TASK FORCES

Report outline

I. Mandate and goals

Synod 2023 appointed the Assisted Suicide Task Force "to make a definitive and comprehensive report on the practice of assisted suicide in all its forms" (*Acts of Synod 2023*, p. 981). The task force was assigned to shape its work according to the premise that there is a unique value to all human life and that humans have a special relationship with God as we bear God's image. Synod asked that the report be in concert with prior synodical work that "condemn[s] the wanton or arbitrary destruction of any human being at any stage of its development from the point of conception to the point of death" (*Acts of Synod 1972*, pp. 63-64). Before we launch into the main portion of our report, we want to explain how we understand our mandate and goal as a task force.

First, we are writing about medically assisted suicide (MAS).[1] The act of assisted suicide involves the situation in which the health-care system uses medicines to intentionally cause death, to which a capable individual has

[1] In this report we have chosen to use the term "medically assisted suicide" because it is deemed to be clear in describing the act, and without tying it to a particular jurisdiction. Some jurisdictions call it "physician-assisted death," "death with dignity," or "medical assistance in dying"; however, none of these phrases are as clear, or accurate, in describing the act to which it refers. In addition, we reject the term Medical Assistance in Dying (MaiD), despite its popularity—particularly in Canada—because it is a euphemism that conflates medical killing with the medical assistance that is given to people in the natural dying process.

consented. MAS has been legalized in Canada and in many states in the United States. It remains illegal for anyone to help someone commit suicide outside of the prescribed processes in these jurisdictions, thus we will limit our discussion to pastoral care and end-of-life decisions in situations in which people are legally able to request that their life be ended with the help of an authorized health-care worker.

Second, we understand that by quoting the 1972 report on abortion, synod has asked us to write a report that is against medically assisted suicide. We focus our work on pastoral care and guidance from the position that a medically assisted suicide is not congruent with a biblical, Christian understanding of life and death.

Third, in its overture requesting that synod "make a statement on assisted suicide" (*Agenda for Synod 2023,* pp. 354-56), Classis Zeeland notes that the phrase from the 1972 report on abortion condemning "the wanton or arbitrary destruction of any human being . . ." does not describe the situation of medically assisted suicide, which is legislated with regard to the principle of patient autonomy and an approval process that includes waiting periods and is thus not arbitrary per se. We agree that a clearer statement on the value of human life would be helpful. We aim to provide a theological and pastoral framework that will help churches support and care for suffering people at the end of their lives or facing difficult life circumstances.

As of 2024, there are some 650 Christian Reformed pastors and chaplains who are doing ministry in jurisdictions where medically assisted suicide is legal. While writing this report, we engaged pastors and chaplains on their experience of providing pastoral care in the context of legalized medically assisted suicide. From our engagement with this group, we learned that MAS is an issue and decision that members of their congregations and communities face, and that some are choosing MAS. Church members hold a range of opinions about MAS. Pastors want people to feel safe to wrestle in community with the issue of suffering and to understand the difference between palliative care and MAS. They desire resources to support individuals and their loved ones in nuanced and difficult situations.

Taking all of this into consideration, we understand that the main question posed to the Assisted Suicide Task Force is as follows: *Given the growing availability and endorsement of medically assisted suicide, how should Christians think about this matter biblically, within the medical context, and in support of practical Christian living?*

In this report we will argue that Christian theology and pastoral-care practices encourage compassionate palliative care and support of suffering, disabled, and/or dying people and their families instead of acting to cause death.

II. Current Context

A. Map of Access to MAS

(*Note:* Medical Assistance in Dying (MAiD) is available in all provinces and territories in Canada.

Key

Medium gray—Bills are in place allowing euthanasia or assisted suicide (California, Colorado, District of Columbia, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, Washington).

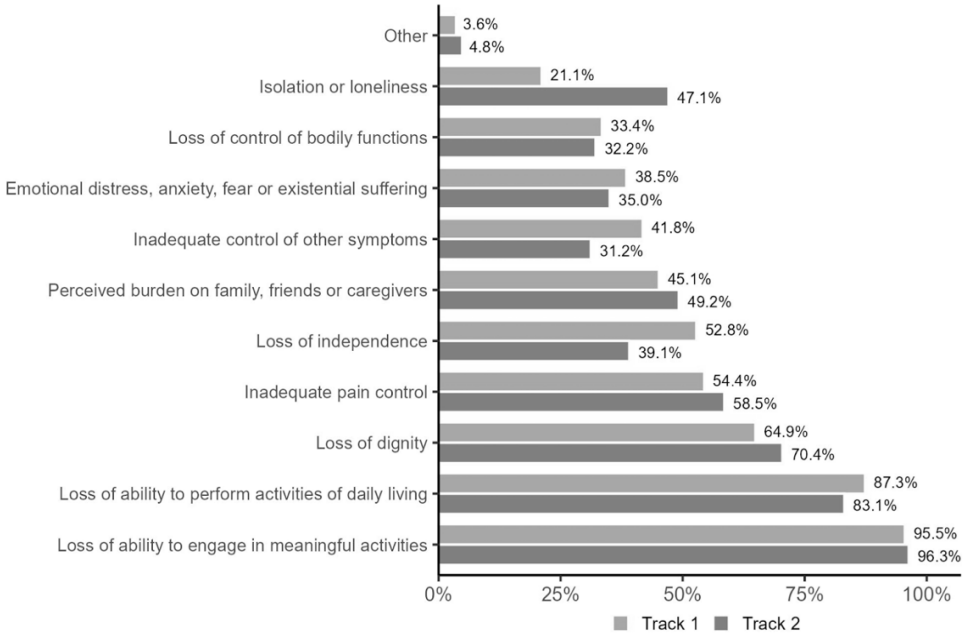
Black—Bills are in place allowing or proposing euthanasia or assisted suicide, but pro-life bills have been introduced (Connecticut, Montana, New Jersey).

Dark gray—Bills allowing euthanasia or assisted suicide are pending (Arizona, Connecticut, Delaware, Illinois, Indiana, Massachusetts, Missouri, New Hampshire, New York).

Note: Oregon allows people from out of state to travel to Oregon to receive euthanasia/assisted suicide.

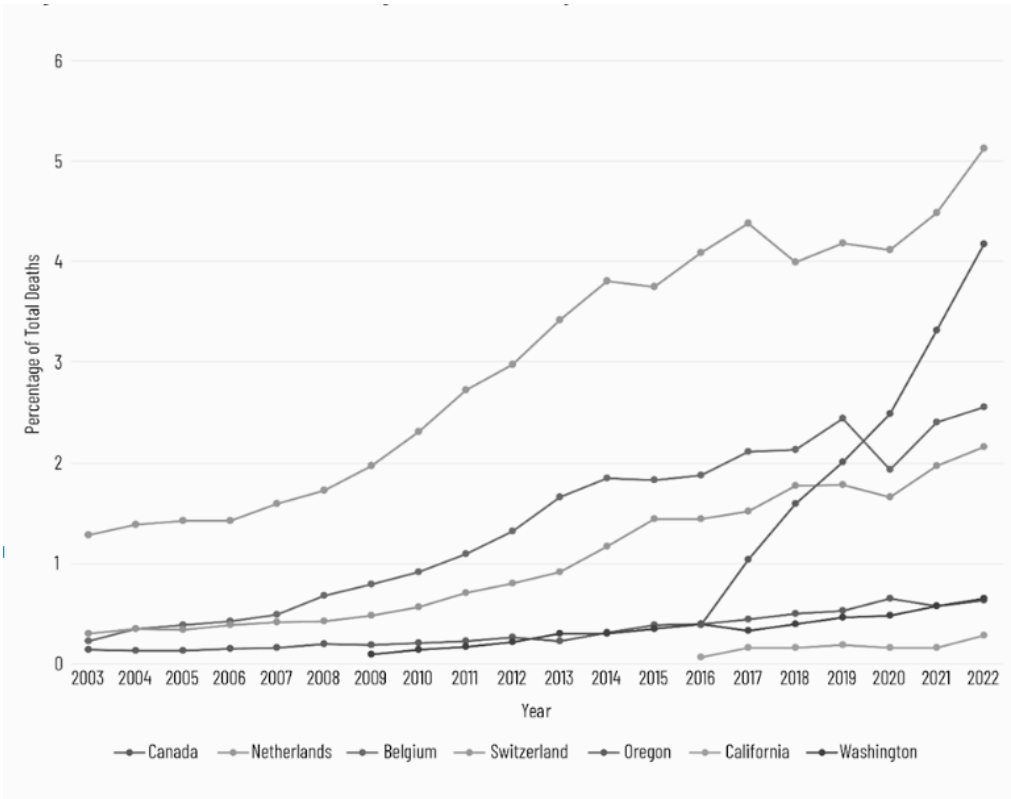
Source: deathwithdignity.org/states (accessed Jan. 22, 2025)

B. Chart showing reasons given for requesting MAiD (MAS in Canada), 2023



Notes: Track 1 MAiD is when a death is reasonably foreseeable.
Track 2 is when a death is not reasonably foreseeable but the patient has a disability, illness, or disease and is experiencing unbearable suffering that cannot be relieved under conditions that the patient considers acceptable.
For more information of the development of MAiD in Canada, see Appendix A.
Source: Fifth Annual Report on Medical Assistance in Dying in Canada, 2023. Stats Canada. (canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#f3.6a)

C. Graph showing assisted deaths as a percentage of total deaths in the eligible population, by jurisdiction[2]



This graph was originally published in color and is available on the Cardus website (see link in footnote). To distinguish the jurisdictions in this grayscale version, we include the percentage of total deaths for 2022: Netherlands, 5.1%; Canada, 4.1%; Belgium, 2.5%; Switzerland, 2.1%; Washington (state), 0.6%; Oregon, 0.6%; California, 0.3%. Note from author of table:

> This graph uses the most recent reported annual number of deaths. While jurisdictions have varying legislation and definitions of euthanasia and medical assistance in dying, the numbers reported here are official government accounts relating broadly to assisted death. The number of deaths recorded in Washington are the number of participants who are known to have died specifically after ingesting the requested lethal doses of medication. Since MAiD is not currently legal in Canada for persons under the age of 18, this Cardus paper calculates MAiD deaths as a percentage of all deaths of persons age 18 and above. Health Canada, however, calculates MAiD deaths as a percentage of all deaths over zero years of age. Consequently, Health Canada data and Cardus's own calculations show minor differences. For example, the 2022 percentage is 4.2 percent in this Cardus report, while for Health Canada it is 4.1 percent.

[2] "From Exceptional to Routine" Cardus, 2024 (cardus.ca/research/health/reports/from-exceptional-to-routine/).

These three diagrams demonstrate that MAS is available and endorsed in Canada and the United States. MAS is legally available in Canada and in a growing number of states in the U.S. In Oregon the allowance for nonresidents means that people can travel to Oregon for MAS. There are various reasons people give for choosing MAS. Deaths by MAS are increasing as a percentage of total deaths year over year, most notably in Canada. Given the growing availability and endorsement of medically assisted suicide, how should Christians think about this matter biblically, within the medical context, and in support of practical Christian living?

III. Reformed Theological Framework

A. Imago Dei and the preciousness of life

Life is a gift from God, and human life is especially precious to God, our Creator. From the beginning of Scripture to the end, God is the giver and sustainer of life. While all life comes from God, human life is given particular value. In their report "Regarding Responsibility and Community at the End of Life," submitted to Synod 2000, the Committee for Contact with the Government (CCG) wrote that "both humankind and animals are referred to in Genesis as 'living beings,' but only of humankind is it said that God 'breathed into his nostrils the breath of life' (Gen. 2:7)."[3] There is something warmly personal and intimate in this picture. God did not just give us life; he gave us something of himself.

Dignity and meaning are not derived from one's cognitive or physical ability and therefore cannot be lost by age, injury, or disease. Dignity and meaning come from God, who created the whole world ex nihilo "out of nothing,"[4] imbued humankind with his image, and declared humanity "very good" (Gen. 1:31; Heidelberg Catechism Q&A 6). All persons have inherent worth and dignity, and all people are invited, in ways respective of their unique gifts, to be caretakers of the world and to reflect God's image in the world (Our World Belongs to God, para. 10).

The preciousness of human life is emphasized in Genesis 9:1-7. This passage begins and ends with the command to be "fruitful and multiply." In between this reiterated command to fill the earth comes a strong warning about extinguishing the life of another person: Genesis 9:6 says, "Whoever sheds the blood of a human, by a human shall that person's blood be shed, for in his own image God made humankind" (NRSV). Taking the life of another person is very serious.

This is also emphasized in the sixth commandment. Exodus 20:13 says "You shall not murder." The sixth commandment forbids any wrongful taking of life and affirms that we honor God when we honor and protect

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[3] *Agenda for Synod 2000*, p. 430. Note that this report is heartily endorsed by our task force as an important statement on responsibility and community at the end of life and worthy of review.

[4] St. Athanasius, *On The Incarnation: De Incarnatione Verdi Dei* (New York: St. Vladimir's Seminary, 1996).

the lives of fellow human beings. In Matthew 5:21-23, Jesus expands this command to include any harboring of anger against a neighbor as well. So we understand that the sixth commandment not only forbids the taking of physical life but also prohibits anything that harms, endangers, or even belittles other people. Further, the sixth commandment in its prohibition of killing is also a call to promote the well-being and flourishing of others. John Calvin, in writing on the sixth commandment, said,

> The purpose of this commandment is: the Lord has bound mankind together by a certain unity; hence each man ought to concern himself with the safety of all. To sum up, then, all violence, injury, and any harmful thing at all that may injure our neighbor's body are forbidden to us. We are accordingly commanded, if we find anything of use to us in saving our neighbors' lives, faithfully to employ it; if there is anything that makes for their peace, to see to it; if anything harmful, to ward it off; if they are in any danger, to lend a helping hand.[5]

As Calvin illustrates, this command is not just about not ending life; it is also about protecting, promoting, and helping life, in whatever ways we can, to flourish.

The Christian value of life is distinct from that perceived by contemporary culture, where the value of one's life is self-reported and assessed on a rubric of quality of life that prioritizes autonomy, ability, wealth, and health. We, however, believe that the value of human life is intrinsic and enduring. The Anglican theologian Rowan Williams writes, "For the Christian disciple, human dignity—and therefore any notion of human rights—depends upon the recognition that every person is related to God before they are related to anything or anyone else."[6] So Christians are to honor all lives, our own and others, even when they look different or seem weak. The CCG writes that the value of human life "is not diminished by the physical or mental ravages of old age, disability, disease, accident, or deformity. We may not terminate life on the basis of any of these things, for doing so places us on a slippery slope of treating life as a disposable commodity when its apparent usefulness is lost" (*Agenda for Synod 2000,* pp. 444-45). We care for others, we receive care when we need it, and we make every effort to protect the lives of all people—especially those whom our culture may deem as less valuable, weak, or unworthy.

The inherent dignity and value of humanity is made most clear in the incarnation and the bodily resurrection of Jesus Christ. Jesus took on flesh and lived among us. Jesus was made like humanity in every way except that he was without sin (Heb. 2:17-18; 4:15). Jesus suffered pain, grieved loss, and experienced suffering in body and soul. Jesus died and was buried. And Jesus' bodily resurrection both affirms the goodness of the body and indicates

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[5] *Institutes of the Christian Religion,* 2.8.39.

[6] Rowan Williams, *Being Disciples: Essentials of the Christian Life* (Grand Rapids, Mich.: Eerdmans, 2016), p. 65.

that death is not the end. Indeed, Jesus' death and resurrection secured our redemption, affirmed the goodness of humanity, and sealed the promise that we belong—body and soul, in life and in death—to our faithful Savior, Jesus Christ (see Heidelberg Catechism, Q&A 1). The incarnation also shows us that we are not alone in our difficulties; Jesus is intimately aware of the suffering and challenges of being human.

B. Suffering

Trouble and suffering are part of being human, and our Lord Jesus is "a man of sorrows, and acquainted with grief" (Isa. 53:3, RSV). He knows suffering. Our good bodies, created by God, can be a source of pleasure and joy, but they also bring us trouble. Disability, disease, and pain change our bodies and the way we live our lives. In our lifespan we grow and develop, and we experience mortal and physical limits that are different for each person—for reasons that may be unclear to us. Suffering involves physical, psychological, and spiritual parts of ourselves, at many times and for many reasons throughout our lives—and often it accompanies the dying process.

We live in a world that urges us to avoid suffering at all costs. Our cultural impulse to flee or eliminate suffering can cause us to miss out on its formative work in our lives. We certainly don't pursue suffering for its sake, but suffering isn't meaningless. Suffering develops character and deepens our dependence on our heavenly Father and on each other. The apostle Paul states that "suffering produces perseverance; perseverance, character; and character, hope" (Rom. 5:3-4). This passage is not a celebration of pain but, rather, a recognition that even in suffering God is accomplishing his purposes in us. Indeed, Paul writes, at times we are "hard pressed on every side, but not crushed; perplexed, but not in despair; persecuted, but not abandoned; struck down, but not destroyed. We always carry around in our body the death of Jesus, so that the life of Jesus may also be revealed in our body" (2 Cor. 4:8-10).

Considering the issue of medically assisted suicide, the loss of autonomy is a significant source of suffering for many people. Ewan Goligher, a Christian physician in Canada, suggests that the suffering that most often leads people to seek out MAS is existential pain, loss of meaning, or other, nonphysical reasons—which government statistics confirm.[7] People wrestle with the loss of autonomy that illness, disability, and aging can bring. People fear being a burden to family or friends. Loved ones may find themselves uncomfortable witnessing the suffering of others, and they may project that concern on those who are suffering in a way that makes them consider ending life. People worry about how the end may come about, and they want control over the time and manner of their death. Understanding the reasons that people consider MAS can help us respond to their concerns.

[7] aaronrenn.com/p/dr-ewan-goligher-a-christian-response (accessed Dec. 6, 2024) and canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#a3.6 (accessed Jan. 3, 2025).

C. Addressing suffering: love, lament, liturgy

As Christians, we are called to respond to human suffering with compassion and care. We are called to *love one another*. Together, young and old, able-bodied and disabled, full of life and nearing death, we fix our eyes on Jesus, who "for the joy set before him . . . endured the cross, scorning its shame, and sat down at the right hand of the throne of God"; in our suffering we "consider him who endured such opposition from sinners, so that [we] will not grow weary and lose heart" (Heb. 12:1-3). We are members of the body of Christ: we belong to God, and we belong to one another. This "belonging to one another" is emphasized in the New Testament through "one another" commands:

- love one another (John 13:34)
- honor one another above yourselves (Rom. 12:10)
- care for one another (1 Cor. 12:25)
- be kind and compassionate to one another (Eph. 4:32)
- bear with one another (Col. 3:13)
- encourage one another (1 Thess. 5:11)
- bear one another's burdens (Gal. 6:2)

We may not be able to alleviate a particular cause of suffering or provide an explanation for the cause of suffering, but God invites us to find personal and practical ways to "carry each other's burdens and in this way . . . fulfill the law of Christ" (Gal. 6:2).[8] The love and help of community play a vital role in helping people who are suffering to persevere in faith. Providing presence and accompaniment can be a source of strength and encouragement, as this story from a CRC congregation demonstrates:

> When Mary was diagnosed with terminal cancer, she was concerned, especially because she did not have family members living locally. When her church family learned of her need, they stepped in, providing people with various skills to walk with her in her final weeks. The list of ready-to-help individuals included drivers who took her to doctor appointments, and nurses who helped trouble-shoot medical needs like bandaging and medication. There were people who loved to read who visited and read books to her when she became too weak to read on her own, and lifelong church friends who held her hand, wiped her brow, and sat with her in her final days.

Receiving a terminal diagnosis is very difficult. So is asking for help. It takes courage and confidence in the community to be vulnerable about needing support. When a person's needs and requests are heard and answered, the church lives into its calling to love one another. Unfortunately, in many situations that doesn't happen. Either those who are suffering are unable or unwilling to share their needs, or the community doesn't hear

[8] The CCG chose Galatians 6:2 as the guiding verse for its report on end-of-life issues. We strongly recommend this report for its explanation of how the church can build communities of care for people at the end of life (see *Agenda for Synod 2000,* pp. 425-48).

and respond. This can bring pain, loneliness, and isolation. We know that some readers will have experienced situations in which they have not cared for or been cared for by their brothers and sisters in Christ. We must pause, recognize, and repent of our individual and collective failures to love each other. And we must begin again, hearing God's call to love one another.

God's people are called to respond with compassion, presence, help, and action to correct unjust situations to alleviate suffering. As followers of Jesus, we care for the vulnerable and for people whom our society devalues or ignores (James 1:27). Christians address suffering by loving one another at a relational level, and we work to alleviate situations like poverty or disasters that bring about suffering. This is of particular importance concerning the issue of MAS because some people may pursue it due to a lack of access to resources that are needed in order to live with a diagnosis or disability. Suffering can be the result of unjust systems and cycles of poverty. Christians work tirelessly to break these oppressive systems to bring about shalom in society.

Our love and care for each other are crucial but inadequate responses to human suffering. When life is a burden and full of suffering, our situations warrant *lament*. Psalms of lament express pain that is physical or psychological, sharing an honest desire for suffering to end and showing trust in God's sovereign care. Lament shows us that God and God's people can hold space for deep feelings; suffering is not to be repressed or hidden. Psalm 13 says, "How long, LORD? Will you forget me forever? How long will you hide your face from me? How long must I wrestle with my thoughts and day after day have sorrow in my heart?. . . But I trust in your unfailing love; my heart rejoices in your salvation. I will sing the LORD's praise, for he has been good to me."

Psalm 88 is the darkest lament in the Bible. This particular psalm does not end with an expression of trust or praise but with the despair of the psalmist: "darkness is my closest friend" (Ps. 88:18). We do not always see the answers for our suffering or even an end to it, but we love and are loved by a God who welcomes even the darkest places of our lives into his presence in prayer. We cannot make another person's suffering meaningful to them, but we can urge them to persevere and encourage them when they despair, and through our presence we can remind them that our good God will not abandon them. Together we remember the promise "My heart and my flesh may fail, but God is the strength of my heart and my portion forever" (Ps. 73:26). Suffering and death do not have the last word, for "our light and momentary troubles are achieving for us a future glory that far outweighs them all" (2 Cor. 4:17).

Lament can be individual or communal, and churches should make space for both expressions of lament in the liturgy of their public worship services. Our weekly practice of communal worship gathers the community of believers who individually and collectively cry out in protest to God and

ask for his mercy. Suffering, death, and the dying process can be frightening to people because it seems unfamiliar, but perhaps it isn't as unfamiliar as people think. Christian liturgy teaches us how to live and how to die. Every time we gather around the baptismal font, we rehearse dying and rising with Christ. This regular liturgical practice deepens our faith for this life, but it also readies us for the resurrection that is still to come: "For if we have been united with him in a death like his, we will certainly also be united with him in a resurrection like his" (Rom. 6:5).

D. Medical care in the dying process

Uncontrolled pain or suffering is a situation that all human beings want to avoid. When facing suffering that is likely to worsen, or unlikely to resolve, there is a strong need for compassionate care, and the health-care system seeks to provide such care to people who are suffering. Palliative care and medically assisted suicide are two different solutions offered for the problem of intolerable suffering. However, the intent behind these offered solutions is quite different: whereas palliative care provides medicines and caring resources to optimize quality of life until a natural death, medically assisted suicide uses medicines to purposefully cause the death of a suffering individual who has chosen to die.

Medically assisted suicide follows established protocols to bring about the ending of one's life. A consenting individual who is suffering and wants to end their life seeks the assistance of the health-care system to do so. Depending on what is legal in one's jurisdiction, there may be the option of assisted suicide or euthanasia. In assisted suicide, medicines are prescribed, dispensed by a pharmacy, and self-administered; in euthanasia, a health-care worker administers a lethal injection via an intravenous line. Medication protocols in use are designed to bring a quick-and-painless end to life. Proponents of medically assisted suicide see it as allowing one to maintain control in dealing with immense suffering when illness or disability cause chaos, uncertainty, and fear.

Palliative care, in contrast, focuses on caring for a suffering individual until the natural end of their life. Palliative care brings together expertise from physicians, nurses, chaplains, social workers, personal support workers, and more with intent to optimize quality of life. Hospice care is health care that is focused on the last stage of life, when death is reasonably foreseeable. Palliative/hospice care can be provided in various settings, such as one's own home, a hospital, or a temporary or long-term care facility. Regardless, medicines and tools can be used capably to help with various symptoms one may experience in their suffering, such as pain, depression/anxiety, nausea/vomiting, bowel/bladder dysfunction, fatigue, shortness of breath, lack of appetite, changing cognitive function, or declining ability to take in food or water.

Thankfully, with modern palliative care it is rare for one's physical pain to be inadequately addressed. However, if pain cannot be helped while maintaining conscious awareness, palliative sedation can be used. Here, palliative-care providers use medications skillfully to induce a loss of consciousness, in much the same way that an anesthetist prevents conscious awareness of pain during a surgery. Though this entails a loss of consciousness, the intent remains the relief of suffering—not the ending of life. To be clear, if an individual dies while unconscious from palliative sedation, the cause is the underlying illness, not the sedatives used to provide comfort. This distinction has already been made in the CCG report (see *Agenda for Synod 2000*, p. 446).

As an example of palliative sedation, consider a patient with ALS[9] who is supported by a ventilator. Her nervous system no longer has capacity to breathe, so a machine pushes air into her body. The disease has progressed, and she can no longer communicate or feed herself. She had previously decided that she would not accept a feeding tube. After experiencing neurological decline for months, she and her family decide she is ready to stop using her life-support system. To avoid the experience of suffocation, her palliative physician provides medications that reduce air hunger and anxiety. She is provided sedation while her body succumbs to death due to her inability to breathe. This is a natural death, in which a health-care worker provides compassionate palliative support without the intent to kill, respecting the wishes of patient and family to stop receiving life-sustaining measures.

When confronted with an illness in which suffering is increasing, without expectation of cure, decisions must be made about whether to continue with life-prolonging treatment. One of the realities of modern health care is medicine's ability to prolong life without enhancing quality of life. This can make decision making about care options very difficult. A positive view of the value of life within the context of a loving community would not typically lead to early abandonment of all medical care. However, believers who have entrusted their life to Christ should not feel the need to pursue medically futile interventions but are free to decline treatment that is intended to prolong but not enhance one's life.

It is difficult to know ahead of time how we will feel and what we will want when there is a change in our health or ability. We may imagine a certain situation to be unbearable—but when it arrives, we may perhaps realize we were wrong. It can be helpful for patients to ask questions in order to fully understand available supports and treatments and discuss those matters with family members. Support from family and community can make difficult situations bearable. Ultimately, as believers, we entrust our lives to our

[9] Amyotrophic lateral sclerosis (ALS) is a disease in which the nervous system governing muscles progressively degenerates, commonly over months to years, leaving an individual fully conscious yet losing the ability to eat, speak, move, and, lastly, breathe.

heavenly Father, seeking his guidance each step of the way, knowing we have hope that extends into eternity.

IV. What about "passive euthanasia"?

Many people have the idea that euthanasia can be accomplished in two ways: first, by "active/voluntary euthanasia" and, second, by "passive euthanasia." This two-part categorization is inaccurate and can be misleading. To be clear, this task force understands *euthanasia* as synonymous with active/voluntary euthanasia: the health-care system's use of medicines to *intentionally cause death, to kill*. On the other hand, passive euthanasia is commonly used to denote *allowing one to die*, usually by declining some level of medical treatment and/or by accepting some level of palliative treatment. "Passive euthanasia" is therefore a misnomer. As a task force, we would unambiguously state that the health-care system should never euthanize people, whereas it should support a person in declining a certain level of medical treatment or in receiving palliative care, in which there is no intent to kill.

Another situation that is sometimes termed "passive euthanasia" and deserves comment is when an individual decides to end their life by declining food and water. In this kind of situation, the context matters. If the individual has accepted a terminal condition, and further nourishment holds little value in sustaining their life, it is quite acceptable to refrain from intake—as is common near the end of life. However, if an individual is overwhelmed by despair and suffering and seeks a means to end it, even without medicines—that is a time to turn to the Lord and his people and thereby find strength to carry on.

Certainly the distinctions described here may be considered a fine line, but the line is real, and most thoughtful Christians who wish to be obedient will, at some point in their lives, have to make decisions involving that fine line. This is not merely a theoretical matter. (See Appendix C for more information on making health-care decisions.)

V. Disability

Medically assisted suicide is not just an end-of-life issue, it is a disability issue. In Canada, "Track 2" MAS allows people whose death is not reasonably foreseeable to access MAS simply on the condition that they have a disability and are suffering. Since we view life as precious, a gift of God and not diminished by age, disability, and disease, "Track 2" MAS involves an alarming devaluation of people who are every bit as valuable as nondisabled people.

People with disabilities experience barriers to participation in community in various ways and situations. The added cost in time and resources to gain inclusion can be weighty, especially when not borne by the larger community/society. Wheelchair users, and those who use assistive devices like a walker or cane, are excluded from physical spaces without ramp or elevator access. People with a hearing impairment or sensory disabilities are

largely excluded from social connection. People with disabilities have more medical and therapy appointments; they have higher costs for adaptive equipment and medication. People with cognitive disabilities are treated as children and experience prejudice based on their disability. In Canada 27 percent of people age 15 and above have a disability.[10] In the United States the CDC reports that 28.7 percent of adults have a disability.[11] Social isolation is a source of significant suffering for people with disabilities.

The church must respond prophetically in a society where people with disabilities are devalued and experience higher rates of social isolation and poverty. First, we must work to understand the disabled experience. Second, we must break down barriers to participation in our churches and across society to reduce social isolation. The work of accessibility and community will shape disabled and nondisabled people to be together in a practical and powerful demonstration of the preciousness of all human life. To be pro-life is to be pro-disabled people.

As Christians, we are called to care for one another. We are usually quite good at embracing this as a Christian duty: we serve and give generously to others. Active doers and fixers, however, can find it very challenging to receive care when they need it. This should spark an important reimagining of the dignity of care: we value life when we give *and* receive care. While disability will likely touch all of our lives, most people do not think about, or prepare for, becoming disabled. As people of faith, is our view of the preciousness of human life robust enough for us to love ourselves when we experience disability personally?

VI. Pastoral Care

When people experience suffering, they don't often need more answers or dogma, they need *people* who can be present with them in their distress, *people* who can hear their questions without becoming anxious, *fellow brothers and sisters in Christ* who can help them "find strength in God" (1 Sam. 23:16). As pastors and leaders in the church, we have the opportunity to walk with people in matters of life and death.

Each person's situation is unique, informed by a person's own experiences and resources, and therefore the pastoral response must also be deeply personal. People find themselves in all kinds of situations and for a variety of reasons may wonder about or even pursue MAS. The Christian community is uniquely gifted to respond to and care for people who are hurting. In life and in death we belong to God, and we also belong to one another. This belonging compels us to care well for those facing suffering, disability, end of life, and any other situation that may lead them to consider MAS.

[10]statcan.gc.ca/o1/en/plus/5980-disability-rate-canada-increased-2022 (accessed Dec. 6, 2024)
[11]cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html (accessed Dec. 6, 2024)

A. The power of presence

The Bible teaches us the importance of being present with people who are suffering, spending time with them, giving them our full attention, listening without judgment, absorbing some of their pain. As the apostle Paul writes, "Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God" (2 Cor. 1:3-4). The book *Compassion: A Reflection on the Christian Life* offers this reflection regarding the gift of Christian community:

> In Christian community we gather in the name of Christ and thus experience him in the midst of a suffering world [suffering people]. There our old, weak minds, which are unable to fully perceive the pains of the world, are transformed into the mind of Christ, to whom nothing human is alien. In community, we are no longer a mass of helpless individuals, but are transformed into one people of God.[12]

Visiting people is a crucial practice for the individual and the church. Pastoral presence can strengthen and encourage. A calm demeanor can help reduce anxiety in a room and connect people who are unable to attend church gatherings. We have provided a document in Appendix B that can be used to equip lay leaders in pastoral visits, especially to those who are suffering and dying.

B. Perseverance in suffering

God has a purpose for our suffering that is not always known to us. Whether or not we understand the purpose for our own or other people's suffering, we respond with love, lament, and liturgy, drawing people further into relationship with God and others.

The first question of the Heidelberg Catechism asks, "What is your only comfort in life and in death?" And the answer, of course, is belonging. In life and in death we belong to our faithful Savior, Jesus Christ. We are not the masters of our own destinies but beloved children, kept and cared for by our heavenly Father, who knows the number of our days and the hairs on our heads.

Even when we suffer, we can trust the Lord's timing with our lives, because we trust that he is good. We serve a Shepherd who promises never to leave us and who will surely be with us even in the valley of the shadow of death. God's pervasive and tender care gives comfort and courage for all seasons of life and enables us to persevere, even in the uncertainty or fear we may feel about dying.

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[12] Henri J. M. Nouwen, Donald P. McNeill, and Douglas A. Morrison, *Compassion: A Reflection on the Christian Life* (PRH Christian Publishing, 2006), p. 54

C. Protection of life

All people are created in the image of God. We are called to protect the lives of vulnerable people. Our bias ought always to be for life; however, we also acknowledge that sometimes harm is done when life is needlessly extended. In our protection of life we must walk compassionately with people as they consider whether or not they wish to begin or continue a treatment that may prolong life but also increase suffering—or merely prolong life but with diminished quality. As Christians, we can count it a privilege to walk with people through these hard places and to bear witness to the gift of life and the hope of our life to come.

D. Promise of the gospel

The Bible teaches that those who believe in Jesus as Savior will spend eternity with him. No distinction is made regarding the cause of a person's death. While the Bible affirms the goodness of this life, it also points us forward to the life yet to come. For many people, waiting for death is difficult, but we believe that the answer to such struggle is not an expedited death but an empowered perseverance, made possible by the sustaining hand of our loving heavenly Father and the hope of the resurrection (1 Cor. 15). We wait for death in hope, trusting that "the one who raised the Lord Jesus from the dead will also raise us with Jesus and present us . . . to himself" (2 Cor. 4:14). Peace is not found in controlling how or when the end comes about, but in the One who is with us always and who promises to receive us into his kingdom with this gracious invitation: "Well done, good and faithful servant! . . . Come and share your master's happiness!" (Matt. 25:21).

VII. What do I say/do when my parishioners ask about medically assisted suicide?

- Listen and then listen some more.
- Refrain from the need to give your own thoughts or answers right away.
- Help them explore their own feelings. What underlying fear may be at work?
- Ask about family involvement. Have they shared with family? Is there family pressure?
- Consider access to resources. Discern whether the decision being made is due to lack of financial resources or concern about the cost or burden of care.
- Encourage other options (hospice, palliative care).
- Share Christian perspective—honor the preciousness of life.
- Keep showing up and involve other people from the faith community to provide consistent presence/care.

VIII. After a death by medically assisted suicide has occurred

In many ways, a funeral after MAS will be like any other funeral and its planning. It will require sensitivity to different dynamics at play, attentiveness to how loved ones are processing the loss, and a commitment to pointing people to the hope of glory. Romans 8 makes clear that there is nothing in all creation that can separate us from the love of God: neither life nor death. When caring for grieving family members or preparing for a funeral for someone who died by MAS, we believe that all the promises of God are still true. We hold on to the promise that nothing in all creation can separate us from the love of God (Rom. 8:38-39); that God is gracious and compassionate, slow to anger, and plenteous in mercy (Ps. 103:8); and that salvation is by grace alone, through faith, and comes to us as a gift from God (Eph. 2:8-9). A funeral is not the time to cast judgment on a person who has died by MAS, or on their family. Rather, a funeral is a service intended to help a family give thanks to God for the earthly life of a person, to say goodbye and grieve their death, to commend or entrust a person to God's care, and to turn in hope to the promise of 1 Corinthians 15:54—that, because of Jesus, death has been swallowed up in victory.

With the prevalence of MAS in our culture, some people in your congregation may, despite their beliefs, be involved in caring for people who pursue MAS. Physicians have colleagues to whom they refer patients for MAS in order to avoid the moral conflict of participating in MAS. However, a referral is understood as facilitating or supporting the intended path of care for a patient; abstaining from even such limited participation is advisable. Conscientious objection must be protected and supported in spheres where MAS is legislated and supported. Health-care workers may experience moral injury, the emotional harm that comes from working with people who choose MAS. This harm may present itself as compassion fatigue or as desensitization to the dying process. The Christian community should provide support for persons experiencing moral injury. We should also support family members who disagree with a loved one's decision to pursue MAS and who feel hurt and helpless as they watch their loved one die by lethal means.

IX. Conclusion

Across North America many people can request help from a health-care worker to end their life. As medically assisted suicide is legalized in more jurisdictions, we see the number of deaths by MAS increase. Medically assisted suicide is often framed as a type of tragic yet beautiful choice, as a kind of compassionate protection for people—protection from suffering, pain, or disability. Given the growing availability and endorsement of medically assisted suicide, how should Christians think about this matter biblically, within the medical context, and in support of practical Christian living?

The Christian understanding of life is rooted in the incarnational vision given to us in Scripture and exemplified in Christ: life is a gift by the grace

of God. Made in his image, human beings are bestowed special honor by God, who deeply desires to be close to us. We view our lives and all human life as precious. "Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your bodies" (1 Cor. 6:19-20). Receiving a terminal diagnosis is very difficult; the decisions for care and treatment are individual and challenging. In these difficult moments, we affirm that life is precious, so we should not act to end life. Human dignity and value are enduring and intrinsic. Disease and disability do not diminish our value—and in all stages of our lives, we belong to God and to each other. We ask for help, and we give and receive care as our Lord Jesus has shown us.

Our commitment to honoring the preciousness of life is a communal practice. We commit to love one another. Someone who is suffering remains a temple of the Holy Spirit—that is, someone to care for, to comfort, and to love, not to kill. Just as the Lord ministered to Job, Moses, and Elijah in their despair, uniquely providing for each of their needs when they wished to die, so we should minister to people who have lost the will to live. By our loving presence and caring for their practical needs, we can remind suffering souls of their worth as creatures loved by God, with whom God is *actually*—not metaphorically—present.

Though we do not always understand the purpose of suffering, the Christian response to suffering is love, lament, and liturgy. Our inclination is toward life, and we do not act to end a life intentionally—yet we do not idolize life as if this life is all there is. We do not fear death; we wait for death in hope, trusting that "the one who raised Jesus from the dead will also raise us with Jesus. . . . Though outwardly we are wasting away, yet inwardly we are being renewed day by day" (2 Cor. 4:14, 16).

X. Recommendations

A. That synod affirm the value of human life as a gift from God, intrinsic and enduring, recognizing that, as Christians, we are to honor and care for all lives—our own and others—especially in suffering and despair.

B. That synod remind CRC members, churches, and classes, in accordance with prior synodical reflections, that the appropriate Christian response to suffering, disability, and/or dying people (and their families) is pastoral, including compassionate palliative care instead of acting to cause death (*Acts of Synod 2000*, pp. 686, 707-8).

C. That synod instruct all CRC members to make every effort to ensure that meeting spaces and programming are accessible so that our churches are prophetic witnesses that disability, disease, and deformity do not diminish the value and dignity of every human (*Acts of Synod 1985*, pp. 348-52, 490, 702-3, 825; *Acts of Synod 1993*, pp. 381-405, 539, 542-43; *Acts of Synod 2011*, p. 817).

D. That synod encourage classes to occasionally provide workshops and training on end-of-life issues such as palliative/hospice care, estate planning, and communicating one's values for care to their health-care proxy.

E. That synod recommend the list of resources appended to this report as helpful resources for members and leaders navigating suffering and/or the end of life.

F. That synod encourage pastors and church leadership teams to develop and share with local CRC churches a list of reputable local palliative/hospice-care organizations so that they can better support the members in their community in the dying process.

G. That synod encourage the churches to provide training and resources to people involved in pastoral care for congregations and communities, such as found in Appendix B of this report.

H. That synod remind CRC members to give generously of their time, treasure, and talents to work that supports people who are vulnerable and suffering, and to support the work of civil government to provide compassionate care so that those who are suffering and vulnerable do not feel pressured to end their lives.

I. That synod recommit to engagement with public policy makers in advocating for hospice and palliative care that is readily available for every person in their jurisdiction.

J. That synod commend to the churches the report of this task force as a faithful response to the reality of medically assisted suicide in our time.

Assisted Suicide Task Force

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Brian Dijkema
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APPENDIX A

Medically Assisted Suicide Today

Opinions on euthanasia in Canada have altered significantly in the past forty years, and this is true within various legal, medical, and other bodies. In 1983 the Law Reform Commission of Canada concluded that neither active euthanasia nor aiding suicide should be legalized, and it recommended retention of the present law (which deemed such actions criminal).[13] Likewise, in 1995, the Canadian Medical Association (which represents doctors in Canada) issued a summary of its policy, saying that CMA members "should not participate in euthanasia and assisted suicide," a policy that was withheld as recently as 2014.[14] However, while both of these major institutions rejected euthanasia and assisted suicide, a review of legal bills and media showed a concerted effort to legalize these practices, as well as an increasing push to normalize them through law and public discourse.[15] In public opinion polls, there has also been a gradual shift toward greater acceptance of euthanasia, some of which was informed by negative experiences regarding the quality of care received by loved ones at their death.[16]

The shift in Canada was driven by a powerful lobby group called Death with Dignity. Individual patients who wanted a medically assisted death put forward legal challenges, with support from some physicians. There were numerous court cases in various jurisdictions that called for the decriminalization of the killing of terminally ill patients. A landmark decision in Canada involved the case of Sue Rodriguez, a British Columbia woman suffering from ALS, who sought to end her life with the assistance of a physician. This activity was deemed criminal under s. 241(b) of the Criminal Code that prohibited assisting someone to die by suicide. Rodriguez claimed the section was unconstitutional, but this claim was defeated by the court. The September 1993 decision upheld the constitutionality of s. 241(b), and assisted suicide remained a criminal act.[17]

While that law was upheld nationally in Canada at that time, various subnational jurisdictions introduced commissions and eventually laws, which attempted to allow for physicians to end the lives of patients who meet certain criteria. After various commissions and committees studied the issue, the Quebec National Assembly introduced (in June 2013) and passed (in June 2014) Bill 52. Despite the existing criminal prohibitions, the province's legislation established rights and rules for "end-of-life care," which included—although not exclusively—"medical aid in dying." MAiD, under

[13] canada.ca/content/dam/lcc-cdc/documents/lrcc-reports/J31-40-1983-eng.pdf
[14] consciencelaws.org/archive/documents/cma-cmaj/2014-06-CMA-euthanasia-policy-correct.pdf
[15] publications.gc.ca/Pilot/LoPBdP/CIR/919-e.htm
[16] angusreid.org/assisted-suicide/
[17] publications.gc.ca/Collection-R/LoPBdP/BP/bp349-e.htm

Bill 52, was restricted to those "at the end of life" but required all provincially funded hospitals and nursing homes to provide MAiD and required physicians unwilling to perform MAiD to provide referrals.

This national expansion is also present in Canada where a Supreme Court decision in February 2015 (the Carter decision) unanimously ruled that two sections of the Criminal Code (which applies in all jurisdictions) related to consenting to death (s. 14) and aiding suicide (s. 241(1)(b)) were unconstitutional because they prevented competent adults from being able to die with the assistance of a clinician. The court's ruling effectively required that physician-assisted death be permitted in some form, and the court gave federal and provincial governments a total of 16 months to determine the legislative and regulatory details.[18] The Carter decision limited its consideration to those suffering intolerably from a "grievous and irremediable medical condition (including an illness, disease, or disability)." The decision explicitly excluded considerations of assisted death for minors, mental illness, and less serious medical issues.[19]

In effect, this decision required Parliament to decriminalize, for those administering MAiD, the otherwise criminal limitations that prevent murderers from claiming that their victims consented to dying and that prevent individuals from aiding someone to die by suicide. It is critical to note that the Supreme Court of Canada decision did not recognize a blanket, or basic human, right to euthanasia or MAiD but limited it to the conditions noted above.

Since that time, some restrictions on MAiD have been removed. This has occurred through the Trunchon decision in September 2019, and the subsequent legislation, Bill C-7, which introduced Track 2 MaiD. This new track removed the limit that restricted MAiD to a "reasonably foreseeable natural death" in some situations. People with disabilities and serious medical conditions who are suffering can apply for Track 2 MAiD when their death is not reasonably foreseeable. While the court challenges that paved the way for Track 2 were brought by individuals with disabilities, there has been an outcry from the disabled community[20] in Canada and the United Nations Special Rapporteur on the rights of persons with disabilities.[21] Unfortunately this outcry was diminished by the outbreak of COVID-19 and the ensuing health crisis that disproportionately affected disabled people. Track 2 MAiD devalues disabled persons' lives because it supports and facilitates their suicide—not because their death is reasonably foreseeable but because they have a disability. For a suffering person whose death is not reasonably foreseeable, they will not qualify for MAiD in Canada.

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[18] justice.gc.ca/eng/cj-jp/ad-am/scc-csc.html

[19] justice.gc.ca/eng/rp-pr/other-autre/ad-am/p1.html#fn7 (Carter, supra note 1 at para. 127)

[20] For a detailed overview of the response from the disabled community to MAiD, see Catherine Frazee, "MAID resistance in Canada: Sounding the Five-Minute Entreaty."

[21] documents.un.org/doc/undoc/gen/g19/348/81/pdf/g1934881.pdf (p. 13)

The Canadian federal government is also set to expand MAiD in 2027 to those whose sole condition is mental illness,[22] and there are calls for MAiD to be expanded to allow for "mature minors" who are children under the age of 18 to be euthanized.[23]

Several American states have passed various forms of physician-assisted suicide or euthanasia, with various levels of restrictions and allowances, including Oregon (1997), Washington (2009), Montana (2009), California (2016), Colorado (2016), New Mexico (2021), Vermont (2013), Maine (2019), Hawaii (2018), and New Jersey (2019). At the time of this writing, there are also other states with pending bills seeking to legalize physician-assisted suicide or euthanasia.

While policy surrounding this issue is worked out at the state level in the United States, a 2022 settlement of a federal lawsuit has effectively removed restrictions that limit physician-assisted suicide to residents of Oregon, and MAS is therefore now accessible to those who are not residents of the state.

In short, the legal, legislative, and policy environment surrounding euthanasia has drastically changed since the synodical study of 2000. In addition, the cultural acceptance of euthanasia has also widened, with one Canadian study showing that "four-in-five" Canadians (80%) now say it should be easier to make their own end-of-life decisions, compared to nearly three-quarters (73%) in 2016. This is in comparison to one in five who say there should be greater restrictions to doctor-assisted dying procedures.[24] This relatively strong support is also mirrored in American society.[25]

The theoretical support for euthanasia changes significantly, however, when it is described in greater detail,[26] when it applies to persons with mental illness, or when it is understood as a replacement for palliative care or for greater investment in health care.[27] It is notable that "62% of Canadians attach a lot of importance to the possibility that the public health-care system will begin to ignore long-term care and chronic disease in elderly people as MAiD becomes more available."[28] Canadians were also deeply concerned that MAiD would deprioritize, or even replace, funding for palliative care and other medical investments.[29]

These concerns appear to be legitimate, as government authorities have studied and found significant cost savings to the medical system as a result

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[22] justice.gc.ca/eng/cj-jp/ad-am/bk-di.html
[23] dyingwithdignity.ca/advocacy/mature-minors/#:~:text=Canada's%20law%20on%20medical%20assistance,or%20refuse%20lifesaving%20medical%20treatment
[24] angusreid.org/social-values-canada/
[25] news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx
[26] ropercenter.cornell.edu/polling-choices-end-life
[27] cardus.ca/research/health/reports/broad-support-for-maid-in-canada-has-caveats-and-concerns/
[28] cardus.ca/research/health/reports/broad-support-for-maid-in-canada-has-caveats-and-concerns/
[29] *Ibid*.

of the expansion of MAiD, and there are already calls for MAiD expansion to relieve the burden of care for elderly, disabled, and other suffering people.[30]

In Canada, MAiD has quickly risen to become the fourth leading cause of death,[31] and the trend in the proportion of MAID requests considered ineligible continues to drop, year over year. In 2019, Health Canada reported 8 percent of requests were found ineligible,[32] dropping to 4.1 percent in 2021 and just 3.5 percent in 2022.[33] While some might point to the fact that California (a state whose population is almost the same as Canada's), where restrictions on who is eligible for euthanasia are stricter and which has one-tenth the death rate by euthanasia of Canada,[34] suggests that it is possible to "manage" these deaths, advocates consider Canada's permissive regime to be ideal.[35]

Our current context is very different from the context at the turn of the century. With some difference in eligibility and process in Canada and in some U.S. states, a medically assisted suicide is accessible to nearly all people in Canada and the U.S. In Canada, MAiD is not limited to a reasonably foreseeable death, people with disabilities can access a medically assisted suicide, and people are choosing to end their lives with the help of physicians at a shocking rate. Further, public attitude and dialogue have accepted medically assisted suicide as an understandable and acceptable choice.

APPENDIX B

Pastoral Care and the Dying Process: Bible Verses, Hymns, and Prayers for Visiting

Note: We have developed this appendix as a tool to equip lay leaders and persons who have limited experienced with pastoral care at the end of life. Pastoral care is the practical outpouring of our theological commitment to the preciousness of life, the acknowledgement that life can be very difficult and that lament and compassionate action are the correct responses to the difficulties of life. Our dream is that all churches may be filled with skilled pastoral caregivers who accompany and strengthen those who are suffering

[30] "Cost Estimate for Bill C-7 'Medical Assistance in Dying,'" Office of the Parliamentary Budget Officer, October 20, 2020; pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-025-M/RP-2021-025-M_en.pdf.

[31] canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html

[32] *Ibid*.

[33] cardus.ca/in-the-news/media-coverage/skyrocketing-maid-deaths-must-prompt-urgent-reassessment/

[34] tandfonline.com/doi/full/10.1080/15265161.2023.2201190

[35] See deathwithdignity.org/about, which states, "Our goal is to ensure people with terminal illness can *decide for themselves what a good death means* in accordance with their values and beliefs."

and dying. We suggest adding a list of hospices and grief and patient support groups that are available in your community context.

Introduction

When people experience suffering, they usually don't need more answers or dogma. *They need people* who can be present with them in their distress. They need people who can hear their questions without becoming anxious. They need brothers and sisters in Christ who can help them "find strength in God" (1 Sam. 23:16). As pastors and leaders in the church, we have the opportunity to walk with people in matters of life and death. Pastoral care is about the power of presence, perseverance in suffering, the protection of life, and the promise of the gospel (see section VI of this report).

As spiritual caregivers, we have the remarkable privilege of walking with people through many seasons of life. This includes the end of earthly life. God calls us to carry each other's burdens and invites us to make Christ's presence known through our presence with people. This is a joyful and holy calling, but it can be painful and difficult at times. Words may fail, and we may struggle to know what to do in response to a person's suffering. As spiritual caregivers, we may hear people speak of their desire to die, a desire that is especially common among the elderly and persons who are suffering. We cannot, however, support the taking of life.

People in your congregation may choose not to share their medical conditions with you, so it may be difficult to figure out how to be helpful. If you visit often, they may be more willing to take you into their confidence. You could ask, however, "Given what you know now, when you think about the future, what matters to you? What is most important for us to focus on?" People may have goals of attending weddings or graduations, saying final goodbyes to certain family members, asking for or offering forgiveness, reaching milestone birthdays or anniversaries. Some people just want to revisit an old family farm, or to go to see a lake one last time. Your congregation may be able to facilitate reaching some of those goals. People who are dying often wish to feel closure about various aspects of their lives. If you have developed a close relationship with the person, you may try exploring some of these thoughts with them.

Understanding the dying process

Sometimes death comes abruptly. However, in many cases death is a slow process. It is helpful for elders, deacons, and other visitors to understand the dying process. Common symptoms at the end of life may include pain, nausea/vomiting, difficulties with bowel and bladder function, fatigue, shortness of breath, reduced appetite, depression/anxiety, reduced cognitive function, and/or changing abilities to take in food or water. Health-care workers care for such symptoms by using devices (feeding tube, IV-line, bladder catheter) and medications (pain reliever, antinauseant, laxative, antidepressant) to optimize function and to relieve suffering. These tools may

come with side effects and secondary outcomes that may or may not be desired. There are a series of decisions to be made in this process. It is important to ask questions and to fully understand the treatment and symptom management options, especially as some interventions (like a long-term feeding tube) can prolong life significantly when that may not be helpful or desirable.

At a certain point, providing further nourishment or hydration to a body that is dying is no longer fruitful, so an IV-line or feeding tube can be discontinued. Medications that have been taken for long-term prevention or for the management of a chronic illness can be stopped. When someone can no longer swallow, medications are often administered directly under the skin (subcutaneously) or as a suppository. Decisions to refuse treatment are difficult—often more difficult for family members and caring community members than for the patient. Open and clear communication is important.

Where pain figures prominently, various medications can be used. After optimizing the environment (positioning, pillows, temperature, noise, lighting, etc.), medications targeting the type of pain experienced should be offered (nerve pain, bone pain, joint pain, organ pain). Narcotic pain relievers work by blocking pain signals from the body's receptors. When used carefully, narcotics are very helpful to relieve pain—but may have side effects such as nausea, sedation, or constipation. If one becomes anxious or agitated, a sedative can be helpful.

As a person dies, their organs gradually shut down. The process can occur rapidly over minutes or hours, or it can take days—even weeks. There are periods of reduced consciousness when there may be little to no responsiveness to external stimuli. Often there are also "rally" periods in which an individual may seem to improve or even partially recover. Loved ones can use such times for making meaningful connections. As this time of "twilight" progresses, limbs may become cool, swollen, and "mottled." Breathing can speed up, then slow, with longer pauses between breaths. An individual may reach out as if to connect with someone or something. Maintaining physical presence and speaking to the person dying are encouraged because a person's sense of hearing often remains intact until the end. Singing or reading of Scripture can be particularly comforting. Death is confirmed when a health-care worker determines that breathing and a heartbeat are no longer present.

Suggestions for visiting aging, terminally ill, and critically injured persons

- Check in on and tend to your own feelings prior to the visit so that you can be a nonanxious presence during your visit.
- Prepare to share a couple of Scriptures ahead of time that may fit for the particular situation. Trust the Holy Spirit to lead you in sharing those Scriptures appropriately, and don't be driven by your own agenda.

- Be respectful of the person's bed or chair; they are an extension of the person's personal space. Be mindful that they have lost control of most aspects of their lives and long to control some small things. If possible, sit in a chair that will bring your eye level below theirs; this gives them a feeling of more control.
- If you know your visit must be short, sit down briefly if you can, because the visit is likely to feel longer that way.
- Acknowledge the person's fears, pain, or uncertainty and offer your presence with them in it. A person's pain is what they say it is, so do not try to diminish their experience.
- Listen attentively and without judgment. We often feel the need to comment or give advice; staying silent requires self-discipline. If you feel that you need to comment, words such as "That must be so difficult" or "I wish I could make it all go away" might be helpful responses.
- Consider whether the person is able to communicate their wishes.
- If you pray with them, name their fears/laments in prayer, reminding them that they can bring all things to God in prayer, including their desire to die and for their suffering to end. Remember that when you pray, you are modeling how they and their supporters can pray.
- If family members are present while you visit, invite them to join you in praying, singing, or reading Scripture. Acknowledge their concerns. A comment that may elicit discussion: "It's really hard to hear your loved one talk about dying, isn't it?" Sometimes a family member may use your visit as an opportunity for respite, which can also be a gift/encouragement to them. Don't be offended if they leave the room for a break.
- When the visit draws to a close, ask if there is anything the person needs. Sometimes moving some dirty dishes out of sight or getting a book from across the room can be a great help. Little courtesies, such as leaving the door ajar to their liking, show your care.
- Commit to continuing to walk with the person on regular visits, and follow through on that promise. If you are unable to provide regular visits, consider connecting the person with another church member who is able to show up on a regular basis. It may be helpful for both you and the other visitor to meet together with the person a time or two during the transition.
- Remember that your visit is confidential. Be careful not to share with others any personal details about your visit.
- Don't overstay your welcome. People may want to please you by maintaining a welcome posture, but they may tire easily and need to rest.

Helpful Scriptures to use when visiting someone who is suffering

Deuteronomy 31:8	Psalm 91	2 Corinthians 1:3-4
Deuteronomy 33:27	Psalm 116:1-7	2 Corinthians 4:7-11
Joshua 1:8-9	Psalm 121	2 Corinthians 4:16-18
Job 19:23-27	Isaiah 40:31	Philippians 1:19-29
Psalm 34:18	Isaiah 41:8-10	Hebrews 6:19
Psalm 56:3-8	Isaiah 43:1-3	Hebrews 10:22-23
Psalm 57:1	Matthew 5:4	Hebrews 12:1-3
Psalm 61:1-2	Matthew 11:28-30	James 1:2-4
Psalm 62:1-6	John 14:26-27	1 Peter 5:6-10:6
Psalm 70:5	Romans 5:1-5	Revelation 21:1-4
Psalm 73:23-26	Romans 8:37-39	
Psalm 90	1 Corinthians 15: 51-58	

Hymns

Hymns bring spiritual encouragement. Their lyrics and the melody call us to faith and can connect us to the worshiping body when we cannot attend worship services. When words fail, sing a song or simply play the music. The songs below are some options that may be appropriate.

Be Still, My Soul
By the Sea of Crystal
Children of the Heavenly Father
For All the Saints
Great Is Thy Faithfulness
He Leadeth Me
How Firm a Foundation
In Christ Alone
I Sought the Lord, and Afterward I Knew
Nearer, Still Nearer
Praise God, from Whom All Blessings Flow
Precious Lord, Take My Hand
The Lord's My Shepherd
When Peace like a River

APPENDIX C

Information about Making Health-Care Decisions

Who Decides?

At present, state governments in the United States and provincial governments in Canada generally allow only an individual person, whether directly or by proxy when the individual lacks capacity, to make nearly all end-of-life decisions.

There are exceptions, of course. Parents are legally designated to make such decisions for minor children. And adults are granted the legal right to name proxies to make decisions for them when they are incapacitated. Where no proxies have been designated (or no designated proxy is willing and able), most various governments have passed differing laws that designate which relatives (in what priority) can make the decisions. And finally, when an individual has made no proxy designations and there is no willing/able family member, the court can appoint a guardian (who is really an agent of the government) to make decisions.

Special note should be made that, at present, at least, and in most if not all jurisdictions, the right to request medically assisted death (or "death with dignity") must be made by the individual while competent and cannot be made by a proxy. The laws on this issue may change in the future.

How Are Decisions Made?

As indicated above, in all U.S. states and Canadian provinces, a competent adult is the presumed decision maker as to his/her own health (medical) care, whether those questions involve end-of-life issues or otherwise, and a parent is presumed the decision maker as to his/her minor child's health (medical) care, although there is a growing list of exceptions to that rule (e.g., abortion, gender-change surgery, etc., where some jurisdictions allow minors to make decisions without consent or even their parents' knowledge).

However, the specific means by which an adult designates a proxy to make such decisions for them varies by state and province.

In some U.S. states, the legislature has created specific written forms for use to name a proxy. In other U.S. states, the legislatures have allowed for the designations of proxies but have not provided any particular form for doing so, leaving it up to individuals (or attorneys or some internet site) to provide the form. And yet in other U.S. states, the designation of a proxy can also be verbal (not a method to be advised). In Canadian provinces, the governments publish forms as resources but generally do not require the use of those forms.

There is also the matter of terminology. Depending on the state/province, the phrase "health-care proxy" may be replaced by "health-care representative" or "health-care decision maker" or "holder of a health-care power of attorney" or some other phrase, like "attorney for personal care."

The name of the document used to appoint a proxy also may differ according to the state or province. Names used include "advance directive" (perhaps the most common), "power of attorney for health care," "medical power of attorney," and "powers of attorney for personal care."

There is also a document called a Physician's Orders for Life Sustaining Treatment (POLST), usually used as one's end of life is imminent (beyond just a possibility). Do Not Resuscitate (DNR) orders are often part of the POLST provisions.

It is important to note that a "general power of attorney" (sometimes called a "financial power of attorney" or "continuing power of attorney for property") is usually not regarded as a document that gives medical proxy authority, even if the language used in such a document may seem to be an all-inclusive grant of power from the person signing the document to the person being granted the power. It is typical that medical/health making power must be granted by a document that only deals with medical/health matters. Certainly that would be the case in those jurisdictions that prescribe the specific form to be used to designate medical/health proxies.

Use of Advanced Requests in Medically Assisted Deaths in Canada

In Canada the legal framework for the use of advanced requests in medical assistance in dying (MAiD) is continually evolving. Some provinces are taking steps to implement these requests under specific conditions. Advanced requests allow individuals to outline their wishes for MAiD in the event they lose the capacity to consent at the time of administration, which is the current federal standard.

Canada's federal MAiD law, amended in March 2021, allows for two main pathways:

1. For those whose natural death is reasonably foreseeable, a simplified process applies.
2. For those whose death is not foreseeable, additional safeguards are required.

However, at present, the federal law does not explicitly permit advanced requests for MAiD except under Quebec's new regulations or in specific, provincially legislated cases. Most provinces, such as British Columbia, Ontario, and Alberta, continue to follow the federal guidelines, which do not yet encompass advanced requests. However, those provinces are closely monitoring Quebec's framework and the broader national dialogue on the issue.

Quebec is the first Canadian jurisdiction to allow for the use of advanced requests for MAiD. An advance request for MAiD is different from an advance medical directive. Advance medical directives allow individuals to state what medical care they would accept or refuse in specific situations if they become incapable, but those directives do not cover MAiD. In order to utilize an advanced request, the person must have a serious and incurable

illness that will lead to incapacity to consent to care. At the time of the request, the individual must be of full age and capable of giving consent to care, meaning they understand their medical situation and can clearly communicate their wishes. The request must be made freely, without external pressure, and must be fully informed.

The individual must consult with a physician or specialized nurse practitioner to obtain the advance request form, which is available only through these professionals. While not mandatory, individuals may designate one or two trusted persons to ensure that their wishes are known and respected when they become incapable of consenting. The request must detail specific clinical manifestations associated with the illness. These manifestations will serve as indicators for when MAiD should be administered after the individual loses capacity. The completed request must be signed in the presence of the physician or specialized nurse practitioner, two witnesses (unless made by notarial act), and any designated trusted third persons. The advance request must be recorded in a legally provided register by the physician, specialized nurse practitioner, or notary. Only the registered request is considered valid.

An individual who remains capable of consenting to care can also withdraw or modify their advance request at any time by consulting with a physician or specialized nurse practitioner, who will ensure that the changes are properly documented and updated in the register.

For MAiD to be administered on the basis of an advance request, several conditions must be met, including the following:

- The individual must exhibit, on a recurring basis, the clinical manifestations related to their illness as described in their request.
- They must be in a state of advanced, irreversible decline in capability.
- A competent professional must determine that the individual is experiencing enduring and unbearable physical or psychological suffering that cannot be relieved under conditions considered tolerable.
- A second independent physician or specialized nurse practitioner must also confirm that all criteria are met.

I. Background and mandate

Remember what it was like in March 2020? Church leaders in the CRCNA and around the world scrambled to discern how they might continue ministry "online" as the COVID-19 pandemic began to force churches to close their doors for in-person gatherings. Many congregations faced questions they had not had to consider before:

- Can we update our website and livestream our worship services?
- Can we post prerecorded sermons on our church websites, Facebook, or YouTube?

Dave Adamson might be correct as he writes, "COVID-19 lockdowns didn't start the online church—they just forced it to go mainstream."[1] Whatever the case, the pandemic ushered in a new reality for nearly all congregations in the Christian Reformed Church in North America.

As a result, important questions emerged within the CRCNA about the opportunities, pitfalls, scope, and limitations of online ministry and the concept of a "virtual church" or "digital church."[2] Various leaders began wondering about questions like this: Temporarily streaming services is one thing, but does a continued, online-only presence of "church" fit within the parameters of our confessions and polity as a denomination?

Seeing the ministry opportunities that virtual church planting might open up and sensing the call of God to virtual church planting, Redeemer CRC in Sarnia, Ontario, with the support of Classis Ontario Southwest and in partnership with Resonate Global Mission, began in 2022 to plant "Redeemer Online," led by Rev. Corey Van Huizen (see redeemeronline.church).

Questions emerged within Classis Ontario Southwest. These questions also came to Synod 2023 by way of an overture sent by the council of Wyoming (Ont.) CRC. Among its three recommendations, the Wyoming CRC council asked synod "to declare that a 'virtual church' (i.e., a 'church' which by design 'meets' only online) is not a church" on the ground that "a 'virtual church' does not meet the biblical and confessional criteria for a church in the areas of worship, pastoral care, fellowship, and the sacraments" (Overture 13, *Agenda for Synod 2023*, p. 400).

In response, Synod 2023 instructed "the Office of General Secretary to oversee the creation of a report that gives thought to and a theological framework for the possibilities and parameters of a virtual church: 'A church

[1] Dave Adamson, MetaChurch: How to Use Digital Ministry to Reach People and Make Disciples (Cumming, Ga.: Orange, 2022), p. 3.

[2] As the task force engaged in its work, it became apparent that "digital church" is a more commonly used term than "virtual church" to describe churches that, by design, meet only online. For the sake of consistency with preceding CRCNA discussions on this matter, however, we will continue using the term "virtual church" in this report.

which, by design, meets only online'"—and the report would need to meet the following guidelines:

a. This report will require input from (at least) a faculty or staff member of Calvin Theological Seminary, Resonate Global Mission, and Thrive.
b. This report should address the marks of the true church articulated in the Belgic Confession.
c. This report might address similarities and differences between online ministry and a virtual church, exploring opportunities and pitfalls for each.
d. This report should be presented to the COD for discernment.

(*Acts of Synod 2023*, pp. 979-80)

Synod's response became the mandate for the Virtual Church Task Force, which began meeting in the fall of 2023. The task force submitted a progress report to the COD in February 2024, and the COD approved a recommendation to expand the team's mandate to "address the important theological, missiological, pastoral, and polity implications of a virtual church" (*Agenda for Synod 2024*, pp. 29-30). The COD also expanded the membership of the task force, which now includes the following persons: Rev. Ben Gresik (chair), Rev. Jerry An (ReFrame Ministries staff), Rev. Young-Kwang Kim, Rev. Zachary King (ex officio), Elizabeth Koning, Rev. Steve Kooy, Dr. Derek Schuurman (Calvin University faculty member), Rev. Timothy Sheridan (Resonate Global Mission staff member and reporter), and Melody Van Arragon (recorder).[3]

II. Introduction to the topic

Reflecting on the COVID-19 pandemic, James Emery White makes clear that many Christian leaders in North America now see the pandemic as an "accelerator." In other words, the pandemic accelerated realities that were already present. He writes, "The pandemic accelerated and widened the effect of two profound cultural changes that hold enormous import for the life and mission of the church: the new reality of a post-Christian world and the digital revolution."[4] The COVID-19 pandemic forced all of us "online" in a way that we had not experienced before and accelerated the digital revolution already under way in the world.

As our task force began its work, it increasingly became clear that there were many questions to consider as we explored and discussed our mandate. What opportunities might ministry online open up for us and our mission? What have we already seen God do through the pandemic and

[3] A staff member of the Calvin Institute of Christian Worship (a joint ministry of both Calvin University and Calvin Theological Seminary) provided consultation for this project as well.

[4] James Emery White, *Hybrid Church: Rethinking the Church for a Post-Christian Digital Age* (Grand Rapids, Mich.: Zondervan, 2023), pp. 4-5.

our efforts to continue ministry online? What might we lose if ministry online is not matched with in-person, face-to-face community?

Our task force had the opportunity to hear firsthand stories from three practitioners within the CRCNA who are engaging with high intentionality in various forms of digital ministry. We were encouraged by these innovative ministries emerging within the CRCNA, and our conversations helped give shape to our discussions by grounding them in the lived experiences of CRCNA ministries.

We heard how God is drawing people to Christ through the ministries of Redeemer Online Church and its efforts to reach lost and unchurched people through its digital content. We heard about the intentional steps Redeemer Online is taking to lead people from being passive consumers of digital content into discipleship relationships and in-person connections with other followers of Jesus in their contexts.

We heard how God has established and grown Living Hope Community Church in Ajax, Ontario, a church planted during the pandemic that began doing all of its ministry online (livinghopecommunity.ca). Living Hope has also begun in-person worship gatherings but continues to offer most of its ministry programs online through digital content and media.

We also heard how Reclaim-App is using digital ministry to connect with people outside the church with its ministries that seek to offer safe spaces of calm and connection with God, with neighbors, and with self (see podcasts at reclaim-app.buzzsprout.com).[5] Reclaim-App has created digital opportunities for weekly practices that integrate Christian spirituality, holistic wellness, prayer, and conversation. And these have led to ongoing discipleship opportunities with people who want to explore the Christian faith.

III. Discussion of the topic

A. Key terms and scope

It is important to bring some definition to the following key terms we have been using here:

- **church**: the gathering of God's people for the purpose of the worship of God, discipleship, formation, and mission
- **virtual/digital church**: "a church which, by design, meets only online." Our research has revealed that "digital church" is a preferred term because "virtual church" is increasingly being used to describe churches that exist in worlds created by virtual-reality technologies.
- **hybrid church**: a mix of online and in-person opportunities for worship, discipleship, formation, and mission
- **livestream worship**: in-person worship that is shared online in real time (often as part of hybrid church)

[5] See "Reaching Seekers Online" by Cassie Westrate, Resonate Global Mission (Aug. 30, 2023); crcna.org/news-and-events/news/reaching-seekers-online.

- **ministry, ministries**: the way or ways in which the body of believers lives out its call of discipleship, formation, and mission

The scope of our report is limited by our synodical mandate. Synod 2024 reiterated the limited scope of this report when it adopted the following two recommendations:

> That synod note that the mandate of the "Report on Virtual Churches" is limited to virtual churches and not online permutations of traditional in-person churches.
>
> That synod encourage the Virtual Church Team to highlight the portions of their work related to online portions of traditional in-person churches or hybrid churches. (*Acts of Synod 2024*, p. 903)

B. The marks of the true church as articulated in the Belgic Confession

Article 29 of the Belgic Confession outlines the marks of the true church when it declares the following:

> The true church can be recognized if it has the following marks: The church engages in the pure preaching of the gospel; it makes use of the pure administration of the sacraments as Christ instituted them; it practices church discipline for correcting faults.

Our task force discussed the implications of this article for virtual churches; we also interviewed church planters Corey Van Huizen (Redeemer Online Church) and Mark Jallim (Living Hope Community Church), digital church practitioner and advocate Jeff Reed, and Calvin Theological Seminary professors Mary Vanden Berg, Ron Feenstra, and Lyle Bierma. We concluded the following:

Pure preaching of the gospel is something that can be done by virtual churches, under the supervision and oversight of ordained officebearers, as is done in physical churches.

Pure administration of the sacraments seems to be more complex. On the one hand, nobody we interviewed had any theological reasons to believe that online administration of the sacraments is impossible. On the other hand, there are important considerations to keep in mind:

- The elements administered should be real, tangible elements and not virtual representations of the elements.
- Of the two sacraments in the CRCNA, the administration of the Lord's Supper in public worship has proven to be the easier to adapt to the virtual church setting. We continue to commend to the churches the wisdom offered by the Calvin Institute of Christian Worship in its important article on church polity and online sacraments.[6] This article is a call to continue to reflect on our theology of the sacraments in our public worship services.

[6] See "Church Polity and Online Sacraments in the Christian Reformed Church" by Kathy Smith (Mar. 7, 2020); worship.calvin.edu/resources/articles/church-polity-and-online-sacraments-christian-reformed-church.

- The administration of baptism in virtual settings is less well explored. The matter of "pure administration" has conventionally been understood to refer to the use of approved liturgical forms and theological teaching and the authorization of the presiding officebearers. In-person administration by an ordained pastor or elder who shares it virtually could help ensure that these characteristics of pure administration are carried out.

The practice of church discipline seems to be fraught with additional challenges and dynamics that many experience in physical, in-person churches. It was noted by our task force that many congregations in the CRCNA already struggle with this practice, given the limited time in which members engage with each other and the changing dynamics around congregational engagement. Our task force sensed that virtual churches would face additional challenges in the practice of church discipline, perhaps most notably with regard to the ability in digital spaces to curate and project an image of oneself that may or may not resemble one's embodied self. One practitioner suggested that his experience has demonstrated a higher intentionality and increased opportunity for practicing discipline than he originally anticipated through the virtual church connections he is forming.

On the whole, our task force agreed that it is not impossible for a virtual church to embody the three marks of a true church, as outlined in the Belgic Confession. However, it is critical that virtual churches be very intentional in explaining how they will administer sacraments in good order and how they will engage church discipline, given the challenges we have noted.

C. Additional reflections on the teachings of the Belgic Confession

Article 27 defines the holy catholic church as "a holy congregation and gathering of true Christian believers, awaiting their entire salvation in Jesus Christ, being washed by his blood, and sanctified and sealed by the Holy Spirit." This church "is spread and dispersed throughout the entire world."

This article seems to imply that the invisible church is spread and dispersed throughout the world in the forms of individual Christians and visible local congregations. Can this also apply to a virtual church of Christians gathering online for worship, discipleship, and fellowship?

Article 28 calls believers "not to withdraw from [this church], content to be by themselves, regardless of their status or condition" but dutifully "to join this assembly wherever God has established it."

Might this admonition not to withdraw apply to someone who is unable to participate in a physical church but can join a virtual church that gathers online?

Moreover, when considering the phrase "wherever God has established it," how might we interpret God's establishment of a church in a digital age? Might there be room to consider digital platforms as spaces where God can gather his people?

D. Theological perspectives

As our task force met, we began to identify theological questions and implications for a virtual church. According to our mandate, we engaged faculty members of Calvin Theological Seminary with our questions. During our interviews with three CTS faculty members, we discovered four things important to note.

First, while some members of our task force initially wondered how the doctrine of the incarnation might have implications for virtual churches, we learned that from a theological perspective there really is not a 1:1 relationship between Jesus' incarnation and the shape of the church, so theorizing about implications of the incarnation for virtual churches could seem like a theological stretch. As Ron Feenstra pointed out, even people in front of their screens participating in a virtual church are physically embodied as they do so.

While we appreciate this kind of concern for theological precision, our task force noted that the incarnation of Jesus is an "extraordinary endorsement" of embodied human existence and community.[7] Moreover, as is practiced in missiological conversations, the incarnation of Jesus is a powerful invitation to an embodied presence in our local communities as we follow Jesus on mission.

Second, all agreed that virtual churches offer a missional opportunity to reach people with the gospel who may not, for various reasons, have access to a physical, in-person gathering of Christians in their community.

Third, while at times we wondered as a task force if virtual churches might promote a modern form of Gnosticism, we learned that there are no theological reasons to believe that virtual churches are inherently Gnostic or would necessarily lead to a modern form of Gnosticism. We recommend that, wherever possible, people meet in virtual spaces that allow for real names, real voices, and real images of the participants rather than the use of completely virtual avatars or "handles" that may be completely different from reality. We also note the need to be on guard against any tendency towards neo-Gnosticism in virtual worlds.

Fourth, from a theological perspective, all of the faculty we interviewed indicated, in varying degrees, that while virtual church may not be the ideal way in which the body of Christ *ordinarily* gathers for worship, formation, and mission, there are no confessional or theological reasons to declare that this way of gathering as a church is not a church.

E. Insights from a media studies perspective

Our task force had the opportunity as well to consider the expertise of and research done in the area of media studies by Quentin Schultze. The following is a summary of some helpful wisdom we gleaned from this interaction.

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[7] See Craig M. Gay, *Modern Technology and the Human Future: A Christian Appraisal*, (Downers Grove, Ill.: InterVarsity Academic, 2018), p. 176.

The church has been disrupted by significant shifts and developments in technology in the past, and it is important to recognize this historical reality so that we approach the advances of our digital age well. For example, the development of print technology in the 16th century and the development of the automobile in the 20th century had massive implications on the church and its ministry. There is a tendency during such times for both utopian and dystopian responses. We need to be careful not to fall into either one of these reactionary tendencies.

The digitization of media is both bringing people together in new ways and pushing people farther apart—at the same time. It is important to discern the impact that this push-and-pull dynamic might have on our ministry efforts. In today's consumerist society, digital tools, while offering connection, can accelerate the trend toward echo chambers and polarization. While they can help bring together people who otherwise could not meet, they can also cater to individual preferences, leading to fragmented communities. This reality clashes with the church's fundamental value of God gathering his diverse community, encompassing all ages and experiences, through his Son, Jesus Christ, in and by his Spirit. It is important to discern the impact that this push-and-pull dynamic might have on our ministry efforts.

Different technologies offer help for different applications. Media studies would encourage the church to think about the specific technology it is using, what the purpose of that technology is, and what the potential consequences of using the technology might be. In essence, all media platforms are value-laden and include biases that will inevitably shape the participation and experience of the users. Churches should consider that online meeting platforms that were designed for business, academic, or entertainment purposes may not necessarily serve the church well.

There is wisdom in learning to discern the function that is needed for ministry settings and to find the media technology that can best fit that function. We note John's words in 2 John 12: "I have much to write to you, but I do not want to use paper and ink. Instead, I hope to visit you and talk with you face to face. . . ."

In times of technological disruption, experimentation is essential. There are not necessarily good or clear answers for many of the questions we might ask. However, leaving space for experimentation and learning to evaluate those experiments with ministry rubrics that help ministry leaders reflect on and evaluate ministry experimentation in the digital world can be invaluable for growth in wisdom and learning. We would continue to commend Quentin Schultze's work on the kinds of questions we should be asking.[8] Ministry leaders should be aware that experimentation comes with risks of problems and failure, so it should be done with caution and high intentionality.

[8] See "Lost in the Digital Cosmos: Trying to Ask the Right Questions" by Quentin Schultze (Feb. 16, 2000) at christiancentury.org/article/lost-in-the-digital-cosmos.

F. Insights from a neuropsychology perspective

Our task force also had the opportunity to interview noted neuropsychologist Warren Brown and to hear of his emergent research on cognition and neuropsychology. The following is a summary of some of the wisdom gleaned and significant concerns raised through this conversation.

There are real limitations placed on our experience of community if our experience of church takes place solely through digital media. It is difficult to experience the reality of being an integrated and relationally connected body through online interactions. Without physical, bodily interaction, an important element of the human experience of relational community is missing.

It is difficult for online communities to serve as a full expression of the shared life of the kingdom of God in their local context, something that seems vital to the church's mission in the world. Without an embodied community in a shared physical space, important elements of this vocation are difficult to experience.

Studies are indicating that online spaces present real limitations on some basic human functions such as empathy, emotional regulation and expression, the imitation and modeling of Christian behavior, the building of mutual trust, and the expression of appropriate care. The experience of a virtual church will likely be that there is a much lower ceiling for these kinds of activities and interactions than an in-person church gathered in a shared physical space. Discernment and wisdom are needed to acknowledge this limitation.

G. Insights from some CRCNA practitioners' perspectives

As a task force, we had opportunities to interact with three different CRCNA practitioners engaged in virtual church ministry right now, and all of these practitioners are connected to and supported by Resonate Global Mission. Two are planting churches, and the third is building community through online and digital engagement. The following paragraphs share insights and wisdom we gleaned from these conversations.

It is clear that there are some people who can access an experience of Christian community online through digital media who may not want to or may not be able to do otherwise. This population can include (1) people who are spiritually far from the church and unlikely to enter a physical church building; (2) people who have had a negative, harmful experience with Christianity or the church; (3) younger generations who are natively online and spend a lot of time online; (4) persons with disabilities; and (5) people who are in contexts where they face persecution and the threat of violence if they associate with a Christian community or gather in-person.

It is clear that important missional opportunities are being discovered and explored by engaging with people online through digital media. Some examples we heard about include the following:

- Digital media increases the capacity to reach beyond a particular people group/community/geographical location.
- Digital media tends to reach people who would not/could not attend a conventional church.
- Digital media can help people experience faith in a new setting and in a new way.

It is also clear that some real pitfalls and challenges are being experienced and navigated. Among those mentioned are the following:

- Digital media and online engagement can generate passive consumers of content.
- It can be challenging to have high intentionality in follow-through engagement with people who use digital media and online content.
- It can be challenging to develop care and "one another" interactions in online spaces.
- It can be challenging to engage in discipleship and discipline with people who are physically distributed in many places but engage together through digital and online media.

For ministry practitioners discerning how to engage in digital media and online community in a way that leans into some of these opportunities and seeks to bridge some of these challenges, the following insights may be helpful:

- Design content that is aimed at people who are disconnected, disaffiliated, and unlikely to attend physical, in-person churches.
- Offer people opportunities to indicate that they want more engagement, and be sure to follow up with them in a timely fashion (for example, invite them to "subscribe" to some of your online content).
- Offer possibilities like email lists, comments, responses, and/or giving opportunities as next steps beyond subscribing/following that indicate a desire for more engagement.
- Consider inviting people who are engaging to join with you in one-on-one discipleship conversations. One practitioner does this to engage in spiritual coaching and in gospel-centered discipleship, depending on the interest level of the person being engaged.
- Practitioners spoke of the surprising capacity of text and video calls within which genuine pastoral care can happen and be experienced.
- Encourage people who engage deeply to find a way to connect with others and to consider gathering in-person with other Christ followers in their context.

IV. Summary of conclusions

As we reflect on the interviews we conducted, the reading we did, and the discussions and discernment we engaged in as a task force, we want to summarize our conclusions.

Blessings, opportunities, and challenges

It is clear that there are blessings and opportunities emerging for ministry leaders who are engaging with virtual church ministry. New groups of people are being reached with the gospel who are not being reached through physical, in-person churches. Content is being developed by CRCNA practitioners that aims to contextualize the gospel and Christian faith for digital media and for online contexts. We have much to learn from people who are on this missional edge in our denomination. Disciples are being formed, and even the beginnings of new communities of Christ-followers are emerging through intentional efforts to use digital media in the formation of online communities. For these and many others, we give thanks.

There are challenges and limits to virtual churches. Some important aspects of human functioning and some elements of relational communities are hindered by experiences that are exclusively online. Some core elements of church experience, like the practice of mutual care and discipline, are difficult to experience through online communities. Many questions do not have clear answers at this point as the church continues to navigate the massive disruptions and changes brought on by the acceleration of the digital revolution. We are very much still living in the midst of quickening developments. Questions about the advancements of artificial intelligence (AI) technologies and the experience of the metaverse and virtual reality are just some of the emergent realities that are raising numerous questions.

V. Recommendations to Synod 2025

In light of our findings and the summary of our conclusions, we offer the following recommendations to Synod 2025.

A. That synod acknowledge that while churches "preferably" gather in person for worship, fellowship, and mission, there should be room for intentional and ongoing experimentation within the CRCNA for digital ministry, including the planting of virtual churches.[9]

B. That synod further encourage classes and calling churches to pray for, partner with, and offer intentional support for church planters who are navigating the unique challenges of digital ministry.

C. That synod encourage classes and emerging church plants within the CRCNA that are experimenting with digital ministry and virtual churches to network with each other for shared learning and discernment.

D. That synod direct the office of General Secretary to work with denominational agencies to be a resource to classes and churches that are considering how best to support virtual churches and virtual-church planting. This would include, but not be limited to, helping these classes and/or churches network with others in our denomination who are also experimenting.

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[9] It is important to note that virtual churches would fall under the Church Order rules for emerging churches and would require the supervision of a local church council, as outlined in *The Manual of Christian Reformed Church Government* regarding Church Order Article 38.

E. That synod encourage virtual-church plants, along with their parent church(es), to provide a clear ministry plan to their classis, including especially how they plan to fulfill the marks of the true church in their context.

F. That synod declare the mandate of the Virtual Church Task Force fulfilled and dismiss the members with thanks.

Virtual Church Task Force

Rev. Ben Gresik (chair)
Rev. Jerry An (ReFrame Ministries staff)
Rev. Young-Kwang Kim
Rev. Zachary King (ex officio)
Elizabeth Koning
Rev. Steve Kooy
Dr. Derek Schuurman (Calvin University faculty member)
Rev. Timothy Sheridan (Resonate Global Mission staff member, reporter)
Melody Van Arragon (recorder)

Team to Clarify Distinctions in Synodical Pronouncements, Decisions, Reports, Positions, and Advice

I. Background and mandate

In 2021, Classis Chatham (now Classis Ontario Southwest) overtured synod to "clarify the distinctions in categories of synodical pronouncements, decisions, reports, positions, and advice and the extent to which they bind the churches" (*Agenda for Synod 2021*, pp. 350-51). Due to COVID-19 pandemic delays and a lack of time at Synods 2022 and 2023, action on this overture was deferred until Synod 2024 (*Agenda for Synod 2024*, pp. 401-2). Synod 2024 adopted the following response:

> 1. That synod appoint a small group to report to Synod 2025 to clarify the distinctions in categories of synodical pronouncements, decisions, reports, positions, and advice and the nature and extent to which each is "settled and binding" on members, officebearers, and churches.
>
> *Grounds:*
>
> a. Interpretations made with respect to the extent to which the "pastoral advice" set forth in the 1973 report on homosexuality is binding have led to turmoil and questions about the actual status of such advice.
>
> b. In 1995, Overture 2 from Classis Wisconsin asked for clarification of the meaning of the phrase "settled and binding." Synod 1995 defeated the majority report's recommendation on what the phrase means but did not further respond to Overture 2's request for clarification (*Acts of Synod 1995*, pp. 749-751, 753).
>
> c. The statements adopted by Synod 1975 (Report 47: Synodical Decisions and the Confessions) "expressing the use and function of synodical pronouncements on doctrinal and ethical matters and their relation to the confessions" (*Acts of Synod 1975*, p. 44) are not uniformly interpreted by those who read them.
>
> d. The potential impact of how the above statements are understood is too important at this time in our denomination's history to seek a quick answer even from an advisory committee of twenty-six very competent people.
>
> e. Recent decisions of synod have led to uncertainty and "angst" about how to interpret pronouncements of synod.
>
> f. The decisions to be made by Synod 2024 may have significant influence on how the statements of Synod 1975 are understood, so there is wisdom in waiting for these decisions.
>
> 2. That synod declare the above recommendation and grounds to be the mandate for the task force.
>
> (*Acts of Synod 2024*, p. 936)

In keeping with the Rules for Synodical Procedure, the officers of synod met in summer 2024 and appointed the following members to this task force: Drew Sweetman (chair), Josh Christoffels (reporter), Harold Caicedo, Kyle Dieleman, Sonya Grypma, and Joel Vande Werken (who served as a staff consultant after being appointed as director of ecclesiastical governance in mid-November).

When the team began to meet and digest the material, it was easy to see how clarity is needed about the settled and binding nature of what synod has decided. When Synod 1973 commissioned a study committee on this question, it said that "there is no clear understanding as to how [synodical pronouncements and declarations] fit into our confessional structure" (*Acts of Synod 1973*, pp. 65-66). Even though Synod 1975's ten-page report "Synodical Decisions and the Confessions" (*Agenda for Synod 1975*, pp. 595-604) sought to clarify the settled and binding nature of synodical pronouncements, questions remain. An overture to Synod 1995 sought further clarity on the matter, but synod defeated a recommendation proposing that full agreement with synodical decisions was not required by all members of the church (*Acts of Synod 1995,* p. 753).

To fulfill our mandate, we will first discuss how synodical decisions might pertain to members, officers, and churches before looking more specifically at the settled and binding nature of the various "categories of synodical pronouncements, decisions, reports, positions, and advice."

II. Distinction between members, officebearers, and churches

Our team was asked to clarify the nature and extent to which synodical pronouncements are settled and binding with regard to members, officebearers, and churches. We note that synod has also tasked the Office of General Secretary to "provide theological reflection and advice" on church membership and to report back to Synod 2026 (*Acts of Synod 2024*, p. 866), so we have attempted to avoid overlap with the mandate of that task force in our own work.

Officebearers have a higher standard than other members because, to be ordained and installed, they are required to sign their name confirming that they agree with the Covenant for Officebearers. They attest that the doctrines of the CRCNA's three confessions—the Belgic Confession, the Heidelberg Catechism, and the Canons of Dort—"fully agree with the Word of God." Officebearers promise that they "heartily believe" the doctrines of these confessions and will "promote and defend" them faithfully, conforming their "preaching, teaching, writing, serving, and living to them." Officebearers also have rules and procedures according to the Church Order that they promise to follow in the event of difficulties.

Unordained members of the church, on the other hand, do not sign their name to a covenant, but they verbally agree to certain statements when they make profession of faith and if they present children for baptism. Because the CRCNA has a variety of synodically approved forms for baptism and

profession of faith (and because Church Order Art. 59 does not mandate profession of faith in all cases when someone becomes a member), the exact commitments inherent in these questions vary from one setting to another. In general, members agree that they acknowledge or affirm that the confessions of the CRC do indeed faithfully reflect the teaching of Scripture.[1] On these occasions members also affirm their willingness to accept the guidance and discipline of the church through its officebearers and the decisions of its assemblies. What is clear is that the confessions are seen as authoritative, and their authority requires a substantial level of agreement in the CRCNA from all members.

It is also important to note the extent to which the decisions of synod are binding on the churches. Because local congregations are governed by officebearers, it might seem at first glance that the same standards of agreement would be required of churches as of officebearers. But it is also possible to recognize a distinction between the agreement required of officebearers individually and that required of churches (that is, their officebearers collectively). Thus churches submit credentials to each classis meeting, testifying that they (collectively) "faithfully adhere to the doctrinal standards" of the CRC and "diligently attend to ministry" within the classis and denomination. This statement reflects a collective commitment to the witness and service of the wider body of Christ in the CRC that goes beyond the agreement or disagreement of individual officebearers with the confessions and with decisions of the denomination, and includes even such practical issues as financial support of the CRC's ministries (see *Acts of Synod 1985*, pp. 810-11; *Acts of Synod 1990*, pp. 704-6).

III. The role of the confessions

Our mandate from Synod 2024 does not include instructions to clarify any language regarding the confessions, confessional issues, or the like. The same is true for what it means to be creedal.[2] Thus we enter into only a brief discussion here regarding the confessions. To frame this report on other various categories and the extent to which each is settled and binding, three main points regarding the CRCNA confessions are worth noting here.

First, the Reformed tradition has long held the books of Scripture "and these only as holy and canonical, for the regulating, founding, and establishing of our faith" (Belgic Confession, Art. 5). Thus Scripture is all that is necessary for the knowledge of salvation, since "everything one must believe to be saved is sufficiently taught in it" (Art. 7). As a result, "we must not consider human writings—no matter how holy their authors may have

[1] See the questions asked in the following liturgical forms found on the denominational website (crcna.org): Service for Baptism (1976), Service for Baptism II (1976), Form for Profession of Faith (1932), Form for Profession of Faith (1976), Form for Profession of Faith (2013), Form for the Public Profession of Faith (2016), Form for New Members (2016).

[2] Subscription to the creeds may seem uncontroversial; however, that is not always the case. For example, what is meant by the statement that Christ "descended to hell" has been the subject of much theological discussion and debate.

been—equal to the divine writings" (Art. 7). The CRCNA has clearly noted this theological principle and held that "the confessions are subordinate to Scripture" (*Acts of Synod 1975*, pp. 596, 601).

Second, what is understood as confessional is subject to change and revision and, in fact, has been altered. An obvious example of an explicit change in the confessions is in Q&A 80 of the Heidelberg Catechism. Synod 1998 directed a study of Q&A 80, which led Synod 2004 to declare that Q&A 80 "can no longer be held in its current form as part of our confession" (*Acts of Synod 2004*, p. 629). Thus Synod 2006 directed that three paragraphs of Q&A 80 remain in the text but be placed in brackets with a footnote explaining that these parts "are no longer confessionally binding on members of the CRC" (*Acts of Synod 2006*, p. 711). Of course, other examples, such as Article 36 of the Belgic Confession on the civil government could also be cited. Therefore, because confessions are subject to Scripture and are to be read as historical textual documents, what has been considered confessional has necessarily changed over time.[3]

Third, the confessions serve a variety of purposes in the life of the CRCNA: expressions of faith, public testimony to the world, forms of unity, instruments for instruction, juridical functions, and missionary purposes (*Acts of Synod 1998*, pp. 596-97). The confessions are also understood as the standard from which our other denominational decisions flow and by which they are regulated (Church Order, Art. 1-a). Thus the assumption is that all synodical decisions should be consistent with the Word of God as summarized in the confessions of the church. Within this framework, the CRC's congregations, officebearers, and members covenant to worship, live, serve, and testify together of the salvation that is ours in Christ.

IV. Categories of synodical decisions

Before defining the various categories of synodical pronouncements, we note that any given report, and synod's response to that report, may include a diversity of types of statements (*Acts of Synod 1975*, p. 600). This is particularly relevant as we seek to apply the decisions of synod today, because, for example, specific items adopted by synod as "pastoral advice" may, either explicitly or even implicitly, contain statements or assumptions that more accurately fall into the category of what we will be calling "doctrinal affirmations" (see section IV, A and the Appendix of definitions below). There is, then, always a measure of wisdom needed to interpret and apply even statements that synod has explicitly made as summarizing the church's understanding of a particular issue.[4]

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[3] On the historical textual approach to reading the confessions, see *Acts of Synod 1959*, pp. 183-84; *Acts of Synod 1961*, p. 88; *Acts of Synod 1998*, p. 427.

[4] For further examples of this point, see *Acts of Synod 1980,* pp. 40-41, and the discussion found in the document "Confessional Commitments and Academic Freedom at Calvin College," *Acts of Synod 2014*, pp. 136-76.

Second, the category of "report" is not included below since it is already clearly defined as a document from a committee that is legally before synod (Rules for Synodical Procedure V, A, 4). Reports are not usually adopted by synod in their own right but are received for information or recommended to the churches. While they often articulate a deeper explanation and rationale behind any given topic, only the recommendations that synod actually approves are settled and binding.

We also note that the categories of synodical decisions do not deal with ordinary items that synod might have to approve, such as board appointments, financial decisions, or commending the work of the ministries of the CRC. The focus, in line with previous synodical studies on this issue, has to do with doctrinal and ethical decisions.

As the study committee reporting to Synod 1975 observed, "Synodical decisions are as varied as the life of the church" (*Acts of Synod 1975*, p. 597). That synod defined six different categories of synodical decisions (p. 44). Synod 2024, however, listed a different set of categories for this team to define: "pronouncements, decisions, reports, positions, and advice" (*Acts of Synod 2024*, p. 936). Rather than using those exact categories, many of which overlap in meaning, we thought it might provide better clarity and simplicity if future synods would rely on the following broad categories and explanations of synodical decisions. The 1980 report on divorce and remarriage, for example, illustrates these categories by stating in its "Guidelines for the Ministry of the Church" that those guidelines "reflect the demonstrable teaching of Scripture" and that churches "must apply the teaching of Scripture to the specific situations and concrete cases" that come before them (*Acts of Synod 1980,* pp. 41, 480-85).

A. Doctrinal affirmations

Doctrinal affirmations are official, declarative statements that affirm Scripture or the confessions in response to questions that have arisen. Not all doctrinal affirmations are "confessional," but synods may declare or recognize them as confessional interpretations or as having confessional status. They can deepen and broaden the doctrines that are found in the confessions, or they can be additions to issues not found in the confessions (see examples in *Acts of Synod 1975,* pp. 598-600). Doctrinal affirmations are settled and binding for officebearers, churches, and members, though we recognize that, over time, synod may change the level of commitment expected (including consequences for nonadherence).

B. Adjudicatory decisions

These are decisions that arise from particular disputes coming from the churches. They are decisions in response to appeals or protests or when the Judicial Code is invoked. These apply to particular situations (*Acts of Synod 1975*, p. 44) unless synod specifically decides that they have universal and binding application. They may also provide precedent for future decisions.

C. Doctrinal applications

These decisions apply Scripture and the confessions to contemporary contexts or situations. They provide ways of further expressing the faith of the church but are not considered additions to the confessions. Doctrinal applications include guidelines for further study, contemporary testimonies (*Acts of Synod 2017*, pp. 699-700), and pastoral advice. Though rare today, some of the CRC's communications to governments (what Synod 1975 categorized as testimonies or letters) have functioned in this way as well. Doctrinal applications should be received with respect and are more than mere suggestions. Officebearers are expected to teach and guide members in line with these decisions. Members should similarly expect pastoral care consistent with the decisions. These decisions are settled and binding but allow for discernment in the way they are applied in local contexts.

V. Applying synodical decisions to the churches

Church Order Article 29 makes clear that decisions of ecclesiastical assemblies are "settled and binding" unless they conflict with the Word of God or with the Church Order. We see the two words *settled* and *binding* as largely complementing each other: because synodical decisions are not intended to be debated endlessly, they obligate churches and members "to live up to the decisions"[5] of the denomination's assemblies. As Henry DeMoor observes, this requires "respect [for] the decisions of the broader assemblies . . . publicly and privately . . ." and "especially in . . . official duties of preaching, teaching, and providing leadership."[6]

At the heart of this group's mandate, however, is a fundamental question: What do synodical decisions mean for CRC officebearers, churches, and members, and *how* do synod's decisions bind the leaders and members of our local congregations? In some ways, the framework of synodical decisions ties into questions of discipleship and discipline: from a positive standpoint, our confessions and synodical decisions should invite church leaders and members to a common set of beliefs and practices. From a somewhat negative standpoint, the church must consider the appropriate consequences when either officebearers or members undermine the beliefs or practices that connect us to one another in our denominational covenants.

Perhaps it will be helpful to offer some examples. Our confessions clearly teach the appropriateness of infant baptism (Heidelberg Catechism, Q&A 74; Belgic Confession, Art. 34). Officebearers should be expected to hold this teaching "without reservation" and to "promote and defend" this doctrine in their ministries. However, while officebearers should be expected to defend infant baptism as the most faithful interpretation of Scripture, this

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[5] Idzerd Van Dellen and Martin Monsma, *The Revised Church Order Commentary: An Explanation of the Church Order of the Christian Reformed Church* (Grand Rapids, Mich.: Zondervan, 1969), p. 124.

[6] Henry DeMoor, *Christian Reformed Church Order Commentary*, 2nd ed. (Grand Rapids, Mich.: Faith Alive, 2020), p. 167.

does not require that they completely deny that biblical arguments can be made for credobaptism (Church Order Supplement, Art. 5, A, 2). Members in general, however, are bound to a somewhat different standard. In expressing a "commitment to" the creeds and confessions of the CRC (Church Order, Art. 59-b), confessing members believe that the doctrines "faithfully reflect" the teachings of Scripture (as one early Reformed theologian put it, "insofar as you have heard, learned, and confessed them"[7]). But in at least in one case, synod gave the right for a local consistory to allow a couple of Baptist persuasion to remain members in good standing in the CRC, provided they did not undermine the beliefs and practice of covenant baptism in their local context (*Acts of Synod 1964*, p. 63). Similarly, we recognize that many of our Hispanic churches are currently wrestling in a similar way with the validity of Roman Catholic baptism for their members, despite our "settled and binding" position that recognizes such baptisms (Church Order, Art. 58; Belgic Confession, Art. 34).

Similar examples could be given for other categories of synodical declarations. On matters that are subordinate in authority to the confessions, even officebearers have permission to disagree with a particular synodical proclamation (as evidenced by their ability to record a negative vote). While these statements remain binding, in the sense that officebearers and members must "abide by . . . synodical deliverances" (*Acts of Synod 1975*, p. 44), and churches are expected to participate collectively in the work done by the denomination whose name they bear, cooperation with such synodical pronouncements is governed by a sense of mutual respect and trust (1 Tim. 5:17; Heb. 13:17) rather than the "agreement" required by the confessions.

Because both the original overture (*Agenda for Synod 2021*, pp. 350-51) and the mandate for this task force (*Acts of Synod 2024*, p. 936) mention recent synodical decisions about human sexuality, it seems important to briefly address those decisions here. As with many other synodical pronouncements, the statements of synod on matters of sexuality contain a mixture of decision types. Some of the decisions related to sexuality matters are "pastoral advice." Other decisions, such as the understanding that same-sex sexual activity is an example of the "unchastity" condemned in Scripture, or the assertion that temptation to a particular sin is not in itself sinful, flow from our interpretation of the confessions as the biblical and theological "baseline" which define the CRC's understanding.[8]

It should be noted, however, that a particular doctrinal affirmation, though binding on all officebearers, need not dictate the same pastoral application in every situation. Similarly, a confessional commitment that views all same-sex sexual activity as sinful does not lock the church or individual members into a particular course of pastoral care in matters beyond those

[7] The original quote comes from Jacobus Koelman (1632-1695); it was adopted by the CRC as part of its General Regulations of 1881, Art. 59.
[8] For further discussion of this point, see *Agenda for Synod 2016*, pp. 363, 365-66.

on which synod has specifically spoken[9] any more than the CRC's decisions on divorce require the same approach to every remarriage (see *Acts of Synod 1980*, pp. 40-41). Because Synod 2022 saw its decisions as consistent with the declarations of past synods, it can be assumed that the pastoral advice of those synods still holds and that local churches have significant freedom for pastoral engagement, provided the specific decisions of synod are heeded.

We believe this approach does justice to both the expectation that churches, officebearers, and members should respect all synodical pronouncements while still recognizing the very real distinctions that exist between categories of synodical decisions as well as between officebearers and members of the church. The principle of the original authority of the local assemblies (Church Order, Art. 27-a) dictates that local leaders do have significant authority to disciple members in ways that make sense in a particular situation, and should be able to do so with the trust of fellow officebearers and members of the CRC. But in the end, as synod has previously said, both officebearers and members *are* expected to "abide by . . . synodical deliverances" (*Acts of Synod 1975*, p. 44) as an expression of our common witness to Jesus Christ in our contemporary world.

VI. Conclusions

Synod has requested that this team provide some additional clarity to the definitions of synodical pronouncements, and to their relative binding weight on officebearers, churches, and individual members. We believe that such clarity is indeed important for the CRC to better understand what, precisely, we have covenanted to believe and to do together for the kingdom of God. To summarize, it is the conclusion of this group that matters that are "settled and binding" are those which have been discussed, debated, and adopted by synod and therefore obligate the churches to live up to the decisions the churches have made together. Local churches and classes "abide by" these decisions—that is, they act in conformity with them and use them as guides for their ministry. Officebearers covenant to teach, preach, and act in alignment with synodical pronouncements, even if they are only obligated to agree with the doctrines taught in the creeds and confessions. Individual members agree to accept the spiritual guidance of the church as part of their commitment to respect their leaders and join with them in carrying out the ministry of the church, and they agree to "acquiesce" in those decisions which they cannot actively support.

We also want to recognize that this team assignment comes, in part, because of an increasing number of relational challenges that cannot be met with administrative solutions. As our recent history demonstrates, even categories requiring little formal agreement can feel like a betrayal of denominational unity if a spirit of mutual trust is not present.

[9] Matters that do bind churches and officebearers can be found, for example, in the list presented in the *Acts of Synod 2024* on page 891.

The biggest contribution of this report, then, might be to ask the question, What can we do to build mutual trust so that the body of Christ (or at least the part of Christ's body that is the CRCNA) can move forward to do the ministry God requires of us? Our denominational structure teaches us to consider the decisions of assemblies with respect and humility, and our conscience guided by the Holy Spirit constrains us to seek points of agreement that foster our unity and strength as the body of Christ. There is great value in the CRC understanding that does not force agreement with every doctrine or practice but allows for continued learning and growth into the matters we confess for both officebearers and other members. Identifying categories of synodical pronouncements cannot create those conditions; they can only be helpful insofar as those categories serve the goal of identifying our common areas of ministry. That task, in turn, requires mutual submission to one another that can come about only when we have first of all submitted ourselves to Christ. We must patiently and humbly seek the wisdom that comes from the Spirit to recognize how we can faithfully apply the shared understanding of Scripture that our confessions offer to us.

VII. Recommendations

A. That synod grant the privilege of the floor to Drew Sweetman (chair) and Joshua Christoffels (reporter) when the report of this team is discussed.

B. That synod take note of the challenge of maintaining trust in the churches in our present cultural context, recognize the inadequacy of administrative categories to maintain harmony in our collective ministry as a church, and encourage all churches, officebearers, and individual members to seek those things which lead to peace and mutual edification (Zech. 8:16; Rom. 14:19).

C. That synod recognize the three broad categories of doctrinal affirmations, adjudicatory decisions, and doctrinal applications as defined in this report and encourage future synods to utilize these categories.

Ground:
Using these broad categories will provide clarity and uniformity around our settled and binding positions.

D. That synod receive this report and its definitions, commend these items to the churches as a faithful explication of the various categories of synodical pronouncements, and dismiss the team with thanks.

Team to Clarify Distinctions in Synodical Pronouncements,
Decisions, Reports, Positions, and Advice

Drew Sweetman (chair)
Joshua Christoffels (reporter)
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APPENDIX

Definitions of Terms Used in This Report

Doctrinal affirmations (sometimes called pronouncements, positions, decisions, and deliverances): An official statement or declaration made by synod, which expresses decisions on matters of doctrine, ethics, church policy, or other important issues. Doctrinal affirmations are authoritative and are meant to guide the beliefs and practices of the church community.

Adjudicatory decisions: Decisions that arise from particular disputes coming from the churches in response to appeals or protests or when the Judicial Code is invoked. Synod may decide that an adjudicatory decision has a universal and binding application.

Doctrinal applications (includes what synod has called guidelines for further study, contemporary testimonies, or pastoral advice): Decisions that apply Scripture and the confessions to contemporary contexts or situations. Doctrinal applications are ways of further expressing the faith of the church but are not considered additions to the confessions. They are settled and binding but allow for discernment in the way they are applied in local contexts.

Advice (also called "pastoral advice"): Strong recommendations provided to help guide, counsel, or support churches. This term is used to describe three types of advice, with distinct purposes. First, advice for providing *pastoral counseling* and care of members (e.g., regarding marital divorce, same-sex attraction). Second, advice for supporting members with *pastoral concerns* (e.g., persons struggling with faith concerns and the authority of Scripture regarding a new societal trend). Third, advice on how to provide advice in a *pastoral manner* (e.g., how to provide a caring posture in controversial discussions). Synodical advice carries the weighty authority of the expertise of the authors of a study report, for example, as well as of synod's adoption. While it is not strictly mandatory for churches to follow synodical advice, they are to receive it with due respect, and they normally act in harmony with it. However, when the purpose of the synodical advice is to provide the scriptural or confessional basis for the advice given, the statements are binding.

Report: A report is a document submitted by a board, committee, or agency of an assembly indicating the work performed in response to assembly mandates and presenting recommendations for assembly action (Rules for Synodical Procedure V, A, 4).

Settled: A matter is settled when it has been discussed, debated, and adopted by synod. The settled matter is considered final. It is not subject to reversal or modification unless new and sufficient grounds are presented to demonstrate that it conflicts with Scripture or the Church Order.

Binding: When decisions are made by ecclesiastical assemblies, the church community is obligated to adhere to those decisions. Those decisions are binding.

Abide: To act in conformity with a synodical decision, via one's personal conduct, teaching, preaching, publishing, discipleship, pastoral care, and church discipline.

Acquiesce: To commit to abide by a synodical decision, even when in personal disagreement with that decision. Officebearers and church members are duty-bound to respectfully receive synodical decisions as bearing the weighty authority of synod, recognizing that "the well-being of the church is fostered when there is substantial unity with respect to all the decisions of synod" (*Acts of Synod 1975*, p. 602).