

Respect for Human Life, III

A very helpful website for you is cbhd.org. This is The Center for Bioethics and Human Dignity that is associated with Trinity University. I ordered some booklets from the website, two of which are directly on the topics we are discussing in this session, basic questions on suicide and euthanasia, and basic questions on end-of-life decisions. I think the one on end-of-life decisions is particularly valuable. If you are in a pastoral situation and folks need to think through some things, this has a series of questions on foundational issues such as “is death a natural part of life? What should my attitude be toward it?” and so forth; and decision-making issues, including whether it is ever ethical to withhold fluids and nutrition. That is the most problematic question that people will have. So these are for giving people something to read and then talking to them about it and the implications as they are going through that process. These can be bought in bulk and I would think as a pastor you would find them very useful in that respect. And there is another one in this series that I think could work that way. It has basic questions on sexuality and reproductive technology for couples who are going through that process or thinking about that process. Couples who are having difficulty having children need something manageable for their thinking. These booklets are an excellent idea, answering the typical questions that people have from a Christian point of view. It is worth knowing about this website. There are larger books that they keep producing in this area, and it is worth visiting this website from time to time. They have a new book out. I have not yet received my copy, but it is on the full discussion of reproductive technology, so you would want to have that in your library to have the full discussion. But I think that these are extremely useful tools in keeping people current and getting the discussion at an advanced level as they are going through these decisions. The PCA report on Heroic Measures was done before a lot of this material was available, so we are sort of working out that position, and I will refer to that later this session. But I think that it is useful to have something that represents a wider Christian consensus now on these issues. There is nothing in here that is not compatible with what we say in the PCA report, and it is in a more attractive and useful format. It is also more current. This area just goes out of date so quickly. So I wanted you to be aware of those booklets.

Let us begin with prayer.

Lord in heaven, we recognize our dependence upon You for every breath that we draw. We pray for strength to do what You have given us to do. We are overloaded with issues. We cannot resolve all these issues. We ask for Your wisdom and blessing upon us as we study them. Create in us a disposition that seeks in everything to subordinate itself to Your will, but be with us and help us to honor You by seeking to fulfill what You have given us to do, as complex and exhausting as it is. We will not fail to pray for our nations also, that You would turn our hearts to You. We know that we are to pray for the peace of the city in which we dwell, for its well-being. We also know that true well-being comes from the Gospel of our Lord Jesus, and we pray that the Gospel may go forth in power in our generation, to turn hearts of those who departed from it back to You, and that our national life may reflect the principles that You have established for godly living in community. Be with us in this session we pray, and in the questions we discuss. For Jesus' sake, amen.

Last session we started the second part of our section on respect for human life. I divided it in terms of nascent human life and then respect for human life at the end, and we began with neonatal neglect. But right after birth, there is a problem with respect for human life, and we started talking about physician-assisted suicide, which the state of Oregon now has made legal. About 14 people a year are opting for that assistance. There are several problems with physician-assisted suicide that I want to mention to focus our attention on why we should be concerned about this issue as a societal issue. So far, there is

only one state that has actually enacted it into law, but it is a very radical thing that they have done. Only Colombia, South America has a similar legislation. It is practiced without legislation in many cases, but not even the Netherlands has enacted euthanasia into law. They have a non-prosecution issue so that they tolerate non-prosecution in terms of various forms of assisted suicide and euthanasia. But strictly speaking, even in the Netherlands the law has not been changed. It was changed in northern territories of Australia but then changed back, so what the state of Oregon has done is really radical. These are the problems with it. First of all, it endorses suicide. That is, it co-opts a society into what is said to be the autonomous choice of the person, and that is a very dangerous matter. If you study suicide, you know that most times people are ambivalent about it up until the end. And what that person needs to hear from the community is that his or her life is worth living, even if he cannot recognize it in his present suffering. We have no right as a society to say, “Go ahead, we do not care what you do with yourself,” which is in effect what you are saying if you adopt a policy that sanctions suicide, which is what is done here. So I think that the case against suicide is really foundational here.

I learned since our last session that the American legal system has never had the same laws against suicide that Great Britain had up until the 1960s. We never enacted laws against suicide, but we have always had laws against assisted suicide. Most states, all but six in fact, have explicit laws or common laws, clear laws against assisted suicide. In a few states, it is ambiguous. In Oregon, it is now the law. That is a very radical step, and it is the opposite of what society should say to its members. It is presented as an autonomous issue and that suits our radical individualism—everybody does what he wants—but we have a responsibility for one another, and we cannot really give up that responsibility for a member of our community. The community needs to say, “Though you do not think your life is worth living, we do, and we will care for you. We will do what it takes.” So it endorses suicide. It compromises the medical profession. The medical profession is to be a healing profession. It cannot always heal, but it must always care, so it is a healing and caring profession. But it is always to heal, always to care, never to kill. And although it does not directly kill in a physician-assisted suicide, it nevertheless is co-opted into the process by giving the means by which the autonomous agent takes his own life.

The appeal of this in the medical profession is to compassion. “Can you not do something for me in my suffering?” And in a caring profession, you feel the pull toward that, but it really compromises the profession. Once you move in this direction, you have become not a healing and caring profession but a killing profession. It seriously erodes the concept of medicine as a profession that goes back at least 400 years before Christ to Hippocrates. So this is also a radical development. It is really returning to an era before the Hippocratic Oath was instituted. And for those reasons, we think we must resist it.

The third point that I would make is that assisted suicide inevitably invites euthanasia. The state of Oregon went the direction of physician-assisted suicide after California and Washington tried a broader use of the medical profession. In California and Washington, attempts were made that actually would have allowed the doctor to administer the fatal dose of medicine. That was turned down in both of those states on referendum, and the state of Oregon, then realizing that public sentiment would not support euthanasia, went the route of assisted suicide. However, there is no way to logically not allow the doctors to administer the fatal dose but simply require the patient to take it. You could even expect discrimination suits where a person has expressed their wishes, has received the medicine, and fallen into a coma. You can expect lawsuits—oddly—on discrimination against the handicapped, for not allowing the doctor to administer the dose that the patient clearly wanted, had in hand, but was unable to take. And so I think that we should be careful about slippery slope arguments. What this one means is that there is a momentum, once you introduce physicians into the death process, to move toward euthanasia on the grounds of compassion. The more compassionate thing is to let the doctor administer

the dose, because death by taking pills can take three hours or more, and there are risks because people are sick and people can spill the medicine, choke, vomit, or fall asleep before the full dose. With an injection, the patient lapses into a coma within about 10 seconds, and often death comes 10 minutes later. If you allow the autonomy issue and you involve the medical profession on compassion grounds, which is more compassionate? Well, it is obvious that euthanasia, physician-administered death, is more compassionate, so I think that this is a clear example of a slope on which it is impossible to gain a foothold and not move toward the other thing. The logic is toward euthanasia. I think physician-assisted suicide is wrong in itself. So I am not saying it is wrong because it invites euthanasia. I think that we should recognize it is inevitable. The logic is inexorable that if you involve physicians in death to this extent, on the grounds of compassion, you are going to take the next step.

A fourth objection that I have is that it puts the vulnerable at risk. I do not know how to say this. I will just say “vulnerable.” It puts the vulnerable person at risk. Once you create the option as a matter of societal permission, you create an expectation for that, especially in a society where the great fear is being a burden on somebody else. I think that that fear of being a burden on somebody else probably stems from our unwillingness to take on burdens. And so we do not want to be a burden because we are rejecting the idea of taking on burdens. That is latent there. But in the climate where the main fear is being a burden, if you create the option of a way out that is painless and socially sanctioned, then people are not autonomous in making that decision. It undercuts the autonomy of the decision, because there are subtle and not-so-subtle pressures to get on with the final exit. And that is already happening as documented in a number of things. So I think that for these four reasons we need to be alert and aware and oppose the movement of physician-assisted suicide. It is involving the culture of death.

You might ask if there is statistical evidence that most suicides occur within the more vulnerable parts of our population. I would say, not to my knowledge; I do not think that there are. Most successful suicides are by white males in terms of percentage, and those are mostly with guns, with firearms. And so there is another issue that is there, but that is the way most suicides happen. More women attempt suicide than men, but more men are actually successfully in carrying it out. One thing about this booklet on suicide and euthanasia is that it answers a number of those statistical questions about suicide. It is very handy for that kind of information. One of my kids when he was taking piano lessons asked me to get him the theme from the American television show M.A.S.H. to play, and so I did. And then to my astonishment, the theme to M.A.S.H. is called “Suicide is Painless.” If there is ever a lie, that is it. Suicide is not painless. It is a terrible event, and the family is left with the consequences.

Painless, you say, what about lethal injection? I am not talking about the pain to the person that is involved. I am talking about the pain to the family, but I am also talking about the pain that comes from being isolated and allowed to commit suicide. Suicide is mainly a cry for help. The authority on suicide in this country is Herb Hendin. One of the foremost American authorities on suicide, he is the executive director of the American Suicide Foundation and professor of psychology at New York Medical College. He came to my attention with a book published in 1997 called *Seduced by Death*. It is an account of the medical situation in the Netherlands. He went with sympathy toward the Dutch cure when he started out; but when he found that the safeguards were violated, he really changed his mind. The various safeguards that are put into law are being ignored, so it is a very important work, *Seduced by Death*. In that book he talks about suicide as well as how there is a movement from assisted suicide to euthanasia, from euthanasia for people who are terminally ill to euthanasia for those who are chronically ill, from euthanasia for physical distress to euthanasia for psychological distress, and from voluntary euthanasia to non-voluntary euthanasia. It is a good exploration of that movement, and virtually every guideline that was established can be violated with impunity. So it is a lesson. As we move into that area, we ought to examine what the actual experience has been in Holland.

Now, we need to talk about a third area here that I call “Medical Non-Treatment.” In the article, “Do Dying Patients Really Need I.V. Fluids,” which is from the Christian Medical Fellowship, there are some reasons why a doctor may avoid, delay, start, or stop a particular treatment, and then it lists 10 key concepts that guide their discussion. It is useful to take a look at that.

I want to say something about the PCA report. On medical non-treatment, we have already seen that sometimes that constitutes culpable neglect, as when Down syndrome babies are allowed to die through either non-medical intervention, not feeding and hydrating them, or by design, so that they would die and you are not burdened with a Down syndrome child. That is euthanasia. The intention is that the child die through its non-treatment. So there are measures that are necessary means for preservation of life.

Our report took the position that food, air, and water by natural routes—that is without technical assistance—may not be denied by the patient or anyone caring for him, and medical treatment that is clearly efficacious to heal or to restore may not be denied either. If it is a reversible condition, that is, a treatable condition, then our respect for life requires us to make use of the medical intervention, including the sustenance that is necessary while that is going on. But on the other side, the PCA report says, “Treatments that are ineffective, minimally effective, or have frequent and serious side effects are not obligatory.” In other words, there are limits to what we can impose by way of medical treatment. We go on to say in the report, “Specific effective measures should be chosen with clear cut goals for the patient’s condition.” These are patient-oriented. You cannot deal with these in the abstract; you have to deal with the particular patient and choose those goals. We say in the report—I think this was important—that “Ethical choices may become more clearly evident if the goals of medicine in these situations are first to heal or restore, but if we cannot do that, secondly to relieve suffering.” And then I underline this: “It is not the goal of medicine simply to prevent death.” The underlying disease takes their lives, and a person in the terminal stages of an illness, one that is irreversible, has a right to say to physicians not “help me to kill myself,” or “kill me,” but he does have the right to say, “It is time for me to die; do not intervene.” There is now widespread agreement that patients that are in an irreversible condition should not be subjected to troublesome treatments that cannot restore to health. And a corollary of relieving suffering is that doctors may use drugs to control pain, even though they may have the effect of shortening life. Your intention in those cases is not to shorten the life. Your intention is to relieve the suffering to make the life more bearable, but it does have as a side effect the shortening of life. Now, this is very different. Dr. Koop made the point this way: “The intent behind the gradual administration of drugs to allay suffering is to keep her comfortable as a person slips away.” The intent behind the drug overdose is to get her out of her misery, off our hands as quickly as possible. Now, this comes down to intent. It has been argued that if you allow drugs that we know will shorten life, why not just give the fatal dose all at once? Well, it does depend upon your intention, and there is a legitimate intention to relieve suffering, even though it hastens death, that does not intend to hasten the death. That is not the motive, whereas a drug overdose is to relieve suffering by taking the person’s life. That is a quite different thing and that, as a matter of fact, was recognized in the Supreme Court as one of these cases came up to it. So the difference between administering drugs that may have the side effect of shortening life and the intentional use of drugs to take away life is now a standard recognition.

I think that the care for the dying mandates a number of things. Let me put it this way. There are these four things that we ought always to have in caring for the dying. First of all is companionship so that a person does not die alone. That is the human contact that really says to die with dignity means to die as a human person to the end, and I will be with you through the dying process. The hospice movement has established itself as a truly viable alternative to the death dignity movement that involves suicide or euthanasia. It is the positive attitude that is transferred to the dying person through this. It lifts the

feeling of helplessness and helps the patient die with a sense of worth to the end. That is true dignity, to help the person die with a sense of worth to the end. Now, along with that is spiritual care. As Christians we must always provide spiritual care, to pray with and for a dying person, even when they slip into unconsciousness. They may be unconscious from our point of view, but there are various testimonies that a person apparently unconscious has been able to make some motion that they recognize what is going on. In any case, we pray for people even if they cannot hear us. But our presence there in spiritual care is needed. Then there is hygiene as a part of respect for human life to the end. Keep people clean and comfortable. That is a part of the care that we must always give. And the fourth thing would be analgesics or painkillers. And those should be administered aggressively. It is now recognized that aggressive use of morphine is not incompatible with respect for human life. It may have the effect of shortening the life, but persons may be lucid in those final days, and the value of being lucid and free from pain outweighs the shortening of the painful experience until the end. It is not a biblical principle that we should suffer as much as possible. We accept suffering when God has it, but God has also provided us ways to alleviate suffering.

So this is comfort care. When we cannot cure, we can always provide comfort care. And out of respect for human life, we certainly should do that even when we cannot treat symptoms, let alone cure. Comfort care is always mandatory on us. Now, we face the question of nutrition and hydration. Because that is so basic to the care we owe one another and symbolizes the bonds of nurturance that we have, sometimes people add as a fifth point that we may never deny a dying patient food and water. If we cannot administer them through natural means, then artificially we may do that. We came to the conclusion in our committee, as a result of the medical doctors on that committee, that even taking nourishment may impose excessive burdens. Artificial administration is sometimes excessively burdensome in that connection. Fluids can be administered intravenously by needle for only a limited amount of time, then you have to go into more radical things, a nasogastric tube through your nose to the stomach or an operation called gastrostomy. And we need some question as to when it is mandatory. I take the position that is also the position of the book *The End of Life Question*. They recognize that this is controversial, and so they leave it to the judgment of the person involved as to whether this is always necessary, but they defend those who would remove it. I take it on the ground that although this is not medical treatment, it is an invasive medical procedure.

The conditions when medically assisted nutrition and hydration are not obligatory are I think these three. The first is when they are futile. That is clear. God does not require us to do something that is futile. And sometimes the effort to provide nutrition and hydration may very well cause suffering and offers no counter balance and benefit. The body is shutting down, it cannot metabolize food, and it is pointless. It is to lose sight of the purpose of medicine. To hold that a patient must be subject to a predictably futile sort of intervention is to lose sight of the purpose for which we are there. I think it is clear cut that if it is futile, it is obviously not obligatory.

My second condition is that a judgment is called for when the burden is disproportionate to any possible benefit, that is, when you are postponing death by measures that increase suffering. That is a judgment that we need to make. The article, "Are I.V. Fluids Always Necessary?" makes the case that though sometimes you may postpone the hour of death, it is only at the expense of suffering.

The third type of condition is when the patient cannot benefit because of pathology. We are talking here about an irreversible condition in which a person is rendered permanently unconscious. Now, you have to make a judgment. There are many different kinds of coma. There are whole books written on the different types of coma, so we have to be very careful here as to whether we are talking about an irreversible condition or one that is reversible. There have been people who have wakened after years of

being in a coma because it was not irreversible, and respect for life requires us to maintain them. But we are talking about the kind of pathology that is irreversible. A person is not dead, because the brain stem is still working so the metabolism functions are still going on. But all upper brain activity is gone so that the person will never regain consciousness and will never function as a person. I think that that is the point where we have to ask what is the benefit to the patient under those circumstances?

Let me say something about the criteria of death, or the clinical signs of death, before I get back to this question. On the clinical signs of death, we have the traditional clinical signs: irreversible cessation of circulatory and respiratory functions. That is your heart and lungs. Once those are gone, you are dead. But now, with our modern technology, we can keep the blood circulating and the lungs oxygenated indefinitely through machines. And so when those traditional signs cannot be applied, then we have had to take as a criterion of death irreversible cessation of all functions of the entire brain, including the brain stem. Human life is then no longer present, because unified human function is not present and cannot be restored. In biblical terms, the body without the spirit is dead. We do not identify the spirit with the brain, but that brain is the organizing principle in this life. And when the whole brain is dead, the person is dead. So turn off the machine. It is clear-cut. And I think that we should be careful about turning off the machine. Because of the transplant industry, people have been precipitous in wanting to pronounce people dead. So again, it is an area of caution. But in principle, when we cannot apply the traditional signs because we have a respirator going, then you take the person off the respirator. Do we then wait until heart and lung function actually cease before we allow transplant? I think yes, but there could be further discussion of that.

You might ask if it is not just a financial consideration to cut off life support. Well, I do not think that I entirely agree with that. I think that it is not entirely financially motivated. We are talking about a person who has no brain function, not a person whose brain stem is still functioning, but no brain function. That person from a biblical point of view is no longer there, and the reason we cannot apply the traditional clinical signs is because the technology is in the way. We have to remove the technology in order to see that that would be the result. The circulatory system's function is to supply oxygen to the brain. If the brain is no longer working, it is pointless to supply it with oxygen. And so, to keep a person in a state of artificially suspended animation seems to me to go against the biblical principle. What is more difficult, where the financial consideration does come in, is when people are in reversible coma, because that is \$100,000 a year. It goes on and on, and it is indefinite, but there is respect for life. When a person is conscious or has the potential of regaining consciousness, that is one set of circumstances. This other circumstance is that the person will never be conscious because the brain is dead, as we say. When the brain is dead, the person is dead.

Further complication is when you have brain stem function, so that there is still life there. There is a movement now to say that we define death in terms of just the upper brain rather than the whole brain, so these people who still have brain stems are dead. I think that is a big mistake. They are alive. The ethical question is whether we are obligated to keep them alive though they will never regain consciousness. They will never function as a person because of their brain stem. They are still persons, but the question is whether it is obligatory on us to sustain them, knowing that they will never regain those functions.

Now, let me just read you a couple of things from the pamphlet here. "Perhaps the most perplexing category of patients are those who are permanently unconscious but not eminently dying." You have a brain stem, but you do not have an upper brain. It is so-called persistent vegetative state. We avoid that terminology, but P.V.S. is what it is called in the literature. What do we do about these people? This is the most agonizing decision. We cannot say that they are dead. They are still alive. And I agree with

their caution with talking about a vegetative state, because that involves a loss of respect. Second, people understandingly struggle as they try to locate such patients on the continuum between life in this world to life in the next. When does a Christian, for example, move beyond interaction with this world to interaction with the spiritual realm beyond? Experientially, permanently unconscious patients have left this world, so the benefit to the patients of continued symptom care that merely keeps the bodily functions from ceasing is far from clear. I think you have to ask what does it benefit the patient?

Now, it ought to be very clear about what the patient's will is. We all ought to decide and get in writing what our will is. If we want that symptom care if we are in that kind of a state, we should say so. And if we do not want it, we should also say that, so we do not put other people in the position of having to infer that decision or make that decision. It ought to be clear, but it is a judgment call. And I think that some symptoms care can be elected out of respect for human life; but in some circumstances, I think it is appropriate to not intervene with intrusive measures for the purpose of keeping a permanently unconscious person from dying. What benefit is that to the person? I do think it is not wrong to factor in the cost of that. It costs \$100,000 a year in order to maintain a person in the unrecoverable unconscious state. It seems to me that this is excessively burdensome, not just financially, but in terms of the patient, in terms of the family, and in terms of the nature of the care itself. What are we doing when we go to these measures simply because we have them now in our modern age, rather than allowing nature to take its course? We are not choosing death in those situations; it would be bowing before the inevitable. Death of course is advanced by the pathology itself. And beyond some point, it is a judgment call. It is useless to fight it. I take the position that for anencephalic children without a brain, we allow them to die. We do not kill them, but it is not culpable neglect not to feed them. We make them comfortable and we switch from hydration to moistening the lips, doing everything we can to make them comfortable. All the scientific details are in that article. There comes a time in which it is futile and of no benefit to the patient to maintain them in that state. They are not dead, and we do not have a right to kill them, but I think that non-intervention or non-treatment is best. And I think that treatment, in this case with food and water, though that bothers us, is an invasive procedure.

The reason why we have the criterion of brain death, at which point we declare a person dead and remove the machine, is because the person cannot function in that condition. We are artificially maintaining a corpse, preventing it from taking its natural course. That is why we declare a person brain dead. Now whether we should actually wait until the person ceases all those functions before we start removing organs is a question I have not decided. But I think that with the brain death criterion it is clear that that person is gone, is no longer with us, and that it is wrong to maintain that person in suspended animation. You know, the death is an event that is clinically analyzed but things like cell division and growth of fingernails and hair and so forth keep going. Morticians have to shave and clip fingernails and all that because processes are still going on while the person is dead. So I think that the criterion of brain death, it seems to me, is sound in terms of looking at biblical principles. We do not have a clinical definition of death in the Scriptures, but I think that the definition of brain death is compatible to everything we know from the Scriptures.

At some point you have to decide whether the treatment is more burdensome or if it is for the patient's benefit. We are talking about individual patients rather than an abstract concept of going on with life. Our tendency because of our strong pro-life commitments is to over-treat and for families to require more treatment than they want for themselves. And so we have to make some judgments. And there is a growing set of criteria that do have to be applied on an individual basis, but ask, what is the good of the patient? That is the question. What benefit does this have for the patient, and is it worth it? All medical interventions are worth it to the patient, and so a person can say, "I have lived long enough. This is not

going to cure me and the side effects of this particular procedure are so horrific that at my age and given my circumstances, do not intervene.” That is a rational and biblical decision that we can make.

People ask if there are any definitions of death in the Bible. The only one that I can think of is in James when he says, “The body without the spirit is dead.” Paul is arguing there, but it is like Ecclesiastes: “The body returns to earth as it was and the spirit to God that gave it.” We do not identify the spirit and the brain, but the brain is the organizing function where the spirit operates in this life, so I think it is as close as we are going to get in an authority that was produced before we had all of this advanced understanding.

We need to start our next topic. I really proposed to talk about too many issues these last few sessions, but I do want to say something about homosexuality, something about the role of women, and something about race relations. For those latter two, I am just going to have to give some principles for guidance rather than a full discussion.

Homosexuality, as you know, is very much in the news right now, so this does require that we give serious attention to it. By way of introduction, to orient us toward the homosexual discussion, I think Mary Stewart van Leeuwen is very much to the point. Most mainline church study documents on the issue simply assume that the biological origins of homosexuality are scientifically established, but this is far from the case. Now, Mary Stewart Van Leeuwen is a psychologist. She is a Reformed Christian, teaches at Eastern Baptist College, and has written a book called *Gender and Grace*. She approaches this from the side of a trained psychologist. And what she talks about is that establishing causality requires a broadly accepted definition of just what it is we are deserving, and consensus is lacking.

A while ago I attended a conference at St. Louis University sponsored by various homosexual groups and heard a really fine lecture by a lesbian psychoanalyst. I invited a fellow colleague to go along with me because you really needed to have some background in order to ask the right question. But under his probing, she really admitted this. She said, “We hear in the news when there is some supposedly genetic connection with homosexuality, but what we do not hear is when further research turns up that that did not pan out.” So she was very honest. I really thought it was good to hear some of this from the other side, so to speak. She also said, as my colleague pressed her on the question of whether persons can change, “In my psychotherapy practice, it really depends where you are along this continuum.” She said a desire for change is a factor. She had an orthodox Jewish woman who was lesbian who came to her. And the psychotherapist took the view that “it is not my role to make a judgment here,” but she led her to decide, “You are going to have to choose whether to remain true to your orthodox Jewish faith or your lesbian inclination,” and the woman chose her orthodox Jewish faith. That was more important to her than the expression of her lesbian inclination. She made that choice. So that was, to me, illuminating. That is a psychotherapist who does not impose her view on her client.

Clearly biology does matter. This also was admitted, and there is still some perplexity. It follows a predictable yet complicated course. Biological aspects of sexuality usually correspond with each other and with psychological aspects to lead to the male-female sexual bonding and subsequent reproductive activity. That is the way we are made. That is what usually happens. The concordance of these multiple aspects can break down on rare occasions. The 10% rule, saying that 10% of the population is homosexual, has been undermined. It is, at most, 3 % now. Recognized homosexual spokespersons adopt that figure now. But the norm is clear; the human biological program is biased toward heterosexuality. And as a species, we are not infinitely malleable in terms of our potential sexual orientation. I think this is well put. Here is the point that I latch onto. “The interplay between nature, nurture, and human freedom also helps to explain that our Old Testament/New Testament ancestors

were correct in treating various non-normative sexual acts as things to which anyone could be tempted.” The Bible, as we will see, approaches this on the level of behavior, on the level of actions, and that is because a number of forces can influence people to engage in variations. That is why people are tempted to speak of the social construction of sexuality. Van Leeuwen rejects that, but we can sort of see why that is the case.

She says, “We need to remember that the concept of constitutional homosexual orientation arose when Victorian doctors shifted attention from individual homosexual acts to the concept of homosexuality as a pervasive personality structure.” This is recent in terms of approaches, and she suggests, “Might it not even be preferable to return to the language of our recent ancestors and try to deal with each case on a compassionate individual basis that declines to make global fatalistic attributions about sexual orientation.” I think that is sound advice.

Let me get a start on my outline on homosexuality. It is pretty simple. It is “Bible, Church, and Society.” I begin with the biblical testimony. Whenever I approach this subject in a forum, I always try to get three evangelical assumptions out early on. They are that first, all human beings are created in the image of God. I think it is important to say that. That has certain implications for the way we treat one another. Second, all have sinned and fall short of the glory of God, and so we recognize our solidarity in sin as well as our common dignity as human beings in the image of God. All have sinned and fall short of the glory of God. And the third aspect of the evangelical perspective is that all are offered forgiveness and renewal through Christ. Now, you will recognize our standard framework of creation, fall, and redemption. All human beings are created in the image of God, all have sinned and fall short of the glory of God, and all are offered forgiveness and renewal in Christ. That is a basic framework. And I think it is useful as you get into discussions of this to let that come through in some way or other. So that is the evangelical perspective that we look at when we consider the biblical testimony specifically with respect to homosexuality. We have a theological framework which I think is useful for that.

I begin with the creation ordinances. I think it is important to begin with Genesis 1:27 and 2:24, the passages that Jesus coordinates in the Gospels. He is actually talking about divorce, but He collates these two passages, and I think they are relevant here. God created humankind as complementary sexual beings, male and female. An erotic desire is rightfully fulfilled in the one flesh relationship of heterosexual marriage. Actually, you could just say marriage, but be explicit about it now. It is heterosexual marriage we are talking about. Now, the reason why I think it is important to begin with the creation ordinances is that the norm of heterosexual marriage is uniformly presented in Scripture, from the creation narrative to the vision of the New Jerusalem. It is literally from Genesis to Revelation. In the creation narrative, God has created male and female, Adam and Eve, one flesh relationship of marriage; and in the New Jerusalem we see marriage as a bride beautifully dressed for her husband. The marriage supper of the Lamb is based on a heterosexual figure of marriage. There is no counter in the text. You know, on the issue of women’s ordination, we have some counter texts to deal with. You have to sort that through. Do you give greater weight to Galatians “In Christ there is no male or female” or greater weight to 1 Timothy, in which Paul does not allow a woman to teach or to exercise authority over man? Well, you have at least a countervailing text in that case, but there is no countervailing text with respect to homosexuality. I think it is useful to say that, because it is sometimes argued that there are only a few texts that deal with homosexuality. That is true. There is just a handful, but they are against the background of the whole teaching of Scripture in which heterosexual marriage is the norm for the fulfillment of erotic desire.

After the creation ordinance, I then go to the Law of Moses. I skip the account of Sodom. I think that that is homosexual activity that was envisioned there, but it is gang rape. Nobody is going to approve

gang rape, heterosexual or homosexual, so I think that it is not the most useful passage to bring out. I think that it is better to go to the explicit text in Leviticus. It is Leviticus 18:22 and Leviticus 20:13. Leviticus 18:22 says, "You shall not lie with mankind as with womankind." And Leviticus 20:13 is an example of case law where the death penalty is prescribed for that activity. Now, these passages are frequently dismissed as part of Israel's ceremonial law, specifically the concern with cult prostitution. Therefore, for both of those reasons, they say they are not applicable to homosexual relations today, but not everything in Leviticus is temporary. Leviticus 19:18 says, "You shall love your neighbor as yourself." Many folks do not realize that that comes from Leviticus, and it happens to be sandwiched in between chapters 18 and 20. So we recognize we have to make some distinctions when it comes to Leviticus. Some of it is what we call "the moral law." And when you look at the surrounding context of Leviticus 18:22, Leviticus 18:20 refers to adultery, verse 21 to child sacrifice, and verse 23 to bestiality, so it is talking about moral concerns. Now, it is true that Leviticus 18 has some other things in there. Leviticus 18:19 prohibits intercourse during menstruation, so there is ceremonial law mixed in. We would say the blood laws have a specific reference in the Old Testament law, and the consequences are certainly on a par with Leviticus 20:13. Compare Leviticus 15:24 and Leviticus 20:13 for the penalty of having intercourse during menstruation.

Well, we need to stop for now. Just to say one thing, in Leviticus 18 homosexual acts are called an abomination. That is clearly a term that is used for moral wrong, but it is not the only moral wrong. Sometimes the only time we refer to sin as an abomination, it is referred to as this sin, and that is wrong. You have to read Proverbs 6:16-19 for the seven things that are an abomination to the Lord, and homosexuality is not on that list. But sowing dissension among brothers is. So let us be even-handed in what we call abomination. To reserve it for homosexuality fails to take account that all have sinned and fall short of the glory of God.