lee, "Infertility: A Silent Grief," Baptists Today 19, no. 9 (September 2001): 28-29, 33. A Southern Baptist pastor and his wife have written a moving book on their struggle with infertility (A. Trent and P. Trent, Barren Couples, Broken Hearts: A Compassionate Look at Infertility [San Bernardino, Calif.: Here’s Life Publishers, 1991]). They discovered that there were no stories of permanent infertility in the Bible, and for them this lack was discouraging and upsetting. (The biblical narratives of Abraham and Sarah [Gen. 16-21] and Elkanah and Hannah [I Sam. 1-2], for example, both end with the birth of a child.) The authors offer a sensitive and insightful approach to a profoundly personal and troubling issue. One of the strengths of the book is that the writers share the problem with hopeful readers; they are not armchair theologians or counselors who do not know the agony of childlessness and/or infertility.


62. A pre-embryo is a fertilized ovum formed in a petri dish or cryopreserved in a fertility clinic.


70. Baptist General Convention of Texas Christian Life Commission, *Genetic Research*. The pamphlet concludes with four guidelines based generally on biblical virtues. *Gratitude* to God for the good gifts of the healing arts and scientific inquiry requires good stewardship of those powers. *Compassion and justice* require us to relieve suffering and create a society in which the benefits of medical science will bless the entire community, and not be used primarily for a privileged few. *Humility* requires patience and leads us to proceed with caution into the uncharted waters of innovative science; new techniques raise new questions and problems. Finally, *courage and imagination* require a positive attitude toward scientific discovery, yet with a sense of its contingency. The promise of the future should generate excitement about the possibility of new cures, but should also remind us of the dangers associated with enthusiasm without wisdom.


74. P. D. Simmons, “To Clone or Not to Clone?” *Christian Ethics Today* 3, no. 3 (July 1997): 10-14. Several factors associated with cloning are worth noting in this context. One is that “cloning” takes place in nature when twins or multiple siblings are the result of divisions of the fertilized ovum. Twins have the same DNA, much as a clone would have the same DNA as the person being cloned. Can it be inherently wrong to imitate a process that occurs routinely in nature itself? Second, children produced by biotechnical means are still persons in every sense. To categorize such children as “artificial” or “manufactured” seems, however unintentionally, to depersonalize and dehumanize them. Third, each cloned person would be an individual in his or her own right, not someone else—not even the “parent” from whom he or she is cloned. We may duplicate genetic information, but not the history or pattern of experiences that make each person unique. He or she would still be created in the image of God and would be an object of the divine love and care. Finally, science does not yet know all the benefits that cloning techniques might bring to human health. To ban such research might be to deprive the future of substantial benefits.


79. See P. D. Simmons, “Ethical Considerations in Composite Tissue Allografts (CTA),” *Microsurgery* 20 (2000): 458-465. The hand transplant in Louisville, Kentucky, have opened the possibility of composite tissue transplants for selected recipients.


82. Ibid.


84. P. D. Simmons, “The Artificial Heart: How Close Are We, and Do We Want to Get There?” *Journal of Law, Medicine & Ethics* 29, nos. 3 and 4 (Fall & Winter, 2001): 401-406.


87. See Simmons, Birth and Death, 212-215.

88. Counseling ministries are included among the ministries of many Southern Baptist churches. The St. Matthews Baptist Church in Louisville, for instance, staffs an office of pastoral care named after the late Wayne E. Oates (see n. 89 below). The Kentucky Baptist paper, The Western Recorder, carries a weekly column called “Family Forum” that is devoted to counseling ministries. (See, for example, the column by W. Rowatt and J. Rainbow, “How Should Parents Respond When Adult Children Divorce?” Western Recorder, August 1, 2000, p. 5. A number of writers contribute articles on various topics to this column.) A children’s home is operated by Kentucky Baptists at Middletown for young women facing out-of-wedlock pregnancies or other problems during their teenage years. Southern Baptists have also developed ministries to persons with Alzheimer’s disease. See J. B. Riley, “Keeping Hope Alive: Spiritual Care for Alzheimer’s Patients,” Baptists Today 19, no. 4 (April 2001): 24-25, 32.

89. Oates, a long-time professor of pastoral care at Southern Seminary in Louisville, wrote over 50 books in the field of pastoral care and was known as the dean of pastoral care in the United States. The Institute can be contacted at: www.oates.org.

90. Individual, marital, and family counseling was offered free of charge to Southern Baptist ministers and their families during the 2001 meeting of the SBC in New Orleans. Counseling sessions and health screenings were provided by LeaderCare and Wounded Ministers, both of which are ministries of LifeWay Christian Resources (LifeWay Christian Resources was formerly The Baptist Sunday School Board). See notice for the counseling ministry in Western Recorder, April 17, 2001, p. 2.

While the National Alliance for the Mentally Ill does not have Convention support as such, some Southern Baptist ministers are involved with the Alliance. A Southern Baptist is vice president of the Kentucky chapter of the Alliance. See K. Walker, “Churches Asked to Help Mentally Ill & Families,” Western Recorder, April 17, 2001, pp. 1, 3.


93. Lasley, Euthanasia, 16; see also “On Euthanasia and Assisted Suicide,” Resolution 13, 1992 Annual, 93-94. The terms “ordinary” and “extraordinary” can be problematic in the clinical setting, but they are still used in common parlance.

94. Lasley, Euthanasia, 18, n. 6.

95. Simmons, Birth and Death, 124-154.

96. See 2000 BF&M, Article X: “Last Things.”


100. Lasley, Euthanasia, 17.


102. Medical Ethics Advisor 2, no. 7 (July 1986): 82. A survey of physicians in the state of Washington showed that 26% (218 of 828) had been asked to provide a lethal prescription by one or more patients. In 38 of 156 cases the request was granted; 15 of the patients did not use the medication.


109. T. Strode, “Powell’s Condom Advocacy Denounced by Land, Others,” Baptist Press news release, February 21, 2002. On the web at: www.bpnews.net/bpnews.asp?ID=1281. The secretary had been on an official visit to parts of the world where the AIDS problem is critical. He had suggested that “safer sex” practices are a step toward avoiding AIDS—a message that many Baptists would support.


117. Lasley, Euthanasia, 4.


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“Southwestern Profs Holloway, Johnson Refuse to Sign Faith Statement; Must Find New Jobs.” Baptists Today 19, no. 6 (June 2001).
Introduction to the series

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

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

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

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

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

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