North American Regional Consultation on “Exploring the Christian Understanding of Health and Healing”. National 4-H Center, Chevy Chase, MD., USA, 2-6 December 1984, 1-5. 66-69. 90-106 (CMC/85/2).

Preface

The TV screens that week were full of pictures of people dying in Bhopal, India, following the poison gas leak at United Carbide's pesticide plant that took between 2,500 and 5,000 lives and disabled over 100,000 more. There were a lot of pictures took of William Schroeder, the man with the Jarvik-7 artificial heart, newly implanted at Humanum Hospital in Louisville, Kentucky, one of the investor-owned hospital chain which is part of one of North America's newest growth industries, health care, worth nearly $1 billion a day. Meanwhile, tensions continued in Nicaragua as the World Court in The Hague acknowledged its government's right to sue the United States government for damages inflicted by the *contras*. Uruguay became the latest Latin American country to replace a dictatorship with a democratically-elected president, but in Chile, the state of siege was tightened and police vans took to the streets again in Santiago … Christmas trees decked shopping malls across North America and Santa Clauses were out on the sidewalks … A debate on tax reform opened in the US Congress and Washington DC got ready for a cold winter by readying the nighttime shelters for its homeless “street people” whose population, according to the WASHINGTON POST, was estimated in the thousands. Those were some of the things that were happening around the first week of December, 1984 …|

Introduction

Questions about medical technology, medicine men, poor people and prayer were raised when the Christian Medical Commission of the World Council of Churches convened the North American Regional Meeting on Health and Healing. It was held at the National 4-H Center in Chevy Chase, MD., from December 2-6, 1984. Co-sponsored by the Canadian Council of Churches and the National Council of Churches of Christ in the US, this was the 8th in a series of meetings exploring Christian attitudes and activities in the health field in different regions of the world. The 100 participants (20 of them from Canada) included health professionals, public health experts, theologians, directors of urban and rural health care projects and those knowledgeable in Native American and folk healing practices. There was an ecumenical mix of Protestant, Roman Catholic, Orthodox, Jewish and Seventh Day Adventist views. North America's interdependence with the rest of the world was brought out not only by the presence of CMC's director, Dr. Eric Ram, a native of India, and Dr. Tony Allen, a psychiatrist from Jamaica, but by the experience of many of the participants who have worked in Third World countries.

The precariousness of our own health – and our dependencies on each other – were poignantly driven home to all during the first morning session when Eric Ram suffered a heart attack. As participants whispered in the hallways, paramedics and attending physicians administered emergency care until the ambulance came and rushed the CMC director to Suburban Hospital. Rev. Howard Moody of Judson Memorial Baptist

Church in New York City, who had been in charge of the morning's opening devotions, led the conference in prayer for Eric's recovery. During the rest of the week, prayers and other expressions of concern greeted regular bulletins from the coronary care unit and criticisms of the high-tech medical model were tempered as we heard how the staff at Suburban Hospital were showing that “caring” is not a monopoly of the churches.

During the days that followed, it became clear from the exchanges of experience that what is called health care in North America is, in fact disease care. From previous CMC meetings in other parts of the world, this message has come out loud and clear: that *health is a state of balance, while disease is a state of imbalance*. To a great extent, health is determined by life style, by environment, the degree of caring in the community, genetic potentials and limitations and by the availability of health care, both curative and preventive. Somewhat surprisingly, front-page issues such as abortion, “Baby Doe”, genetic engineering and organ transplants took a back seat at the North American meeting to the question of meeting people's more generalized health needs, especially of those who are medically under-served.

The participants recognized the historical and continuing contribution of North American medical missions toward improving the health of people in the Third World. Often when government programs sink into the mire of bureaucracies, it is church-based programs which bring primary health care to people most in need. Still, churches need to give local inhabitants the chance to set their own priorities and set up their own health programs without strings attached to the dollar, Canadian or American. It was also recognized that Third World medical students studying in North American universities, are more likely to be trained to practice in suburban Toronto, for instance, than in sub-Saharan Africa. Further, the “Taj Mahal” hospitals built with North American money in the Third World, often exist as islands within an urban slum, providing only token efforts to serve those outside their walls. |

No one left the tranquility of Chevy Chase with answers. Instead, these men and women took home a lot of questions for their churches to face. The discussions begun here must continue as local or state/province-wide parallels of the Christian Medical Commission are set up in small towns and university communities across Canada and the US, which was one of the recommendations adopted at this meeting (see page 104). It was an outward-looking group who agreed that improving health in North America or anywhere else depends on bringing healing to those who are not reached, either by stained-glass religion or by high-tech medicine.

The CMC Study

The Christian Medical Commission, a sub-unit of the World Council of Churches, was mandated in 1978 to explore the Christian understanding of health, healing and wholeness. This has been done primarily through a series of consultations around this theme, held in the Caribbean, Central and South America, Africa, the Indian sub-continent, Southeast Asia and the Pacific. The North American was the first to be held in a “First World” region; the European meeting will take place in 1986. All have brought together people from the same professional disciplines as those who came to Chevy Chase: nurses, pastors, doctors, public health workers, educators, lay people, theologians. Roman Catholics have participated in all the regional consultations and persons from other faiths and cultures have also come to share their perspective on the art of healing. In many of the regions where CMC consultations have been held,

Christianity is a minority religion and traditional healing practices and attitudes toward disease and misfortune are still strong.

The North American Meeting

The men and women who took part had been proposed by their churches and selected by the CMC in consultation with a preparatory committee formed in 1983 and made up of representatives of the Canadian Council of Churches, the National Council of Churches of Christ in the US, from a number of major denominations and from the CMC. It was this committee which set the goals for the North American meeting:

- To study the theological imperatives of health and healing (see page 90).
- To identify and discuss issues and concerns of health and healing such as: primary health care in industrialized countries, ethical issues of health and human values, alternative approaches in health care.
- To examine opportunities and responsibilities of congregations as healing communities.
- To determine how churches can become more actively involved in health and healing in an inter-dependent world.

The seven papers that were presented in the course of the meeting (see pages 6-70), the ten discussion groups which formed and the final recommendations (page 102), all came to grips with one or more of these goals.

The meeting was opened on Sunday evening, December 2, by Sylvia Talbot, former Moderator of the Christian Medical Commission, President of Church Women United and a vice-president of the World Council of Churches. The invocation was given by Rev. Rena Karefa-Smart from | Howard University. Participants were welcomed by Edith Shore for the Canadian Council of Churches, by Tyrone Pitts for the National Council of Churches of Christ in the US and by Dr. Eric Ram for the CMC, who cited the tangle of issues affecting health, particularly in North America, which would make this one of CMC's most complex meetings. Participants expressed their expectations for the next few days: “How can we deal with health problems created by our own life styles?”, some people wondered, and among the problems, many of them included the stresses of modern life experienced by church executives and inner-city dwellers, by health professionals as well as by their patients in the normal course of getting by in the 1980s. Eric Ram's example was before us all the while. “What ethical issues raised by North American medical technology must the churches address?”, others questioned. “How can we reclaim the role of healing in our churches?” Clearly *we* are part of the problem.

Monday's session, chaired by Dr. Marion Powell, was overshadowed by Eric Ram's heart attack. But to everybody's credit, the show went on with Dr. Donald Shriver, president of Union Theological Seminary, speaking on “Healing and Wholeness: the Medical Ministry of the Church to the World”. Two views of primary health care in industrialized countries were given by Dr. Janelle Goetcheus from Washington DC and Dr. John Hastings from Toronto. There was a plenary discussion of the keynote themes and group discussions focused on experiences with primary health care. On Monday evening, Rena Karefa-Smart chaired a panel on groups with special needs – women, children and young people, persons with disabilities and older people.

Bob Zimmer, president of Wheat Ridge Foundation, chaired the Tuesday sessions with devotions led by Rev. Robert Strommen of the United Church Board of Homeland Ministries. Dr. John Bryant, CMC's first moderator, raised a central question in his

presentation: “What Are the Ethical Issues of Health and Human Values?” Dr. Bryant, from the National Institutes of Health in Bethesda, MD., had recently returned from Greece where he took part in an international conference on medical ethics. In the afternoon, participants were free to visit either Dr. Goetcheus's Columbia Road Health Center in Washington or the St. Luke's Health Ministries in Baltimore, whose director is Dr. Kenneth Bakken. In the evening, Dr. John Hatch from the School of Public Health at the University of North Carolina, spoke on “How Can Churches Function as Healing Communities?” This was followed by a panel on the concerns of Black Americans, Hispanics and Native Americans, chaired by Dr. David Hilton.

Edith Shore of the Canadian Council of Churches chaired on Wednesday and Rena Yocum, a minister of adult education in Kansas, led the devotions. Dr. Kenneth Vaux from the University of Illinois in Chicago and Dr. Jan van Eys, a pediatrician from the University of Texas' Anderson Hospital, examined together the relationship between religion and health. They had previously submitted to the meeting their Declaration of Faith and Health (see page 66). Eric Ram's paper on “Health and Healing in an Interdependent World”, was presented by Drs. David Hilton and James Kipp, both of whom had worked as medical missionaries in Nigeria. An example of one church's healing ministry in the Caribbean was given by Dr. Tony Allen from Kingston, Jamaica, who is director of the Bethel Health Center there. The afternoon was given over to group discussions and in the evening, people had a chance to share experiences. |

Thursday, Dec. 6, was the last day of the consultation. The ten groups had wound up their discussions and the leaders – facilitators – presented their conclusions. Out of these, the Drafting Committee came up with 12 pages of recommendations (see page 102). After a plenary session where the recommendations were discussed and accepted, Rev. Harold Wilke led the closing eucharist, assisted by Lynda Katsuno.

Special thanks go to the Consultation's coordinator, Toby Gould, and to the ten facilitators and to the members of the Drafting and Steering Committees. The facilitators included David Hilton, Florence Montz, Sylvia Karcher, Cathie Lyons, Judith Ray, David Stein, Ralph Scisson, Andrew Nichols, Sister Simone Marie Roach, and Beverly Scott. Serving on the Drafting Committee were Cathie Lyons, David Stein, Bob Hoover, Gwen Crawley and Anne Callan and on the Steering Committee, Edith Shore, Gwen Crawley, Marion Powell, Bob Zimmer, Toby Gould and Jeanne Nemec.

... Eternal God, for the gift of life, even with all its pain and sorrow, we give thanks. Teach us that wounds and scars and mended bones are testimonies to the healing mystery of our bodies. Give us the patience and courage to face illness and disease with its pain and dysfunction. Help us to love our bodies in all their shapes and sizes, in their supple youth and in their wrinkled age. Heal the wounds of our psyches that make our bodies ill against their wills. We give thanks for the walk and run of our bodies, the mind's radar and the heart's insatiable dreams. Heal us in the wholeness of our needs and teach us to live healthily with our afflictions and our disabilities. Amen.[1] |

[1] From the morning meditation on December 3, given by the Rev. Howard Moody, pastor of the Judson Memorial Church in New York City.

Declaration of Faith and Health – submitted by Dr. Kenneth Vaux and Dr. Jan van Eys

A. Preamble

1. "For no one of us lives, and equally no one of us dies, for himself alone. If we live, we live for the Lord; and if we die, we die for the Lord. Whether therefore we live or die, we belong to the Lord" (Rom. 14:7f.).
2. There is a grave defect in our religion that has led to an idolatry in medicine. This is a threat to humankind's relationship to God. The idolatry causes us to seek unlimited life for ourselves and by our own power. We are guilty thereby of inflicting untold suffering to the helpless, individually and in populations. We are guilty of aggrandizing the few rather than to seek relief for the many in need. We humbly and sincerely confess our guilt.[2]

B. Therefore as persons of faith, we declare

1. Humans have been given the opportunity to learn and acquire great powers to remove disease and alleviate suffering. It is God's gift that we may partake of the succor we can extract from His creation. We must reject the false doctrine that such relief of suffering and cleansing of disease is other than God's mercy to us. We must reject the idolatry that prolongation of life at all cost constitutes a good that glorifies God. Just as it is a sin to appear before God before being called, so it is a sin to refuse to appear when His call is unmistakable.[3]
2. For all the suffering we undergo, there may be greater suffering in others. We must acknowledge the call of God to relieve the suffering of others just as we seek relief of suffering for ourselves. We must confess our lack of wholeness and our need of being healed. It is our physical suffering that so often confronts us with our need for healing; the mercy of God to allow us to be relieved of such suffering should make us all the more mindful of our need to be healed. It is when we are healed that we can understand what suffering in others calls us to do.[4]
3. There is knowledge to ease and even avoid unnecessary suffering. Such suffering can occur in individuals and in populations. Not to·use the knowledge that we are allowed to learn is to reject God's mercy. We must confess our manifold unwillingness to be used by God to help others.[5]
4. We must reject the false doctrine that health equates with the absence of disease and that therefore it is within our power to maintain health. The prevention of disease is a good insofar as it allows us to prevent unnecessary suffering. However, the obsession with personal health alienates us from the world and

[2] (Cf. B.1. 5, C.5, D.2) Life at all cost is the dominant theme of modern Western medicine. Technology supports physical life. The degree to which the sentient human and the feeling being remains in that body is independent of the continued life support of the physiological functions. That spectre of extremes in health care is the very paradigm of our idolatry.
[3] See A.1.
[4] (Cf. B.3, C.3f.) There is much more that modern medical knowledge is able to do for the masses. There are simple diseases that are devastating on grand scales, because of underlying malnutrition and the lack of prevention and care. The starvation in Ethiopia is just the latest in an endless series of such disasters.
[5] See B.2.

denies God's sovereignty over us. “For the mind that is set on the flesh is hostile to God; it does not submit to God's law. Indeed, it cannot; and those who are in the flesh cannot please God” (Rom. 8:7f. RSV).[6]

5. There are many helpless victims of our idolatry. In our search for physical cure and endless pursuit of life prolongation, we often | sacrifice the helpless, the children and the elderly, to demonstrate our misplaced faith. In the eyes of God, the most helpless is precious and His mercy and grace extends to all. When entrusted with the care of the helpless, we must allow His mercy through the relief available to them in medical knowledge while accepting His grace when He deems it more merciful to deliver them from all suffering. Such as we treat the helpless, so do we treat God (Matt. 25:45f.).[7]

C. Those persons who are entrusted with the care of the ill will declare

1. To learn and research about diseases, understanding their causes, exploring their prevention and attempting their cure is a moral obligation for humanity in general and the medical community in specific. All of biology is part of God's creation. “And God saw all that he had made and it was good” (Genesis 1:31).[8]
2. Patients represent suffering humanity whatever their affliction. Some diseases are inherent in our finite bodies, but many are either inflicted by human actions on defenseless persons or allowed to strike by human inaction. However much our quest for answers to diseases is a good, the contribution of our sins to human suffering must never be forgotten. “When I want to do the right, only the wrong is within my reach” (Romans 7:28).[9]
3. The goal of medicine is the prevention of disease and the restoration of full health of those humans afflicted by disease and its consequent threat to body and spirit. Physicians must continually keep before them that withholding the application of effective knowledge and extending a promise based on unproven knowledge are equal abuses of their privileged status. We must not lead physicians into such temptations.[10]

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[6] (Cf. C.4) The concept of health is generally defined as the United Nations defined it. However, the concept of health as seen in modern medicine is that of personal freedom of abnormality, as seen by the person him or herself. That would reject even wholesome aging as a lack of health. It allows all to define the norm themselves. The consequence is an arbitrary rejection of the functionally imperfect and the person who is different from self-centered standards. It is an insidious form of discrimination in the guise of health.

[7] (Cf. C.5) By the acceptance of self-determination in health, the voiceless are at the mercy of the enfranchised. Children are rejected on arbitrary standards of normal and elderly are subjected to life at all cost. They are used to bolster our own perceptions.

[8] The tendency exists to reject the inquiry into as yet greater medical knowledge and consequent technology. However, it is not the technology that is evil and certainly not the description of the functioning of God's universe. It is what man uses the result of the inquiry *for* that matters. However, even more the reasons and objectives of the inquiry are what determine the ultimate outcome.

[9] Diseases are defined as all biological and psychiatric disturbances of physical function. Some are inherent in the time clock of aging and are as yet poorly understood and thus neither curable nor preventable. Other examples are genetically defined malfunctions, such as sickle cell disease or hemophilia. However, much other disease is directly or indirectly man-made. Child abuse, torture, willing starvation are directly inflicted illnesses. Many epidemics especially affecting the young are preventable. Because we do not do so, for whatever reason, a child dying of measles anywhere in the world is indirectly made ill by adults.

[10] Diseases always mean more to patients than mere physical discomfort. It is relief of the angst caused

4. We must reject the temptation to exclusively address our physical problem. Disease that was unnecessarily inflicted upon others confronts patients with the evil in their fellow humans. Disease that was inherent in the patients' bodies confronts them with the dread of latent evil in themselves. The task of physicians is healing as well as cleansing. At times this means demonstrating the power of good to the patients and at other times it means helping individual patients become at ease with themselves. When Jesus saw the paralyzed man descend from the roof and forgave his sins, he challenged us through the question: “Is it easier to say, 'your sins are forgiven you', or to say, 'stand up and walk'?” (Luke 5:23).[11]
5. We must reject the false doctrine that our medical knowledge gives us power over the unborn and the voiceless. In our idolatry, we so often turn, for children, from nurturing to abusing and, for the elderly, from caring to terminal torture.[12]

D. Therefore the church will affirm

1. “Therefore, my brothers (and sisters), I implore you by God's mercy to offer your very selves to Him: a living sacrifice, dedicated and fit for His acceptance, the worship offered by mind and heart. Adapt yourselves no longer to the pattern of this present world, but let your minds be remade and your whole nature thus transformed. Then you will be able to discern the will of God and to know what is good, acceptable and perfect” (Rom. 12:1f.). |
2. Let us all approach the pain in ourselves and the needs in others with Paul's words in mind, lest we continue our idolatry of the perfect body that we want to be made in our image and maintained at all cost.[13] |

… Can we attack health problems created by our own life styles? – Eric Ram |

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by the threat to being that humans seek. The greater the threat to life the disease poses, the greater we try to stave off our angst. That is expressed especially acutely when a patient in our care or under our responsibility acts out our own deepest feelings. It is that drama we see enacted and with which we resonate that causes the excesses on the one hand and the callousness to disease in masses that we do not first-hand witness. Humans are very vulnerable at such times. Patients are easily misled into research.

[11] Helping patients come to terms with their illness is the primary task of the physician. That is always true, even in the most clearly human-inflicted illness. The consequence of child abuse is not just the pain and bruising, but the loss of faith in the world and the fear that will interfere with normal development. The consequence of hunger is not the potential of dying from infectious diseases to which the child has no immunity, but the lack of brain development that may follow and the complete loss of trust in the world that is necessary to bring the world forward. To just send food is a necessary but insufficient approach to starving children and adults.

[12] (Cf. B.5, C.3) We arbitrarily define who is normal and who is acceptable in the family of humankind. We defend that by claiming to have knowledge of disease and its course. We are responsible for our decisions. Humans have indeed a freedom to choose. There may be diseases that are genetically inherent in the body that are of such horror that God's call ought to be followed. However, it is a decision that must have an accounting. Freedom of choice is a responsibility and a burden. It is here that our idolatry is most apparent. Yet it is here that we argue most often from self-centered positions, failing to see the self as the measure of decision.

[13] It is not the relief of pain, the cleansing of disease, the prevention of suffering that is our idolatry. It is the need for perfection by our measure that creates the crisis in religion. In matters of health, man is not the measure of all things, but the relationship of man to God. It is not necessary to have a sound body in order to be accepted by God. To say that it would be is to reject Christ's sacrifice to us. Neither is it possible to be in harmony with God when we omit those acts of healing of others of which we are capable.

Theological Imperatives which give Meaning to Health and Healing and to the Church as a Healing Community – In Conlusion

"I reckon that the sufferings of this present time are not worthy to be compared with the glory that shall be revealed in us … for I am persuaded, that neither death, nor life, nor angels, nor principalities, nor powers, nor things present, nor things to come, nor height, nor depth, nor any other creature, shall be able to separate us from the love of God which is in Christ Jesus our Lord" (Romans 8:1. 38f.).

The fullness of life is to be discovered in the brokenness of the Healer. The Christian story turns life upside-down. The Gospel imperative is paradoxical, "who saves life will lose it, who loses life for the sake of Christ will find it." Healing is salvation; woundedness is wholeness.

The life and ministry of Jesus showed special emphasis on healing as one aspect of enabling the abundant life. That story of love (agape) is the saga of the Cross. The Church has no alternative but to say yes. "If anyone will follow me, it must be with a cross." Those who are prepared to say yes have a role/model to follow.

This should inform us about our theological imperative concerning health and healing. The language of health and healing cannot be bound by space and time; it cannot be made medical or clinical; the language of the Christian church must embrace faith, hope, and love. |

The Meaning of Health, Healing and Wholeness and the Tsaks of the Church as a Healing Community

"I beseech you therefore by the mercies of God to present Your bodies as a living sacrifice, holy, acceptable unto God which is your reasonable service; and be not conformed to this world: but be transformed by the renewing of your mind; that you may prove what is the good and acceptable and perfect will of God" (Romans 1:1f.).

"And the very God of peace sanctify you wholly; and I pray God that your whole spirit and soul and body be preserved blameless unto the coming of our Lord Jesus Christ" (1 Thessalonians 5:23).

The issues of health, healing and wholeness, for the whole church as a pilgrim people, deserve serious study and need definition. There was criticism of the WHO's definition of health (even adding a spiritual dimension). *Health* was defined as meaning "integrity", "wholeness" and a *right relationship* between the self, others and God; while "brokenness" in these areas was defined as *disease*. Native peoples of North America generally consider health to be a state of balance; disease to be a state of imbalance.

Healing is even harder to define. Healing is a growth process toward well being. Healing addresses brokenness, calls for compassion, caring and curing; healing lays claim to the transforming event of God incarnate; healing confronts causes, it cannot be simply focused on symptoms. Healing is ministry in its broadest sense, it is servant to fallen human beings in every facet of life, in every individual person and life situation. The meaning of healing is to be discovered and clarified in the | acts of redemptions, resurrection, reconciliation and the repentant life.

As the marks of the Christian church are one, holy, catholic and apostolic we need to surface and make visible those characteristics of healing which address the needs of the Christian community, namely, healing which is:

a. sacrificial – becoming broken so the self and others may be whole;
b. covenantal – a bonding with suffering and ill persons;

c. wholistic – embracing the emotional, physical, intellectual, social and spiritual needs;
d. communal – fellowship with and support for minority and ethnic groups;
e. spiritual – a bold witness to God, the creator, redeemer and sanctifier as the source and enabling power of all healing.

To reclaim the role of healing in the church might better be phrased – “the role of the church in reclaiming the ministry of kind of relationship (confrontation) with the so-called health care industry.

The role of the church is:

a. To acknowledge, articulate and develop healing ministries;
b. To respond to appropriate health-related needs;
c. To work with medical and other health care | professionals;
d. To integrate liturgical and devotional materials about life crises into the life of the congregation;
e. To help the poor and under-served;
f. To enable communication on all levels with those who have experienced common insults, sickness and other problems;
g. To view the congregation as the redemptive community for caring and healing ministries.

Today the church is striving to reclaim its healing ministry. This includes a collegial relationship with other health professionals within secular society. In its health ministry the church is not to perceive of health as an end in itself. The church's healing ministry is a means of service and support for the body of Christ in a broken world. Advocacy for health policies which support equal access to health care for all is a legitimate part of this ministry. In its healing ministry, the church must strive to integrate and recognize the importance of using scientifically sound knowledge and practice in cooperation with the tools of psychology, sociology and religion. Prayer, confession, anointing, laying on of hands and communion need to be recognized by scientific medicine and religion alike as essential elements in caring for a person in his/her wholeness.

The church as a healing community must focus on the full range of human life experiences, many of which are external to the practice of medicine. There are crisis periods in the normal process of growth from birth to death during which the church has special ministry responsibilities and abilities. These include periods of personal transition, stress and pain, such as the death of a spouse, the illness of a child, the responsibility of caring for an aged parent, forced or planned retirement, the loss of a job or one's home. Persons going through such crisis | periods need the support of a caring, supportive community which understands the needs peculiar to each of these crises and how to minister to these needs. It is part of the church's healing ministry to be such a community.

The church as a healing community must also be a health-promoting community of faith. It must work with the children and youth of the congregation and local community who feel a sense of hopelessness, confronted, as we all are, with the possibility of nuclear holocaust. It is a responsibility of the church, in its healing ministry to teach about and respond to the inter-connectedness of God's family. A health-promoting, healing community of faith demonstrates its awareness of the common humanity of us all by proclaiming a Gospel of peace, justice and love. In its healing ministry the church must continually reclaim its stewardship responsibility for

God's good earth.

The Advocacy Role of the Church as a Healing Community

Through the Gospel we are given courage to be advocates and to move out into the streets whenever this is required in order for the church to be a healing community.
New and continued consciousness-raising must occur within the church. Congregations can become “conscience constituencies” and have an impact on church policy statements and the media; support demonstration and self-help projects, vitalize the Impact Network, interact more intimately by sharing experiences with the members of risk groups, and – when necessary – by employing health workers.
For the church, advocacy involves both support for direct services and action to develop public policy. Church leadership, | both clergy and lay, needs to capture a vision of health promotion and healing as part of their roles. Seminaries must include training for pastors as health advocates and health promoters.
In its advocacy role, the church often must become involved in legislative issues. One group of participants has recommended that:

1. Churches take the initiative in re-opening the dialogue in the United States on the basis of which a *comprehensive national policy for health and health services* can be constructed.
2. Denominational and Inter-denominational church courts or legislative bodies develop policy statements which will be useful to the dialogue leading to a national policy.
3. The role of the church in the national policy dialogue includes working with legislators so they can understand the difference between “health care” versus “illness care”.
4. The churches guide legislative policy toward the *transformation of existing* institutions, making use of all opportunities to “retool” present services and facilities so as to make them better responders to the human needs of health e.g., lifestyle and counseling services, positive health promotion, timely intervention for illness prevention and healing.
5. The churches and their judicatories and ecumenical groups become involved in the struggle for the control or cessation of nuclear power for civilian or military purposes as hazards to health.
6. The churches seek legislation for the monitoring and regulation of for-profit enterprises engaged in health care provision (including for-profit HMOs, hospitals, clinics etc.) to ensure that they operate appropriately and fairly within the framework of a broad-based health care system which provides | affordable access to all sectors of the population.
7. The churches develop a transformed national and local orientation toward health legislation in the larger framework of a global health mission, i.e. acting locally while thinking globally.
8. In pressing for legislative action, churches and local congregations consider serving as health centers in their own local communities, combining political action with community service, advocacy and counseling.
9. The churches coordinate their legislative activities as well as health services provision through intercongregational, denominational and interdenominational

networks and information exchanges.

Ethical Issues to be addressed by the Church as a Healing Community

Ethical issues created by North American medical technology which must be addressed by the churches include the following:

1. *How far do we go in maintaining life*? It was one group's position that the following should be guiding principles:
    a) In cases where the patient cannot participate in the decision (e.g. deformed and/or brain-damaged infants, incapacitated adults etc.) the family as well as physician should be the decision-making authority with regard to life maintenance.
    b) *Institutional ethics committees* should be used only where there is no family or responsible relatives available for consultation; or where the family and the physician fail to reach consensus.
    c) The churches should encourage the practice of well persons, or persons in charge of their decision-making faculties, to make *Living Wills* to govern the actions of the | physician where heroic life maintenance measures are being considered.
    d) The churches should develop rights of passage for the dying. These might include opportunities for review of one's life, delineating particular significant experiences and involve the use of tape recorders or word of mouth transmissions to the younger generation.
2. *Health care versus disease care*
    a) *Health* was defined as meaning “integrity”, “wholeness” and a *right relationship* between the self, others and God; while “brokenness” in these areas was defined as *disease*. Native peoples of North America generally consider health to be a state of balance; disease to be a state of imbalance.
    b) The determinants of health under this definition are seen to be: Lifestyle, Environment, the degree of caring in the community, Genetic potentials and limitations, the availability of health promotional and healing arts.
3. *The impact of cost containment on the quality of care*. The principal response of this issue was in terms of providing adequate care to persons at all economic levels.
    a) *The cost of care can be controlled*, while providing adequate care, to some considerable extent while requiring that; 1. Primary care centers be readily accessible | to all levels of the community, 2. in urgent medical matters all persons utilize the PHC centers before using the high tech centers where costs are necessarily higher.
    b) *Costs can be contained* by the adoption of a genuinely wholistic approach to the health of all income groups. This means health promotion which includes all systems impinging on health with special emphasis to the needs of the poor, disenfranchised, powerless and disadvantaged. 1. A truly wholistic approach requires adequate housing, meaningful employment, personalized care and fair distribution of resources. In short, “How we deal with the *health* of persons who are poor is a function of how we deal with persons who

are poor, period." 2. The churches need to influence all systems of the community not merely those agencies which post a sign saying "health done here."

4. *Responsible use of medical resources*. There should be a broader approach to the teaching of medical and health care ethics, and all physicians and health care workers should be enabled to benefit by such instruction.

The Life Style of Individuals and the Life Style of the Church as a Healing Community

1. To address the societal problem of achieving a wholesome, fitting and healthful life-style, the Church should itself become a model of a healthful and healing community. So a faith community, the congregations, and the churches, can model, in precept and in life-style practices, as a way of life which reflects what we know about being a healthful people. |
2. In so doing, the congregations and the churches can provide support, and support to support groups, e.g. by helping people with grief and life-style-related problems such as cigarette addiction, over-use or abuse of alcohol and other drugs, lack of exercise, obesity, stress and other forms of enslaving dependency. Likewise, the congregations and the churches, so engaged as a healing and healthful community, have the advantage of undertaking this mission in the theological dimension, i.e. under the Cross. In this way health and healing become transformed into ways of glorifying God, and not merely obtaining relief from suffering. And this is the only frame of reference within which both high technology and "high touch" can be genuinely reconciled and made servants of health and healing in the radical sense. The task for congregations and churches is to make their liturgical witness and life-style witness mutually self-reinforcing so that each flows from the other.
3. *A Larger List of Life-Style Problems* to be so addressed, would include: diet, smoking, unhealthful social norms, including roles which are rewarded economically but health-destructive, television abuse, violence, especially normative violence, misinformation and propaganda, advertising and media manipulation.
4. *The Church as the Supporter and Support-Group Supporter* is called to work through channels of theological re-examination, education for missions, group formation and therapy, training and training of trainers, stewardship, and other related channels.
5. Some *contingent objectives* in working towards the more transcendent goals of the health missions would include: enablement of self-help and reduction of dependency, development of peer groups to support those who reject the unhealthful | life-style norms of the North American world, reconciliation and prevention of violent acting-out behaviors in family and neighborhood living situations, networking of the churches with each other, and with other groups in the community in pursuit of all of the above.
6. In the *process of becoming a community of healing and of health*, the congregations should work through their theologies of health, and, in company, work toward a theology of the healing community which faithfully

reflects and operationalizes Shalom.

Resource Allocation Questions for the Church as a Healing Community

Pursuant to the end of affecting the allocation of resources in order to achieve a healing and healthful community, the churches are summoned to the task of *raising the critical questions* and to *advocate* the humanizing answers to such questions including:

1. What is the theological imperative supporting the church's work toward Health for All?
2. What is the fitting allocation of resources when considering the demands for heart transplant and high technology research over against the needs for disease prevention efforts and primary health care services?
3. What priority for purposes of public budgeting can genocidal weapons morally claim over the claims of health and healing?
4. *How can an early and substantial shift in resource* | *allocation be achieved* which reduces the conventional proportional allocations to high-cost, high-credentialed, high technology, late-intervention care – and, by contrast increases the proportional allocations to relatively lower-cost, non-institutional, early-intervention care?
5. What are the *new metaphors* and theologically informed *vocabularies* essential to the life style of health and healing?

Third World Concerns

Where North American churches attempt to relate to Third World conditions, local peoples must be given the freedom to establish their own health care programs without strings attached to the Canadian/US monies, commodities or personnel. Church organizations and other non-governmental agencies often have better channels for funding local projects. The partnership model of church relationships (Third World-North America) needs to be used more widely.

The grave disparity between the percent of GNP given to developing nations compared to the percent of GNP spent on military budgets must be confessed. Further, the style of medical education that does not equip physicians to work in low-tech settings also need to be questioned. When churches investigate corporate practices in the Third World their task forces should also evaluate drugs and other chemicals such as pesticides.

The Christian Medical Commission should consider using pharmacists and others knowledgeable in pharmaceuticals to lend further direction regarding the sale of drugs nationally and internationally. |

Recommendations

Even in a continent like affluent North America, it is getting harder not to notice that a lot of people are *poor*. Participants felt strongly that any document coming out of the North American consultation should reflect their concern for this large segment of their neighbors. They pointed out that getting to know them not as the faceless Poor, but as people, can be a healthy and illuminating experience that can transform “bleeding-heart”

church-goers into enlightened Christians. Time did not permit exploring a number of other critical issues for which deep concern was expressed. Biomedical ethics and abortion were only two of them.
Call it “change of heart”. Call it conscientization, conversion or *metanoia*. But it was agreed that this is essentially what needs to happen first: that we deepen our own understanding about our own health and our behavior and reflect on the quality of our relationships with others and with God, on suffering and the limits of what we must accept and what we must try to change. That we be more sensitive to all members of the health care team, to those we serve and those who serve us.
Those of us who took part in this conference feel a commitment:

1. To share our experiences with our own congregation and to encourage it, singly or with other churches, to have some program focused on health.
2. To keep in touch with people and resources which have come to light during our week together, utilizing this expertise wherever we can.
3. To interpret what we have learned here within our own denomination, communicating our conviction that people bear a responsibility for their own health and helping to put medicine and technology into proper perspective.
4. To provide written feed-back from the conference as soon as possible.
5. To write articles about the conference for those publications with which we may have some connection.
6. To help other organizations to which we may be related (e.g., the Protestant Health & Welfare Association) to understand the issues voiced at this meeting.
7. Hold regional ecumenical meetings within North America on issues discussed and recommendations emerging from this meeting.
8. Place more emphasis on geriatric problems and attitudes toward aging and older persons. |

What can be done by local congregations to articulate their healing ministry?

1. The local church can perform acts of healing and contribute to the health of its community in many different ways: by running a child care center, through prayer, by offering the sacraments for the sick at home or in the hospital, by setting up a health committee to become more knowledgeable about health issues and by being a Christian presence within the community, drawing attention to local resources and needs and supporting efforts to meet these needs.
2. Teaching: practical health education (courses in nutrition, for instance, in responsible self-help), Bible study on healing, ethical questions, personal responsibility for one's life-style), recognize inter-cultural contributions in attitudes toward health and healing and by enabling discussions with other ethnic groups.
3. Counseling: encourage pastors to take family histories as part of their pastoral responsibility in order to be aware of problems and tensions that may erupt in illnesses or behavior changes.
4. Some congregations may want to investigate the possibility of using their premises for a wholistic health center. Several participants are themselves working in such centers and were able to share some of their experiences during the meeting. Visits were also arranged during one free afternoon to the Columbia Road Health Center in Washington DC and to the St. Luke's Healing Ministry in

Baltimore, MD.

5. Support and utilize health professionals within the congregation, enabling them to articulate their faith; encourage physicians among them to challenge their colleagues on the cost of medical care and what is a fair income and to speak out within the health care systems, to urge that patients' “spiritual profiles” are taken with the aim of cooperating with their supporting community or group. Think about how medical school curricula can be expanded to include courses on human values.
6. Seek out and empower others in the congregation who can help in other ways to minister to each other's needs in times of crisis like illness, death, divorce, unplanned pregnancy, unemployment etc., recognizing that people who are depressed and oppressed need spiritual renewal as much as they need social, economic and political support.
7. Explore healing services as a way in which the church can reach out to those in some kind of need. Consider the use of imaginative liturgy in tires of life crises.
8. Within their own communities, congregations might engage with other churches and civic groups to study and take appropriate action on issues like plant closures, welfare, unemployment, pollution, alcoholism and drug abuse and the problem of the homeless, all of which directly affect the community's health. |

What can be done at the denominational level?

1. The emphasis on community medicine and primary health care expressed at this meeting should find its way into our legislative concerns. Speak out with passion and humility on behalf of the medically under-served. In their advocacy of a just society, churches should give urgent attention to health policy, especially about budget allocations and government health planning. This should include challenging member churches to recognize that the nuclear arms race is not only draining our resources, but it is distorting our judgment and attitudes by consciously and unconsciously conditioning us toward solving problems by violent means.
2. Encourage member churches to assume responsibility for good health programs in their communities which are victims of cutbacks in national, state or local funding.
3. Re-examine denominational policy statements on health and healing in the light of placing medicine and technology in their proper perspective, without a shroud of unrealistic expectations. Examine whether medicine and technology empower people to take responsibility for their own health care.
4. Have denominational magazines and newsletters give more space to issues of health and healing.
5. Establish national denominational, inter-denominational and cross-faith task forces on health and healing.

Within North America?

1. Canada took the lead in proposing the setting up of local and regional chapters of the Christian Medical Commission throughout Canada. Possibilities for doing the same thing in the United States will be taken up too.
2. Health legislation will become increasingly important in both countries despite

differences in their systems. Whatever group or persons within the Canadian Council of Churches or the National Council of Churches of Christ in the US will take responsibility for this, should build up networks of persons or groups concerned with these same issues.

3. The meeting sharpened people's awareness of the differences between the health care systems in Canada and the United States. Canada, with a national health care program, has a problem with *access*; in the United States, with a mixture of private and government health facilities, the problem is *eligibility*. Obviously, all problems are not solved when health care is nationalized.
4. Many of the objectives of the CMC exist right on our own North American doorsteps, like the need to promote comprehensive, community-based primary health care and to find ways to encourage self-reliance and personal responsibility. This entails acquainting our churches in Canada and the United States with the CMC and its program and philosophy. One way this could be done is through increased circulation of CONTACT in North America. |

Within the Third World?

The churches of North America have for years been generous in their support to medical missions in the Third World, both in funds and in expatriate personnel. A number of people at this meeting were former medical missionaries. Eric Ram's paper on health care in an interdependent world, along with some personal experiences shared by some of the participants who had served as medical missionaries, spoke of a new trend. They described the shift toward primary health care and away from big hospitals, toward programs that deal with basic needs for adequate food, clean water and away from the strictly curative, "white doctor" approach. This came out in the hope expressed that this way of thinking should instruct the churches when they give money to health projects run by affiliated churches in Third World countries.

Other recommendations directed toward donor churches in Canada and the United States:

1. Re-examine Western assumptions of what people in the Third World need.
2. Examine and evaluate primary health care programs in the Third World with an eye to adapting them for use in North America.
3. Encourage and assist Third World colleagues to assume full responsibility for their health care systems and make this possible through adequate training and experience so they can make responsible decisions in the light of their own cultural values. While recognizing that there is need for medical training, it was strongly felt that this should be done in the Third World and that giving scholarships for medical studies in North America is not the answer.
4. Give financial assistance and share resources with priority to basic health services supported by the communities themselves, using health personnel at all levels, linked with support capabilities in the local health care system.
5. Exchange health care personnel between the Third and First Worlds.

What can the CMC do?

1. Share information with the Canadian Council of Churches and the National Council of Churches USA and with people who have attended the North American meeting about the structure of the CMC and what it can and cannot do.

2. Encourage the development and monitoring of a small number of action/reflection models in the US and Canada like health care projects designed to serve the poor, traditional healing methods used by different ethnic groups, theological training programs in health and healing and others which came to light during the conference. By following the successes and failures of these projects over the next few years, CMC could then report on and disseminate whatever learnings may emerge.
3. Find appropriate and readable ways to share the ideas, recommendations and stories which have come out of other regional meetings.
4. Develop a bibliography of books and audiovisual resources referred to during the conference and make this available to participants and other interested persons.[14]
5. Continue to share, through CONTACT, stories about innovative forms of church-related health care and development projects in other parts of the world. |
6. Encourage national councils of churches in other countries to create mechanisms to facilitate information-sharing about health and healing programs. (Such health committees already exist in a number of countries.)
7. Identify health professionals and clergy within other regions who could become a resource network for developing wholistic health care centers.
8. Consider whether the CMC might not change its name to the Christian *Health* or Christian *Healing* Commission.

[14] This bibliography will be mailed to your separately. It includes most of the printed matter referred to during this meeting, as well as a number of periodicals and church statements related to health and healing. Please see it as an ongoing project. If you find omissions, please let us know, so we can update this bibliography and perhaps eventually expand it to include material on the church's healing ministry published elsewhere in the world.