

The Standing Commission on Health

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MEMBERSHIP

The Rt. Rev. Hays H. Rockwell, Diocese of Missouri
The Rt. Rev. William E. Smalley, Diocese of Kansas
The Rev. Carol Cole Flanagan, Diocese of Maryland
The Very Rev. George L. W. Werner, *Chair*, Diocese of Pittsburgh
Mrs. Hope Hendricks Bacon, *Secretary*, Diocese of Mississippi
A. Dale Brandt, M.D., Diocese of Eastern Oregon
Nancy B. Cummings, M.D., *Vice Chair*, Diocese of Washington
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The Rev. Robert J. Brooks, *Presiding Bishop Liaison*, Washington Office
Ann S. Chinnis, M.D., *President of House of Deputies Liaison*

In addition, the Commission is grateful to Lynda Johnson Robb and the Rev. Gary J. Barnett Young, who testified in Oregon; the Rev. Philip W. Turner III, Ph.D., and Prof. Timothy F. Sedgwick, Ph.D., who reviewed the Bishop of Missouri's work on our theological discussion; and the Very Rev. J. Earl Cavanaugh, Chair of the Legislative Committee for Social and Urban Affairs for the 71st General Convention, who attended our final meeting in St. Louis.

SUMMARY OF THE COMMISSION'S WORK

The Commission met four times: Delray Beach, Florida (Duncan Center); Washington, D.C. (Sheraton National); Portland, Oregon (Franciscan Renewal Center); St. Louis, Missouri (Airport Hilton).

FINANCIAL REPORT

Income	<i>1992</i>	<i>1993</i>	<i>1994</i>
Appropriated	\$11,500	\$11,500	\$5,000
Expenditure	\$10,798	\$12,857	

REPORT OF THE STANDING COMMISSION ON HEALTH (1991-1994)**I. PREFACE**

During this triennium, the Standing Commission on Health was faced with an area of concern which dominated our society. Whether it was the Clinton Health Plan or the innovations of high technology and the resulting ethical questions, we realized that whatever we did would be subject to the headlines and even the most careful work might be outdated by the beginning of the 71st General Convention.

Therefore, we have centered our work in a theological statement crafted by the Bishop of Missouri, but representing the work and thought of the entire Commission. It is our hope that this invitation to theological discussion and the five principles or elemental objectives for an approach to health care by Anglican Christians will assist the Church in coping with the chaotic and complex world of health in the coming century.

We also are aware of certain specific areas which we felt important to bring to the attention of our Church. Our strategy is to mail the complete reports of this Commission to each diocesan bishop and the chair of each deputation. Aware of the request to use other means as well as legislative resolution, we have only included those resolutions that we feel absolutely necessary at this time.

Our hope, our goal, is to start a discussion in this Church that will be more than strident parties defending a rigid position, but rather the work of pilgrims seeking God's Kingdom and truth.

II. CHRISTIANS AND THE FORMATION OF PUBLIC POLICY ABOUT HEALTH CARE**A Theological Rationale****Introduction**

What follows is undertaken as the beginning of a conversation. It is the first segment of a work in progress, a work to which Episcopalians are invited to contribute throughout the upcoming triennium. Over the next three years, particular groups will be asked by the Standing Commission on Health to respond to this essay; e.g., Episcopalian ethicists, liturgists, theologians, physicians and nurses and research scientists in the health care field, and health care workers of all kinds. It will be important that the diverse elements of the Episcopal Church be drawn into the dialogue so that voices from every corner of our communion may be heard and heeded. The contributions of these groups, and others, are intended to enlarge the conversation, broadening and deepening it, and the outcome will be a second version of this essay, to be published for the Convention of 1997. It is proposed

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that the exercise be repeated in the *next* triennium and a final Teaching Document for the Church be published for the General Convention in the year 2000.

The purpose of this undertaking is to engage the Church, over time, in serious discourse about Christian social responsibility in the area of health care. It is our conviction that the separation of church and state in our society does not preclude Christians from taking part in the formation of public policy, including policy respecting health care for all Americans. The present document seeks to make a beginning at involving Episcopalians in an important public debate and to instruct conscience in respect to certain fundamental precepts to be used as guidelines in that debate. We have no illusion that people of Christian conscience (or Episcopalian Christian conscience!) have exclusive access to the moral truths that should govern the formation of public policy in health care. We believe only that our tradition both equips and commissions us to engage fully in the discussion of these issues which so greatly affect the common good.

The Baptismal Covenant in *The Book of Common Prayer* includes two questions, put to those who seek to commit themselves to Christ by baptism, and to those who renew their baptismal vows:

"Will you seek and serve Christ in all persons, loving your neighbor as yourself?"

"Will you strive for justice and peace among all people, and respect the dignity of every human being?"

The answers to those questions are the same: "I will, with God's help."

To say, "I will" to those central questions of faith is to be summoned into the realm in which social policies are made, the realm where the commonwealth is shaped. Very many others occupy that realm: Politicians and economists, clinicians and surgeons, insurance executives and benefit managers, social philosophers and professional ethicists. It is essential that those who mean to be true to their baptismal vows join that large and diverse company and give voice to the imperatives of Christ the Healer. Absent their voices, the decisions about health care in our nation may be left to those for whom health care is a mere commodity, and those in need of it considered to be only consumers.

The Biblical Imperatives

To find a response to the question, "Why should Christians concern themselves with issues of health care?" one need only refer to the Bible. There is a sense in which the whole of the biblical story, from the third chapter of Genesis forward, is the tale of the Creator seeking to mend the broken creation. Moreover, as the texts reveal, God persistently calls men and women to join in the work of mending the creation, to be themselves healers, both of individuals in need and of the social order.

In Jesus Christ, the sign of God's presence as healer in the world's life is supremely expressed. In Jesus of Nazareth is the full disclosure of the divine intention to seek out the weak and the sick and the outcast and to heal them, restoring them to the communities where they belong. In the healing presence of Christ there is the proclamation that God heals, and also that God *reigns*. The Gospel accounts include the mandate of Jesus to his followers that they go into the world to "heal the sick" in his name. As they go, they become signs of the inbreaking of the rule of God. In the summary of his teaching which is Jesus' description of God's Great Assize, He says of the true servant of God, "When I was sick you came to my help." As the story of Peter and John healing a crippled beggar in Acts 3 illustrates, the infant Christian community saw the care of the sick as among its

principal works of ministry. What is plain from the biblical texts is that Christ the Healer charges those who would follow him with the works of consolation and comfort, of sacrifice and compassion and healing. The community of the baptized is empowered by the presence of the healing Christ. Each individual Christian, organically joined to Christ in baptism, is equipped to function as a healer in his name. These works were not just good undertakings of individuals, but of a people fortified by the *community* of faith, in which each received according to need. (Acts 2:45).

The Church as the Evidence of the Healing Presence of God in the World

Christianity brought into the world what one commentator has described as "the most revolutionary and decisive change in the attitude of society toward the sick....It addressed itself to the disinherited, to the sick and afflicted, and promised them healing....It became the duty of the Christian to attend to the sick and the poor....The social position of the sick...became...a preferential position" (Henry Sigerist, quoted in *Health/Medicine and the Faith Communities*, M. Marty and K. Vaux, eds., Fortress Press, 1982, p. 110). Across the centuries of the Common Era, there are very considerable evidences of Christians caring for the sick, honoring them as they ministered to their needs, risking illness themselves by exposure to victims of plagues. By the early medieval period, the centrality of the ministry to the sick appears in *The Rule of St. Benedict*: "Before all things and above all things care must be taken of the sick..." (Chapter 36). From this conviction, especially as it was manifest in the monastic orders, hospitals were born. These were meant as signs and emblems of the presence in the world of Christ the Healer. Indeed, the sick themselves were seen as evidences of the presence of the suffering Christ, such that in certain parts of western medieval Christendom the sick were declared as an "ordo" of ministry, a distinct category of sacred ministers along with catechumens, widows, and so on.

Anglicans, of course, inherit this tradition, and nowhere is it more apparent than in the service for the "Ministration to the Sick" in *The Book of Common Prayer*. The three-part service—The Ministry of the Word, The Laying on of Hands and Anointing, and Holy Communion—asserts that God is present, in and for and to the sick person. The sign of unction is primarily the sign of God's presence, just as the proclamation of the Word and partaking of the bread and wine are signs of a present, restorative God. As hands are laid upon the sick one, the priest beseeches "our Lord Jesus Christ to sustain you with his presence."

So it is that the participation of Christians in the public dialogue about what constitutes sound and appropriate and equitable health care is sponsored by the determination that it is a Christian calling to represent the healing power of Christ in the midst of the world's life.

Precepts to Guide a Christian Approach to Health Care

The fundamental assumption of the Christian approach to the issues of health care is that human life is of infinite value, that every individual is of irreplaceable worth. This conviction is derived from the Christian doctrine of creation. It declares that because it is of God, all creation is good and that humankind is the apex of the divine work, the masterwork of God. God entrusts the created order to human beings, at the same time blessing them, in the words of a eucharistic prayer, with "memory, reason, and skill," making them stewards of creation. That trust requires that all life be treated with reverence,

but that human life has the highest claim. The incarnation of God in Christ, in Jesus the God-human, puts a seal upon that claim. To be obedient to the baptismal promise to "seek and serve Christ in all persons" is to acknowledge the infinite sanctity of every human life. Acknowledging the sanctity of life, however, does not mean honoring life in a merely vitalistic definition. What is to be acknowledged and honored is the sacred gift of selfhood. When that sacred, personal reality is gone, life in the sense in which God gives it is also gone. Determining the presence or absence of selfhood is not an easy undertaking. It is clear, in the Christian—and specifically in the Anglican—tradition, that such decisions belong to the community. Hard choices about the continuation or discontinuation of medical treatment, for example, need to be made by means of dialogue among the patient (if possible) and the patient's family and the physician and nurses and all other relevant parties. Those difficult choices need to be made in the light of the good stewardship and allocation of resources to which Christians are called.

The Christian view of the value of human lives leads to a determination to build a social order in which each person is cared for according to his or her needs. That distinguishes the Christian social view from one that would serve each individual according to his or her assets, or serve each according to some definition of "societal worth."

At present, in the matter of the distribution of health care assets in American society, very many with need are unserved or underserved. Where Christians would contend that *need* alone is the criterion for receiving health care, the present society distributes health care according to the *assets* of the recipients. Those who can pay (or are insured) are cared for, and those who cannot, go without. At the same time that a large segment of the population is made to go without adequate health care, (approximately 36 million uninsured Americans in 1992), large sums are spent by the whole society to provide for those who can afford it. There is a striking equality among the sick. As one contemporary ethicist has put it, "When we are sick, we are as human beings on a level playing field in a way characteristic of few other circumstances" (Philip Turner). That such fundamental human equality is addressed in unequal ways constitutes a failure of justice that strikes at the heart of Christian convictions about human worth. In the Baptismal Covenant the worth of every individual in the eyes of God is firmly established, as it is again in the Burial Office, where the same pall lies upon the casket of people of every kind and condition.

Christians and the Making of Public Policy in the Health Care Field

Christians, and those in the Anglican tradition in particular, can bring to the public discussion and the making of public policy certain perspectives that are capable both of elevating the discourse and of bringing it into line with the reality of human existence.

Episcopalian Christians can, for example, stand fast against what one commentator has called, "A Promethean vision of medical possibilities" (D. H. Smith). That is a vision that characterizes some approaches in American medicine and it fails to account for finitude and the truth that "ultimately all medicine is palliative." It is a vision that is blind to the inevitability of suffering and death, realities that are at the heart of the Christian diagnosis. "The brokenness of life—of healer and patient—is there for anyone with eyes to see" (Smith, *Health and Medicine in the Anglican Tradition*, Crossroad, New York, 1986, p. 7).

The truth that life is limited is joined by the fact that there are limitations of all kinds in the world, including limitations of health care resources. Issues arising out of the way in

which those resources are distributed—to high technology neo-natology units or to programs in pre-natal care among the undereducated poor, for example—are issues in which people of conscience, and especially people of Christian conscience, should have important things to say.

Essential to the discussion and to the making of health care policy is the need to agree upon the common good. Christians must approach that definition, not as utopians, but, recognizing that, as Dean Turner has put it, "We wait with eager longing in a world that cannot yield all we want it to. In public policy, we can only hope for a good enough society." The resurrection of Christ is the sign that the ultimate outcome is God's and *also* the holy encouragement to Christ followers to strive mightily for a social order that is grounded in righteousness.

Whatever the definition of the "good enough" society turns out to be in this country, some elemental objectives for an approach to health care are clear:

- That universal access to quality, cost effective, health care services be considered necessary for every one in the population, including those requiring long term care.
- That "quality health care" be defined so as to include programs in preventive medicine, where wellness is the first priority.
- That "quality health care" include interdisciplinary and interprofessional components to insure the care of the whole person—physiological, spiritual, psychological, social—in the community in which that person lives.
- That "quality health care" include the balanced distribution of human resources and not merely of financial resources, so that no region of the country is underserved by health care professionals, including primary care providers and nurses.
- That "quality health care" should include the treatment of incurably ill persons such that pain and distress are relieved even if life is shortened. Followers of the crucified and risen Christ do not place highest value on mere biological existence.

Conclusion

As stated at the outset, it is the hope and expectation of the Standing Commission on Health that these observations, including the five basic principles at the end of the document, become the basis for discussion and debate within the Episcopal Church. That proceeding should include attempts to refine the broad statements of this essay and begin to address the particular questions posed, for example, by the tension between the development of high-technology medical remedies and the crying need for primary care among large segments of the population.

Let the conversation begin.

III. VIOLENCE

Violence as a Health Care Issue

A public health epidemic exists in the United States and it is called violence. Violence touches the lives of every citizen, every Christian, every Episcopalian. It is costly in terms

of dollars and lives. Violence saps medical resources and overburdens an ailing health care system. Violence is preventable.

In our study we discovered that more than 20% of the 457 trauma centers in the United States closed between 1985 and 1991. At least 80 inner-city hospitals have shut down their emergency departments. The cost of violence, especially involving uninsured patients, has become unmanageable. The security of the hospital and its personnel is increasingly at risk.

Soon after we made the subject of violence a priority, the very large American Medical Association made violence its project for the year. Other health-related groups followed suit, especially the American College of Emergency Physicians.

We found four areas that have made the situation in emergency rooms close to impossible: substance abuse, firearms, attempted suicide, and so-called domestic violence.

Substance abuse: Alcohol, drugs, especially crack cocaine, continue to bring hordes of people to emergency rooms. It is not only the case of overdose or adulterated substances but also the drunk drivers and their carnage; the drug deals gone bad; the shootings and knifings of dealers trying to control "turf."

In addition to the direct costs of trying to save these lives, hospitals have had to deal with increased security measures as gang members carrying weapons come to emergency rooms to check on their wounded colleagues. When members of rival gangs are admitted, the hospital has to place them on separate floors and increase security personnel to prevent confrontations in the hospital.

Firearms: The average cost of a gunshot victim is \$12,000, of which only \$4,000 is reimbursed by Medicaid. Automatic and higher velocity weapons raise that figure to a range between \$22,000 and \$150,000. Over a decade, Cook County Hospital (Chicago, Illinois), has seen cases with multiple wounds increase 500%. Add to this some new ammunition designed to explode throughout the body and leave sharp edged fragments that tear through the gloves and the flesh of physicians and you understand the reluctance of health care personnel to continue working in emergency rooms.

Suicides: Currently, the third cause of death among older teenagers is suicide, almost two-thirds of whom use guns. In the gay and lesbian community, suicide is the number one cause of death among young people, with more than twenty percent of these youth attempting suicide. As the suicide statistics have grown, so has there been an increase in admissions to the emergency rooms and trauma centers.

Domestic Violence: While visiting the Vietnam Memorial on the Washington Mall, one gazes upon the names of 58,000 citizens of our country who died during that controversial war. It is startling to realize that during the same period almost the same number, more than 55,000 women in the United States, lost their lives as victims of so-called domestic abuse. There is no indication that this unspeakable statistic has been reduced in the generation since.

Though statistics can vary widely, and it is certain that some crimes such as rape go unreported often, more than 650,000 women are known to be raped each year in our wonderful country. More than one-third of the women who are treated at emergency rooms are the victims of ongoing domestic abuse. Statistics also show that between one million and two and one-half million children are abused and neglected annually.

Rather than propose our own resolution on violence, we are asking the Church to consider in serious discussion what may be done to reduce it in each of these areas. Some years ago, Mothers Against Drunk Driving and others were able to educate the people as to the horrible cost of mixing alcohol or drugs and driving. Statistics clearly show that once we were aware of the extent of the cost, physically, emotionally, spiritually and financially, we were able to reduce this carnage significantly. In 1993 alone, Federal officials credit this awareness with a further reduction of 12% of deaths caused by driving under the influence.

Some will say that the answer is more gun control. Some, including the National Rifle Association, will claim that the problem is a judicial and penal system that is dysfunctional. We would say, it isn't either/or, it is both, and we need to stop trying to find simple answers to complex questions, which serve our own self interest, and look at the larger tragedy. It will require many solutions and much cooperation to reduce the daily horror of our emergency rooms. As one physician put it, "We are up to our hips every night in blood."

Good people, Anglican Christians, need to stop shouting slogans and find ways to help each community reduce this crisis even as M.A.D.D. and others have succeeded with impaired driving. We will strongly support the pertinent resolutions of the Standing Commission on Peace with Justice and any other resolutions that we believe will help reduce this violence and its resulting destruction and carnage.

IV. PROLONGATION OF LIFE

During the 70th General Convention, an eight-point policy concerning prolongation of life was overwhelmingly adopted by both Houses. The entire text is available on pages 383 and 384 of the Journal of that Convention and in a Forward Movement pamphlet entitled *Prolonging Life*.

These guidelines have generally received strong support both within and without the Episcopal Church during this last triennium. However, the second guideline has been questioned, especially by physicians. It reads:

Despite this hope, it is morally wrong and unacceptable to intentionally take a human life in order to relieve the suffering caused by incurable illness. This would include the intentional shortening of another person's life by the use of a lethal act of medication or poison, the use of lethal weapons, homicidal acts, and other forms of active euthanasia.

In essence, the argument is that administering morphine or other drugs to relieve crippling pain and restoring some quality of life to final days may well reduce the length of those final days.

The incredible advances in modern medical technology enable us to keep someone alive, at least technically, while they suffer intense pain that becomes so dominant that they are left with no opportunities for meaningful relationships or for any participation in life as we understand it. Palliative treatment, that is medication to alleviate the pain, should not be denied on the grounds that death might come a bit sooner.

We recognize the delicacy of this distinction, especially in light of the current activities of Dr. Jack Kervorkian and members of the Hemlock Society. Therefore, our proposed amendment to the guideline is clear that medication is not to be given to end the

person's life but for the purpose of bringing comfort and some quality of life *even if that might bring death sooner.*

The amendment to be added to the second guideline is:

Palliative treatment to reduce the pain of persons with progressive incurable illnesses, even if done with the knowledge that a hastened death may result, is consistent with theological tenets regarding the sanctity of life.

Health Care for Women

Heart Disease

Heart disease, the leading cause of death for women, causes four times as many deaths as lung cancer and breast cancer combined (*Health*, July/August issue, 1993). In recent years we have become more conscious of the underrepresentation of women in clinical research studies. While research on male subjects has led to early diagnosis and treatment in men, the same has not been true for women (National Breast Cancer Coalition, 1993). Studies show that many women with symptoms of heart disease are either ignored or treated too late (Campaign for Women's Health, 1993). We know that women do not respond as well as men to bypass surgery. Studies on the effects of caffeine and aspirin on heart diseases included no female subjects, so we do not know the effects on women (NBCC, 1993). If women are to receive appropriate care, research and development, prevention and care must target women as well as men.

Cancer

Cancer is the second most common cause of death in women. In the ten years of the AIDS epidemic, nearly 133,000 Americans have died of AIDS. In that same time, we have lost more than 404,000 women to breast cancer alone, according to the National Breast Cancer Coalition. For women between the ages of 32 and 52, breast cancer is now the leading cause of death (*U.S. News and World Report*, November 23, 1992). The Older Women's League reports that physicians refer older women for mammography less often than younger women despite the greater cancer risk for older women. Only 31% of women receive regular screening (CWH, 1993). According to the Campaign for Women's Health, research indicates that universal access to mammography would reduce breast cancer mortality by 30%.

Quality of Life

Fifteen million women and 12 million children have no health insurance coverage of any kind (CWH, 1993). Millions more have inadequate, tenuous coverage based on employment or marital status. Women live longer and have more chronic diseases than men. The National Breast Cancer Coalition reports that research on diseases unique to or prevalent among women, such as osteoporosis, ovarian cancer, and breast cancer, have been of very low priority. In 1990, for example, the National Institutes of Health "spent only about 13% of its \$5.7 billion budget for the study of women's health risks." (NBCC, 1993).

As Christians, we cannot be seduced by the notion that mortality is essentially an accident that we can ultimately correct with sufficient time, money, or human ingenuity. Death is not a medical accident or research failure. We are those who, by faith, see in death

the gate of eternal life. However, we are also those appointed by God as stewards of all whom God has made, and of the resources provided for their care. In a society that concentrates so many of its resources on acute care and life-threatening illnesses, women are underserved by the relative lack of resources for the chronic conditions that compromise their quality of life.

Osteoporosis is a major cause of death and disability in women. It is a preventable and progressive disease that affects 50% of women over the age of 45, and 90% of women over 75, according to the Older Women's League.

Battering is the single major cause of emergency room visits by women. The *Journal of the American Medical Association* (June 17, 1992, Vol. 267, No. 23) reports that in addition to cuts, bruises, black eyes, concussions, broken bones, damage to joints, and partial loss of hearing or vision, the health consequences of domestic violence included disease, infection, drug use and abuse, alcoholism, miscarriage, abortion, attempted suicide, and mental illness. Women are twice as likely to be injured by violence as to be diagnosed with cancer. The rate of injury to women from battering surpasses that of car accidents and muggings combined. JAMA further reports that up to 64% of female psychiatric inpatients are abused adults.

Women suffer twice the rate of clinical depression as men, and 75% of women who experience clinical symptoms of depression never receive treatment (CWH, 1993). Women's experience of mental illness differs from that of men, requiring appropriate screening and treatment.

Reproductive Health

Most women spend 90% of their reproductive lives trying to postpone or avoid giving birth, according to the Older Women's League. The Alan Guttmacher Institute reports that 25% of women of child-bearing age have no public or private maternity coverage.

Contraception continues to be a significant health concern for women. No new contraceptives have been developed in this country since the introduction of the pill and IUD more than three decades ago. According to the National Academy of Sciences, the U.S. lags behind Western Europe and some less developed countries in the array of contraceptive methods available to women, the degree of access, and the development of safe and effective methods. A recent study finds that 51% of women who obtained abortions were using contraceptives at the time they became pregnant. (Family Planning Perspectives 20:1988, 158). Pregnancy was the result of contraceptive failure. Funding research and development in this field is critical if we are to minimize the rate of abortion.

Contraegestives represent new possibilities with the development of mifepristone, or mifegyne, also known as RU 486, which is a synthetic hormone, administered orally, that prevents gestation and the establishment of a pregnancy when used in conjunction with prostaglandin. The Reproductive Health Technologies Project reports that the female body naturally washes away an estimated 40% of all fertilized eggs. A contraegestive acts to prevent the implantation and gestation of an egg. The drug has a 96% effectiveness rate and shows promise for the treatment of endometriosis; glaucoma; brain and spine tumors; breast, ovarian, endometrial, and prostate cancers (RHTP, 1993).

Studies show that the availability of legal abortion was the single most important factor in the decrease of neonatal mortality between 1964 and 1977 (CWH, 1993), and that maternal mortality decreased by 26%. The Episcopal Church first addressed the matter of

abortion in 1967. The most recent statement on abortion, adopted by the General Convention in 1988, was twice rejected by the House of Deputies in 1991. We propose a brief resolution to safeguard religious freedom and individual conscience from intrusion by the state.

Maternal mortality and morbidity including infection, hemorrhage, toxemia, and surgical interventions are reduced with appropriate and timely maternity care. Women who lack access to prenatal care are twice as likely to give birth to low-birth-weight and premature infants, according to the Older Women's League.

While menopause is a natural physiological process and not a medical condition, little is known about it. A majority of American women spend up to one-third of their lives post-menopausally. Further research is needed on the natural course of menopause, as well as on the long-term risks and benefits of hormone replacement therapy. In 1992 the National Institutes of Health launched the Women's Health Initiative, which will involve 60,000 women in studies of hormone replacement therapy and nutrition (National Women's Health Network).

As in the case of discussing firearms and violence, the consideration of abortion immediately brings strong proponents to the fore. Again, this Commission is asking the Church to get beyond the basic arguments and consider some of the other complex questions. For example: If the studies are correct that 51% of the women who obtained abortions were using contraceptives at the time they became pregnant, shouldn't both the "Right-to-Life" and "Right-to-Choice" groups get together to support new research in contraceptive medicine to reduce significantly the number of possible abortions?

Or, if RU 486, the so-called Abortion Pill from France, has strong potential for the treatment of endometriosis, glaucoma, brain and spine tumors, breast, ovarian, endometrial and prostate cancers, should the Episcopal Church oppose its introduction to the United States solely on the role it might play in abortion?

Finally, one of the two resolutions we offer asks the General Convention to add to the 1988 policy on abortion the long-standing position of our Church concerning intrusion by Government on matters of religious freedom and individual conscience. We recognize that these are difficult questions but we think that the Church needs to consider our position on difficult and complex issues such as these.

V. EARLY CHILDHOOD INTERVENTION

Mothers, Prenatal, Neonatal and Early Childhood Care

In the more complete report of this Commission, which will be sent to each diocesan bishop and each diocesan deputation chair, there will be detailed information on an early intervention system concerning the care of children.

In addition, Lynda Johnson Robb attended one of our meetings to urge the Church to get involved with low-birth-weight programs such as the one she helped develop for the Southern Governors when her husband was Governor of Virginia.

Mrs. Robb's programs were typical of what we as the Standing Commission on Health would urge every parish and diocese to consider. The Elizabeth Guild is a church-based group of volunteers who assist young women during their pregnancies, largely by seeing

that young women get to their prenatal visits. In Virginia alone, the number of low-birth-weight babies dropped from 11% to 5% with the help of this program.

We would like the churches to consider efforts to assist nutritional programs for young children, local health screening programs for mothers and young children, parish nurse or other efforts to make available health screening for those less fortunate.

Local health departments, women's groups and foundations throughout our country are trying to tackle the problems that result from 20% of our children living below the poverty line. We do not believe that the Church needs to reinvent programs or set up its own networks but that each parish should be aware of what is or is not happening in its own community and how it might be of help.

It may be as simple as providing space for neighborhood clinics or helping to find volunteers or calling on health care professionals who are parishioners or friends of the congregation to educate. But the reality is that in a country of unparalleled resources we have too many children getting off to a bad start. Early health and nutrition efforts will positively affect a lifetime.

VI. TUBERCULOSIS AND CONTAGIOUS DISEASES

Tuberculosis in the 1990s

The focus of the Standing Commission on Health has been the American health scene and its particular and personal challenges, but our theological position must be universal. Thus the concerns about infectious disease and the approach to dealing with it must be global as well as local. These clusters of disease may or may not be respecters of class, race or privilege. It is with these thoughts in mind that we must remind the Church that the Number One infectious disease in the world is still tuberculosis. We have not eradicated it. Because we relaxed politically and cut our funding from public health efforts to continue case finding and adequate treatment surveillance, we now have the growing problem of multiple-drug-resistant tuberculosis threatening us all, as it is an airborne disease.

There are estimated to be 10 to 15 million people in the United States alone with latent infection of this disease. With HIV spreading rapidly, the number of persons susceptible to infection with tuberculosis is growing markedly.

This can be controlled with proven methodologies of case findings and treatment-monitoring techniques through established public health policies. That plus internationally supported research into the development of new drugs for the drug-resistant strains needs to be supported. It is our hope that Diocesan Commissions on Health will monitor this issue locally.

VII. CLERGY WELLNESS

It is clear that efforts towards clergy wellness, such as the Clergy Wellness Project of the Rev. Gary J. Barnett Young in Oregon, are desirable and important for our Church. The clergy are to be examples for the people. Clergy medical insurance is also an expense for the parish or other church institution or organization. Preliminary testing shows that too many clergy have habits detrimental to their health and have not worked at proper diet and exercise.

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Improving the health of the clergy should be an important goal for the Episcopal Church, and we urge the Cornerstone Project and diocesan leadership to consider carefully how this might become a priority for the coming years.

RESOLUTIONS

Resolution #A054

1 *Resolved*, the House of _____ concurring, **That this 71st General Convention of the**
2 **Episcopal Church express its unequivocal opposition to any legislation on the part of**
3 **the national, state or local government that would abridge or deny the responsibility**
4 **and rights of individuals to reach informed decisions in the matter of abortion and to**
5 **act according to conscience.**

Resolution #A055

1 *Resolved*, the House of _____ concurring, **That this 71st General Convention urge**
2 **adequate government funding and support for research and development, prevention**
3 **and treatment in matters affecting the health and quality of life of women, including**
4 **domestic violence, AIDS, heart disease, breast, ovarian and endometrial cancer, safe**
5 **and effective contraceptives, contragestives and barrier methods of pregnancy**
6 **prevention, maternity care, menopause and chronic illnesses unique to or prevalent**
7 **among women.**

Resolution #A056

1 *Resolved*, the House of _____ concurring, **That the 71st General Convention amend**
2 **point two of the eight-point principles and guidelines concerning prolongation of life**
3 **set forth in Resolution A093a of the 70th General Convention, to read as follows:**

4 2. Despite this hope, it is morally wrong and unacceptable to intentionally
5 take a human life in order to relieve the suffering caused by incurable
6 illness. This would include the intentional shortening of another person's
7 life by the use of a lethal dose of medication or poison, the use of lethal
8 weapons, homicidal acts, and other forms of active euthanasia. *Palliative*
9 *treatment to relieve the pain of persons with progressive incurable illnesses,*
10 *even if done with the knowledge that a hastened death may result, is*
11 *consistent with theological tenets regarding the sanctity of life.*

(Italics represent amendment.)

Resolution #A057

1 *Resolved*, the House of _____ concurring, **That this 71st General Convention of the**
2 **Episcopal Church adopt the following five principles as the position of the Episcopal**
3 **Church regarding health care:**

- 4 • **That universal access to quality, cost effective, health care services be considered**
5 **necessary for every one in the population, including those requiring long term**
6 **health care.**
- 7 • **That "quality health care" be defined so as to include programs in preventive**
8 **medicine, where wellness is the first priority.**
- 9 • **That "quality health care" include interdisciplinary and interprofessional**
10 **components to insure the care of the whole person—physiological, spiritual,**
11 **psychological, social—in the community in which that person lives.**
- 12 • **That "quality health care" include the balanced distribution of human resources,**
13 **and not merely of financial resources, so that no region of the country is under-**
14 **served by health care professionals, including primary care providers and nurses.**
- 15 • **That "quality health care" should include the treatment of incurably ill persons**
16 **such that pain and distress are relieved even if life is shortened. Followers of the**
17 **crucified and risen Christ do not place highest value on mere biological existence.**

Resolution #A058

1 *Resolved*, the House of _____ concurring, **That the sum of \$30,860 be appropriated from**
2 **the assessment budget of the General Convention for the expenses of the Standing**
3 **Commission on Health.**