

**THE COVENANT OF LIFE
AND THE CARING COMMUNITY**

AND

**COVENANT AND CREATION:
THEOLOGICAL REFLECTIONS ON
CONTRACEPTION AND ABORTION**

The 195th General Assembly (1983)
received the reports and adopted the
policy statements and recommendations

Published by the
Office of the General Assembly
100 Witherspoon Street
Louisville, KY 40202-1396

OGA-88-109

The 197th General Assembly (1985) approved the following statement and directed that it be printed in all copies of the Covenant of Life document:

“We are deeply aware of the concern and pain in the church as expressed in the many overtures from presbyteries which deal with the question of abortion. We are disturbed by abortion which seems to be elected only as a convenience or to ease embarrassment. We affirm that abortion should not be used as a method of birth control.”

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronically, mechanically, photocopying, recording, or otherwise (brief quotations used in magazine or newspaper reviews excepted), without the prior permission of the publisher.

The sessions, presbyteries, and synods of the Presbyterian Church (U.S.A.) may use sections of this publication without receiving prior written permission of the publisher.

TABLE OF CONTENTS

Preface	1
THE COVENANT OF LIFE AND THE CARING COMMUNITY	
Introduction	3
Section I. Where Are We Coming From?	4
Chapter 1, “The Church as a Covenant People,” sets forth the biblical foundation of the dignity of human life and the church as a caring community.....	4
Section II. Where Are We in the Development of Biomedical Technology?.....	9
Chapter 2, “Options and Integrity at the Beginning of Life,” deals with four areas of concern:	9
(1) Decisions regarding care	10
(2) Crises in wanted pregnancies.....	11
(3) Infertility and options for couples who cannot conceive	14
(4) Dilemmas surrounding unintentional pregnancies	15
A companion paper, <i>Covenant and Creation: Theological Reflection on Contraception and Abortion</i> , deals at much greater length with these concerns.	
(5) Parenting as Covenant Initiation	17
Chapter 3, “Genetic Choices and the Ethics of Dominion,” focuses on the implications of applied genetics for medicine, particularly as it relates to issues of parenting and the decision-making that is thrust upon humans as a result of these developments.....	20
Chapter 4, “The Provision of Health Care: Obedience to Divine Purpose,” deals with justice and injustice in the health care delivery system and the church’s vision for a more just allocation of resources.....	28
Chapter 5, “Decision-Making at the End of Life,” with special attention to the need for persons to think through and make known their wishes regarding treatment and care at the end of life.	37
Section III. What Are We to Do as Responsible People of Faith?	45
Policy Statement and Recommendations	45

Appendixes.....	56
A. Directions for My Care.....	56
B. Christian Affirmation of Life	56
C. A Living Will.....	57
D. Form of Declaration	58
Notes.....	59

**COVENANT AND CREATION: THEOLOGICAL REFLECTIONS ON
CONTRACEPTION AND ABORTION**

A. Introduction: Responsibility in Creation and Covenant.....	63
B. Contraception: A Question of Social Justice	66
C. When Contraception Fails: The Unanticipated Pregnancy	69
D. Moral, Legal, and Medical Histories Regarding Abortion.....	72
1. Medical Developments That Generated the Possibility of Safe Elective Abortion	72
2. Medical Developments That Changed Our Understanding of the Religious and Moral Issues in Family Planning	73
3. Moral Judgments and Social Consensus Regarding Abortion Throughout Judeo- Christian History: Protection and Prohibition.....	75
E. An Analysis of Four Questions and Concepts Assumed to Be Necessary for Under- standing the Morality of Abortion	83
1. The Question of the Morality of Abortion Is Not Dependent on an Analysis Based on a Theory of a Conflict of Rights	83
2. The Question of the Morality of Abortion Is Not Dependent on the Question of the Inviolability of Autonomous Human Life	88
3. The Question of the Morality of Abortion Is Not a Question of When Human Life Begins.....	90
4. The Question of the Morality of Abortion Bears No Relation to Questions of the Morality of Sexual Activity.....	92

F. The Church's Ministry	94
G. The Special Problem of Teenage Pregnancy	96
H. Public Policy in Relation to Our Theological Perspective	98
Appendix I: A Chronology of Theological, Legal, and Medical Developments Related to Contraception and Abortion	103
Appendix II: The Testimony of a Woman.....	107
Policy Statement and Recommendations	109

THE COVENANT OF LIFE AND COVENANT AND CREATION

The Advisory Council on Church and Society transmits to the 195th General Assembly (1983) the following two reports, “The Covenant of Life and the Caring Community” and “Covenant and Creation: Theological Reflections on Contraception and Abortion,” and recommends that both be received by the 195th General Assembly (1983) and their policy statements and recommendations adopted. It also recommends that both reports be reprinted by the Office of the Stated Clerk and made available to the church for study.

We are not yet home, but we are going home. Going home to that homecoming banquet where elder brother and prodigal son . . . exile and stranger, man and woman, white and black, East and West, Arab and Jew, poor and rich, lion and lamb will sit down together in peace . . . As in the Nicene Creed, “I look for the resurrection of the dead and the life of the world to come. Yes, I look and keep on looking, and sometimes I think I glimpse it from afar....” (Robert Raines, *Going Home*.)

There is a part of each of us that has an eye on the homeward journey. We are making that journey together, not always speaking of it, but always moving toward that time when we shall all be made whole and when the human family, the covenant community, will become whole and perfect.

It is this yearning toward wholeness, part of which is the need to be relieved of suffering, that has stimulated the revolution in medicine that has occurred during the last thirty years. It is this same yearning that leads us to reflect upon and question the use of those advances. Within the memory of most adults, organ transplants, open heart surgery, and prenatal diagnosis of genetic disease have become everyday occurrences. We can scarcely imagine the new frontiers and the new heroes of the next few years. As new options are offered in the realm of health and new possibilities found for the quality of both living and dying, no one can remain detached from the discussion of the meaning of these developments. They speak to us about our dreams of being healed.

The 191st General Assembly (1979) requested the Advisory Council on Church and Society to study the implications of genetic research and human engineering. The advisory council appointed a task force that prepared a resource issue of *Church and Society* magazine entitled “Genetics, Health and Personhood” (Sept.–Oct. 1982). Through its work, the advisory council now submits a report with a policy statement and recommendations entitled “The Covenant of Life and the Caring Community.” The report seeks to identify and provide a context of theological and ethical interpretation for the personal and social decisions that recent advances in medicine make both possible and necessary, particularly at the beginning and end of life. It also identifies the impact of these advances in health care needs and the system for responding to them.

Several General Assemblies in recent years have briefly considered issues related to abortion and the church’s attitude and policy in regard to it. In response to one such request in 1981, the Advisory Council on Church and Society agreed to a full policy review of these concerns, which had not been analyzed in a major way since the early

1970's. The General Assembly, by referring several overtures to the advisory council, suggested that such a review link the "dual affirmation of the freedom of conscience and the sacredness of life."

The task force already at work on other issues of "Science, Medicine, and Human Values" was expanded and asked to add this analysis to its agenda. From its work, the advisory council has prepared a packet of papers and articles on abortion representing a variety of viewpoints to facilitate study and discussion of the related questions. The advisory council is also submitting a report of its review, together with a statement of policy and recommendations entitled "Covenant and Creation: Theological Reflections on Contraception and Abortion." The adoption of this report will provide the Presbyterian Church with a comprehensive and contemporary base of reflection and policy for responsible decision on the personal and social issues presented by advances in science and medicine related to conception and birth.

The members of the task force that served the advisory council in drafting these reports and recommendations were the Rev. J. William Carpenter, Pastor, Philadelphia, PA; the Rev. Edward Daub, Historian of Technology, Madison, WI; the Rev. Fay Ellison, Pastor, Bangor, ME; Dr. Jan van Eys, Pediatrician, Houston, TX; the Rev. Bobbi Wells Hargleroad, Vice-Chairperson of Task Force, Member of the Advisory Council, Pastor, Huntley, IL; Ms. Frances Hollis, Lawyer, Los Angeles, CA; the Rev. Carl G. Howie, Pastor, Dearborn, MI; the Rev. Osmundo A. Miranda, Member of the Advisory Council, Professor of New Testament, Tuscaloosa, AL; Dr. Robert Schimke, Molecular Biologist, Palo Alto, CA; the Rev. Joy D. Skeet, Nurse and Medical Ethicist, Toledo, OH; the Rev. James A. Todd, Pastor and Medical Ethicist, Tulsa, OK; the Rev. Kenneth Vaux, Chairperson of Task Force, Medical Ethicist, Chicago, IL.

Staff resource persons were the Rev. Dean H. Lewis, Director of the Advisory Council, New York, NY; and the Rev. Mary E. McNamara, Staff to the Task Force, New York, NY.

THE COVENANT OF LIFE AND THE CARING COMMUNITY

Introduction

Central to the Reformed understanding of faith and obedience is that they are ever becoming new, *reforming*, rather than reformed and finished, under the Word of God. Recent advances in biomedicine have pushed Christians to seek anew the basis for faithful response to basic issues of life. Throughout history, it could be argued, questions of the meaning of human life have been raised with each biomedical advance; but these recent developments are perhaps the most disturbing in the history of medicine, for they go to the heart of the definition of life and the nature and limits of our responsibility for it and they come at a time of deep politicization within the church as well as society over many of the issues. Moreover, even while definitions are still in flux and no societal consensus has been reached, persons of faith are forced to act on these hard issues regarding their own health care and that of ones they love. This paper, thus, is offered as an attempt to enter the dialogue from a reforming theological perspective and to be of service to the pastoral needs of the Presbyterian family of faith.

Though created in response to an overture to the 191st General Assembly (1979), the task force that attempted to deal with these issues was not alone in this struggle to discern new meanings. The World Council of Churches has been monitoring genetic research for a number of years. The National Council of the Churches of Christ in the U.S.A. (NCCCUSA) during the lifetime of this task force's work, created a Panel on Bioethical Concerns, which has distributed a paper for study throughout the Protestant communions in the United States. The NCCCUSA also prepared one of the first church study resources on the ethical dilemmas raised by amniocentesis and fetal diagnosis. Several denominations have done work in this area in recent years. Most recently the United Church of Christ completed a book, *Genetics, Ethics and Parenthood*, which deals, at much greater length, in much more depth than this paper can, with the issues of genetics and new means of procreation.

Many of these studies have been prepared with congregational study as their major purpose, and we call them to the attention of Presbyterians in order that the usefulness of this study may be supplemented by the fruits of others' labor. (See the Bibliography for full citations of these resources.)

This paper will deal critically with three focuses: the biomedical developments; theological-ethical issues and reflections raised by these developments; and the role of the community of faith, both as caregiver and as supportive companion to those who must deal with these issues and make decisions. The issues can perhaps be summarized in three broad questions: Where are we coming from as people of faith? Where are we in the development of biomedical technology? and What are we to do as responsible people of faith?

In response to the first question, the introductory chapter develops the theological themes that flow throughout the paper. Each succeeding chapter deals with specific concerns as they are raised across the life cycle of persons in relationship with the

medical care system. Ethical issues and guidelines for institutional response follow. Generally these issues can be described as tensions between bases of power and conflicting claims on resources. Briefly, the vision this paper holds of the church is that of a covenant community that cares for persons, aids them in their decision-making, supports caregivers in its midst, advocates for new forms of care where society has not yet realized a need or has chosen not to fill it, and bears witness against the human pride that distorts community or challenges God.

A final word on usage: The idealistic and encompassing phrase “health care” is used intentionally throughout this paper in lieu of the more specific phrase “medical care.” What is largely available—and certainly more prestigious—in the United States at this time is “acute care” or “curative” medicine. This area of medicine is favored in terms of funding and prestige because it produces tangible results by working to arrest disease and save lives. As Alastair Campbell notes, “Help to the handicapped, care of the elderly and dying, reintegration of the mentally ill into the community, education for healthy life-styles, and so on, do not have the same tangible results and so fail to gain the same degree of support as acute care. Yet the acute services do not in themselves increase the health of a society.” (Alastair V. Campbell, *Medicine, Health and Justice: The Problem of Priorities*. Edinburgh, London and New York: Churchill Livingstone, 1978, p. 75.)

This emphasis on “health care” for this country seems even more idealistic in the face of the current administration’s policies, which have slashed funds for basic health and human services. Some areas that have sustained serious cuts are grants to the states for preventive services such as high blood pressure screening, health education, lead poisoning prevention, venereal disease, and rat control. Areas that have suffered worse cuts are grants to the states for maternal and child health services, including nutrition and family planning. With the cuts in Medicare and Medicaid, even the concept of “medical care” for the poor and the elderly may be threatened.

Nonetheless, “health care” will be used throughout this paper and will be held up as a vision for the Presbyterian Church and for the people of the United States.

Section I: Where Are We Coming From?

CHAPTER 1: THE CHURCH AS A COVENANT PEOPLE

The essential relationship surrounding all questions of life in the Judeo-Christian tradition is that of covenant. Covenant is the relationship, initiated by God in the very creation of the world, that informs not only human interaction with the Creator but also the interrelationship among humans and between humans and the rest of creation. Covenant informs the entire biblical story and is perhaps the most basic of the doctrinal understandings that have evolved from the biblical foundations of faith. As a key to unlocking the mysteries of the covenantal relationship, the first eleven chapters of Genesis are particularly illuminating. Thus we turn to an examination of that primordial “history” that encompasses so briefly our self-understanding as a people in relationship with God.¹

Creation, God-Image, and the Ethics of Dominion

In the first chapter of Genesis, God's Word is spoken and the world is created—first light, then the heavens, then oceans and dry land, then plants, the sun and moon, birds, sea creatures, and animals. The process culminates in the creation of human life, male and female, in the image of God. At each step, creation is declared good, and in the end the God-image human creatures are given a special relationship to the rest of creation.

And God blessed them, and God said to them, "Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the seas and over the birds of the air and over every living thing that moves upon the earth." (Genesis 1:28.)

The critical words *image (selen)* and *dominion (radah)* both come from the realm of politics. Human life is created and placed in the world, bearing God's image, as God's surrogate, much as a statue is placed by a ruler in a distant land where she or he cannot be in person. Thus to bear God's image is to carry on God's relationship with the rest of creation, that of ruler, one with dominion, *radah*. Humans are created with power and authority, the right of sovereignty and control. The commission to rule, however, is the consequence of bearing the image of God; humans are created capable of ruling because of God's image and are commanded to rule as a consequence of it. As God's representatives in the distant earthly creation, humans are summoned to maintain and enforce God's claim to dominion over the earth as creator.

Theological interpretations that have blamed Genesis 1:28 for exploitation of the natural environment² are based on an inaccurate understanding of the meaning of *radah*. Here Walter Brueggemann is helpful:

The "dominion" here mandated . . . is that of a shepherd who cares for, tends and feeds the animals. Or, if transferred to the political arena, the image is that of a shepherd king (cf. Ezek. 34). Thus the task of "dominion" does not have to do with exploitation and abuse. It has to do with securing the well-being of every other creature and bringing the promise of each to full fruition. Moreover, a Christian understanding of dominion must be discerned in the way of Jesus of Nazareth (cf. Mark 10:43–44). The one who rules is the one who serves. Lordship means servanthood. . . . The human person is ordained over the remainder of creation but for its profit, well-being and enhancement. The role of the human person is to see to it that the creation becomes fully the creation willed by God.³

Human dominion is to image God's dominion or risk alienation from God the creator. It is a rule of responsibility, not self-centered and exploitative. It is the rule of servanthood rather than narcissism; it is the rule exemplified by Jesus of Nazareth, God's ultimate *selen*, shepherd, who laid down his life for his sheep.

The Distortion of Human Destiny

In Genesis 2:4–3:24, the narrative focuses on human life in God's creation and the difficulty of trying to live here on God's terms. First the human creature is set in a garden "to till and keep" it. (Genesis 2:15.) Thus, work for the human is part of creation, and the garden is entrusted to this most special of creatures for safe-keeping and nurture. Second, there is permission to act, specifically to utilize the garden, as gift, for human sustenance. ("You may freely eat of everything of the garden." (Genesis 2:16.) Third, there is a terse prohibition: "But of the tree of the knowledge of good and evil you shall not eat." (Genesis 2:17a.)

There is no debate, no qualification—simply a brief outline of the three terms God has set out for life in the garden: vocation, permission, and prohibition. Each of the three is qualified by the other two, not by God, and the human creature is free to determine the balance among them. God intends work and responsibility, sufficiency and well-being, but these gifts are placed within boundaries—the boundary of the covenant relationship with God and the boundary of a simple prohibition.

Unfortunately, the story generally is remembered only for the prohibition: God is the one who prohibits; humans are the ones who disobey. But the prohibition is only one of the terms for life in the garden, a boundary intended to guide the human in the pursuit of vocation and limit the freedom of sustenance-seeking. God's purpose for human life cannot be seen in any one of the three terms by itself. Any two, without the third, is a perversion of divine intent; any one held in isolation from the other two is a distortion of God's vision for human life. The major human task, according to this story, is to balance the three terms in the day-to-day choices faced in the garden.

The story continues. Enter the serpent, and suddenly the balance is disturbed. The prohibition becomes the term of most importance, is debated as an option rather than a ground rule, and is finally broken. Despite the clear indication that death would result from violating the prohibition, God sentences the human couple to life—but to life apart from the garden's goodness—life filled with pain, sweat, distortion of the covenant partnership for which they were made. The inability to live on God's terms has led to a new situation for human beings and a new situation for God in relationship to them. Human destiny has been distorted, and God's vision for human life has been thrown off balance.

The story insists that the freedom to enjoy and exploit life and the task of managing creation are boundaried. It raises questions of knowledge and control and human autonomy. The gift of life remains a mystery illumined by trust and the seeking of wisdom. God's desire is neither for ignorance on the part of humans nor for blind obedience to a cosmic rule book. Human destiny as willed by God is neither unbridled freedom to exploit and consume nor a life mired in prohibition. It is a life of genuine decision in the context of stewardship. It requires a wise and trusting balance.

The Burden of Decision-Making

In Genesis 4:1–16, the vertical problem of living in creation on God's terms becomes a horizontal problem: to live in creation on God's terms in relationship with other human beings. The story focuses not on the morality of murder but on the choice that faces Cain before the murder. God offers Cain the grace of acceptance and opens the door to a destiny of moral decision-making: "If you do well, will you not be accepted? And if you do not do well, sin is crouching at the door; its desire is for you, but you must master it." (Genesis 4:7.)

The word translated "master" in the RSV is from *timshel*. Brueggemann translates it "you shall rule" and reflects that the role of humans as rulers degenerates in these early chapters of Genesis.

In Genesis 1:28, the human pair is to have dominion over plants and creation, even as the great lights are to govern (1:16–18). In the disordered, oppressive world of 3:16, it was the man ruling the

woman. Now, it is this pitifully rejected man taking responsibility for himself. He has the capacity to tame the beast at the door.⁴

Cain's decision, however, is to submit, to succumb to distortion, to be ruled by the predatory beast. Cain seeks release from the empowerment of verse 7. He shuns responsibility for Abel, and in so doing, he discovers that the question of "brother" cannot be separated from the question of God. Even so, God does not give up on Cain but marks him protectively in anticipation of an ultimate reconciliation.

Chapter 3 of Genesis is frequently seen as the basis for human freedom and decision-making, but Cain is the stronger model of both the freedom and the failure of human choicemaking. Created with the capability of ruling, he prefers to be ruled. Granted dominion, he fails to enhance the other in his midst. He rejects the critical link between God and neighbor—lashing out in violence instead of responding in love. He murders and condemns himself in the same act—a dual death. In the New Testament, Cain is the example of moral death, which is contrasted to life in Christ, based on love:

We know that we have passed out of death into life, because we love the "brethren." He who does not love abides in death. Any one who hates his brother is a murderer, and you know that no murderer has eternal life abiding in him. By this we know love, that he laid down his life for us; and we ought to lay down our lives for [others]. But if any one has the world's goods and sees his (brother) in need, yet closes his heart against him, how does God's love abide in him? (1 John 3:14–17.)

The burden of decision-making is integral to humanness. And it is in making critical choices that human beings demonstrate their true values. A truly moral decision cannot be made in isolation—for decisions arise and must be faced before God and in the context of community.

The Dignity of Each Human Life

The story of Noah (Genesis 6–9) is both a judgment and a promise. God created the world to be a faithful covenant partner; God willed unity, harmony, and goodness. But the creation's human choicemakers have turned against God and are working against the purposes of the one by whom and from whom the world exists. God's terms are violated; the covenant is broken. God reacts, strongly, to the distortion of human decision-making. No more will God's life-giving spirit be available to distorters and disorderers. However, even in despair over creation, God holds on to the expectation that the world can be in covenant relationship. God grieves, but then takes action to start anew, to re-create. God's grief has turned to firm resolve: "Never again!" (Genesis 9:11.) The covenant with humankind and with all of creation is renewed.

In the re-creation there are parallels to Genesis 2. The vocation of dominion is mandated once more. All of creation is now under human responsibility; and animal life, as well as plant life, is permitted for eating. The new prohibition has to do with blood, animal blood and human blood: "Only you shall not eat flesh with its life, that is its blood . . . Whoever sheds the blood of (a person), by (a human) shall (that one's) blood be shed; for God made (persons) in (God's) own image." (Genesis 9:4, 6.)

This segment of the new covenant probably originated in a cultic rule, but here it stands as a central piece of the new ground rules for life in creation: Human life is

worthy; human worth is affirmed by God. Human enhancement and valuing is part of the expectation God sets forth in the postflood new creation. The sanctity of human life is held up against every ideology or idolatrous force that would cheapen or diminish it. The valuing and dignifying of human life is a cornerstone of both Jesus' ministry and the centuries of theological development that have followed.

Diversity and the Listening Community

In the final chapter of the primordial history, the intent of another segment of God's first words to human beings ("fill the earth") is fulfilled. The "whole earth" is united by a common language as the story begins, and its people migrate to the plain of Shinar where they decide to build a tower and make a name for themselves, "lest we be scattered abroad upon the face of the whole earth." (Genesis 11:4.) Often seen as an anti-urban text, the story of Babel has little to do with cultural critique. Rather it is a comment on self-serving unity, which people use to protect themselves. The tower is for them a safety zone where homogeneity can be assured. Traditional readings of this text that see pride as the disobedience and scattering as the punishment miss a subtle but critical differentiation.

According to Brueggemann, the story is based on two understandings of unity. The people in the story desire unity in resistance to God's desire that they "fill the earth." Whereas God wills a unity that permits and encourages scattering.

The unity willed by God is that all of humankind shall be in covenant with him (9:8-11) and with him only, responding to his purposes, relying on his life-giving power. The scattering God wills is that life should be peopled everywhere by his regents, who are attentive to all parts of creation, working in his image to enhance the whole creation, to bring "each in its kind" to full fruition and productivity ... The purpose of God is neither self-securing homogeneity as though God is not Lord, nor a scattering of autonomous parts as though the elements of humanity did not belong to each other.⁵

But seeing that still another disruption of covenant was intended, God fractures the self-centered attempt at unity and confuses the speech "that they may not understand [hear, listen to] one another's speech." (Genesis 11:7.)

It is the end of community. No longer are there shared meanings. People are estranged, no longer acknowledging the worth of others. Says Brueggemann, "A society which suffers failed speech, as in our text, not only cannot build towers, it cannot believe promises, cannot trust God, cannot be human." (P. 103.)

Thus the prehistory ends on a dissonant note. Humanity is dispersed in punishment for a skewed understanding of unity and God's purposes. There is a scattering but no listening, only a waiting for a new call, a new covenant that will bind humanity to God in new ways. The covenant with Abraham follows, of course, and throughout the history of Israel there are times of listening and times of not listening. The shema, "Hear, O Israel, the Lord your God is one God," is a central word in the Old Testament, as is the prophetic condemnation that Israel does not "listen" to God in its life. While there are new modes of speaking and attempts at listening throughout the Bible, they are all provisional until Acts, when the Spirit is given in the wind of Pentecost, giving birth to the church as listening and caring community. The willful disunity of the past is overcome, and the covenant between God and creation is embodied in a new form in human community.

In the pages that follow, the themes of covenant and creation, dominion and distortion, decision-making and dignity, and diversity and listening will appear again and again, for they are basic to life in covenant with God. The issues addressed by this paper are basic to life in human community; and for the Christian, questions of human community are questions of relationship with God as well. Briefly, the chapters that follow will address the issues of human life and medical interventions to create, inhibit, enhance, preserve, prolong, and relinquish human life.

Section II: Where Are We in the Development of Biomedical Technology?

CHAPTER 2: OPTIONS AND INTEGRITY AT THE BEGINNING OF LIFE

It was all so different than I had imagined. Bright lights, machines clicking, people coming in and poking and probing but never telling me what was happening. What did women do before all this stuff existed? We've been having babies for centuries; when did it get so complicated?

• • •

It must have been God's will. Don't worry—you can always have another baby...

• • •

I wanted to love Joshua, but I felt the need to protect myself from loving him too. I worried that every day we spent together would make it harder to lose him. In spite of ourselves we grew to love him, even as his life became more and more fragile and we saw him slipping away from us. We wanted him to come home, to live with us, to be normal—but we knew that wasn't possible. As the days went on I found that I got used to the idea that he was going to die. He was a very special part of our lives, even if for a short time ...

• • •

When Rachel saw that she bore Jacob no children, she envied her sister; and she said to Jacob, "Give me children, or I shall die!" Jacob's anger was kindled against Rachel, and he said, "Am I in the place of God, who has withheld from you the fruit of the womb?" (Genesis 30:1,2.) (RSV)

• • •

I knew I was pregnant from the very moment—and I knew from the core of my being that it was wrong. Even though I love children, I had no doubt that an abortion would be the right thing in this particular situation. That was five years ago, and every time I think about it I always have the same feeling—relief, almost a sense of deliverance. It would have been unbearable to have had to live with that mistake for a lifetime. My life was changed in this experience, transformed. I like to think I'm stronger now, more able to be my own person. I can't help think that making that decision was probably the beginning of a new life for me. It was probably when I became an adult . . .

The passing of life from one generation to the next through the procreation of children is surely one of God's greatest gifts. In Genesis 1, God's blessing and the injunction "Be fruitful and multiply" follow immediately after the creation of human life as male and female. Procreation was also seen as a sign of the earliest covenants between God and the people. (Genesis 9:1, 17; 4:6.)

When everything goes "naturally," we take the gift for granted and counsel contraception to avoid unintentional pregnancy. Yet human reproduction is not always the

easy and automatic result of our simply wishing it to be. One in five couples in the United States is infertile. A high percentage of all diagnosed pregnancies end in miscarriage, spontaneous abortion. Thousands of adolescent girls and women seek first trimester abortions each year because of unplanned or unwanted pregnancy. Stillbirth remains a painful problem; even when reasons can be found, there is little that can be done to assure that it will not happen again. It is estimated that 5 percent of all pregnancies that are liveborn have a severe disability that could have a genetic origin; approximately 4 percent of pregnancies that undergo fetal diagnosis are either selectively aborted or face the need for specialized care from the moment of delivery. Sadly, without any advance notice or warning, thousands of babies a year are born dying.

We have been nurtured to think of birth, the advent of new life, as a moment of joy. And for the vast majority it is—a time to be cherished and remembered, a family event, not a medical emergency. Unfortunately, however, for many, the inability to become pregnant and deliver a healthy baby forty weeks later is a source of deep despair. For some, joy becomes despair in a short while as new techniques bring awareness of genetic flaws. In others, unintended pregnancy raises other issues—how to cope? What are the alternatives? Is abortion a responsible choice in this particular pregnancy?

How is the church to deal with these concerns? As new options become available to correct or overcome particular problems, how are they to be evaluated? What is the pastoral role of working with families as decisions are made? What are the public policy dimensions of these most intimate of issues and decisions?

Generally, the beginning of life concerns may be categorized in four ways: (1) Decisions Regarding Care; (2) Crises in Wanted Pregnancy; (3) Infertility and Options for Couples Who Cannot Conceive; and (4) Dilemmas Surrounding Unintentional Pregnancies.

1. Decisions Regarding Care and Access to Adequate Care

The practice of obstetrics and gynecology in the United States has gone through radical transformation in this century. In 1900, nearly every child was born in the home, with family members nearby and a woman attending the local doctor, if a physician was present in the community. Birth was a common event; and though it was not without problems, it was not seen as a time of crisis. Gradually, however, as the medical profession became more established and institutionalized, the locus of decision-making and care gradually shifted from the family to professionals, from the home to health care centers and hospitals. Now, in the 1980's, sophisticated new technologies abound, deliveries are often done at the convenience of the doctor's schedule; and while improvements have brought about change, pregnancy is still treated like a disease and delivery is assumed to be a time of medical emergency.

Childbirth is not a disease; and while medical care and monitoring are critical to assure that all goes well, in the vast majority of cases, delivery need not be seen as a time of crisis. Over the past two decades, as women have become more involved in their own health care, particularly in obstetrics and gynecology, even to the point of establishing their own clinics, another trend has also been developing.

Family-centered birth is a trend that came about through the efforts of women and families in communities and in relationship to particular hospitals and physicians. It began with prepared childbirth classes to prepare women for the rigors of labor and delivery and to make them aware of the various stages of pregnancy and birth. It moved then to getting the classroom “coach” (usually the woman’s husband or sexual partner) into the delivery room. From there a variety of developments have evolved, including lying-in arrangements, alternative birthing centers, birthing rooms in hospitals with other children and family members allowed to be present, and the revival of home delivery and the practice of midwifery. The more informal hospital arrangements and home deliveries are recommended and used only in cases where the pregnancy has been declared to be “low risk” and no problems are foreseen that would necessitate extraordinary care during or after delivery. Even so, precautions are generally taken to assure that such care is readily available should it suddenly be needed.

Thus we see two trends—one toward greater dependence on hospital-based, high technology during pregnancy and childbirth and one toward more family-centered, “natural” deliveries. Both trends are needed to provide good care, to assure the birth of healthy children, and to correct the abuses of unwarranted medical intervention. Seen together, they can complement each other and provide appropriate care in particular situations as services and sites for services are selected in a partnership between couples and health professionals.

Unfortunately, however, access to good care and the luxury of decision-making among alternative types of care are not available to all. Thousands of teenagers conceive each year in ignorance of the biology of conception and without contraceptive protection. Denial, desire to hide the pregnancy, and lack of information result in little or no prenatal care. Poor nutrition and self-care during the pregnancy frequently result in low birth weight, permanent brain damage, and a lifetime of ill health for the babies who are born.

The pregnant population in the United States is divided. One group, largely white, affluent, and educated, seeks and gets as much medical care and attention as well as access to the new “toys” of technology as is wanted or needed during the childbearing years. The other, largely minority, poor, and undereducated, lacks even the most basic services to assure healthy births and children. Cutbacks in federal programs that have served to alleviate some of these problems in recent years are now re-creating a situation like that of the nineteenth century before the clear relationship between maternal nutrition and the health of babies was established.

2. Crisis in Wanted Pregnancy

Nearly every family has been affected at least once with a crisis in a wanted pregnancy—miscarriage, premature birth, stillbirth. Moreover, as will be discussed more fully in the next chapter, genetic and congenital problems, normally revealed only at birth, can now be detected through fetal diagnosis. These tests, while reassuring to the vast majority of couples who participate, bring tragic information to others. The joyful anticipation of a new child is dampened by the word that all is not well and the agony of deciding whether or not to continue the pregnancy to term.

Only recently have we developed sensitivities to the bonding of pregnancy and the need for grieving over the loss of a wanted child.¹ Even now we don't know what to say to couples unable to conceive, and we are awkwardly silent in the presence of those who have suffered miscarriage, stillbirth, or neonatal death. Liturgically we celebrate marriages and baptize infants; we have few resources, either ritually or pastorally, to offer in those events that fall between.

a. Miscarriage or Spontaneous Abortion

A large number, sometimes estimated to be close to 40 percent, of all fertilized eggs either do not implant in the uterine wall or do not continue to develop after the first few weeks of gestation. They die and eventually the woman's body readjusts to the new state of non-pregnancy and expels the embryo or fetus in spontaneous abortion. While there can be many reasons for this, generally, early abortion is because of a defective egg or sperm or the result of an aberration that does not allow the embryo to develop properly. The common counsel that it is "nature's way" of preventing the birth of children who would be grossly deformed is a reasonably accurate diagnosis in many cases. Genetic counseling professionals are beginning to be concerned, however, that such miscarriages may signal reproductive problems of a genetic origin. In addition to the counsel of their physicians, couples experiencing more than two early abortions without a full-term pregnancy would be well-advised to seek genetic counseling as they explore the implications and seek causes of these events.

While not as common, fetal death can also occur later in pregnancy and result in miscarriage. As bonding between parents and the pregnancy will have had more time to develop, there is an even greater sense of loss with later miscarriages and fewer easy explanations are available to soften the grief. Study of the fetal remains may reveal causes. Cervical or other problems, sometimes correctable by surgery, may be prohibiting the woman from being able to carry the pregnancy to term. Even if the couple is able to find answers to their questions, however, they will face grief and ambiguity about whether or not to "try again." The woman, particularly, can be overcome by depression, guilt, and anger that her body is not "working right." The fear that childbearing will not be possible looms larger with every incident.

Miscarriage, while common and usually not life-threatening to the woman, is a tragic loss of life and a source of anguish. Rather than being brushed aside, miscarriage should be taken more seriously by physicians, other family members, and congregations than has often been the case.

b. Premature Birth

When a fetus is developing normally but the pregnancy is cut short by premature labor and delivery, the family is suddenly thrust into crisis and ambiguity. While medical technology has made it possible to preserve the lives of smaller and earlier "premies," there are moral questions about the extent and cost of extraordinary care and the long-term implications for the quality of the infant's life if it is able to be sustained outside the womb. Happily, many premature infants undergo extreme crisis in the early days and weeks of life and develop with few, if any, problems. Long-term study of others, however, shows neurological damage and other catastrophic health

problems, which questions the wisdom of attempting to preserve, at all costs, these fragile human lives so abruptly brought to birth.

c. Abnormal Birth

With any birth there is some minimal risk that all will not go well. Not all genetic or congenital defects can be detected through fetal diagnosis. Environmental factors, including exposure to disease and chemical agents during the early weeks of pregnancy, may affect the offspring of even those who are “healthiest” genetically. In the passage through the birth canal, even the most routine of births can turn anticipated joy into sudden tragedy. Here, as in premature birth, the family is thrust unprepared into sudden crisis and the nightmare of an unknown future.

At moments such as these, medical resources can do their technological tasks, but the human resources, within the family, among hospital staff, and from clergy and congregations, are most critical. The sudden grief and agony of decision-making as a newborn is rushed to surgery or neonatal intensive care are crises parents cannot meet alone. The support of caring persons will be critical as they seek to understand options and make decisions. Insofar as it is possible, these times should be ones of partnership between families and physicians; options should be explained and time given for careful and thoughtful decision-making. The nearly automatic plea of the frantic parents to “save our baby” needs to be followed by careful consideration of what life for the child will be if extraordinary care does assure physical survival and what the long-term implications for other family members entail. The resources of prayer and counsel will serve to lessen the anguish and restore wholeness. Families need to be assured that the cataclysmic emotions they are experiencing are acceptable—and that their decisions are good ones.

d. Stillbirth and Neonatal Death

Likewise, the trauma of stillbirth or the unexpected loss of an infant through Sudden Infant Death Syndrome or some other fulminating disease can be devastating to a family. Unlike the premature or abnormal birth, there are no decisions—only the stunning sense of loss and helplessness. To deliver a dead fetus can create great anxiety for a couple as they contemplate future childbearing, particularly when no reason for the fetal death can be determined. As with those parents who have lost an infant, there is often reluctance to risk the emotional investment of another pregnancy for fear that life will be snatched away by a cruel and unseen fate.

Here again, support is critical as parents return home alone and face the emptiness where a child was to be or the devastating loss of one they had grown to know over several weeks or months. There will be grieving and the need for a liturgical response. Funerals or memorial services provide ways for families to cope with both stillbirth and infant death and for the community of faith to share with them their grieving, their loss, and their hope for the child they will not be able to nurture to maturity. Beyond the service, however, the companionship of the congregation is essential as lives are reconstructed after such a loss and patterns for future living are established. The church can provide informal networks of support within the congregation or organize groups of grieving parents that go beyond the church’s membership to

meet a need within the community at large. Frequently this ministry is best provided through the ecumenical cooperation of several congregations working together.

3. Infertility and Options for Couples Who Cannot Conceive

Increasingly, as couples delay intentional childbearing and use contraceptives to suppress fertility during their twenties and early thirties, they later face the painful realization that they may not be able to conceive. Others, having defined their marriage commitment in terms of mutual childraising, face almost immediate disappointment when no children are conceived. Reluctant to seek medical attention “so soon,” they think things will “work out” if only they are patient; but patience seldom solves the problem.

While the causes of infertility in either partner may be many, the consequences are shared, as are the disappointments, feelings of dismay, helplessness, and envy of those who conceive without complication. It has only been in the last twenty years that research on fertility problems has been sustained on a significant level; male fertility problems have been the focus of study in the last five years only. Structural damage from disease or accidents, impairment as a result of exposure to work-related hazards or environmental pollution, hormonal imbalances, or factors related to age can all have an effect. Research on causes has also led in many cases to means of overcoming the problems. Drug therapies can regulate ovulation or increase the chances of effective implantation. Surgical means have been developed to unblock diseased fallopian tubes or improve the passage of sperm through varicose scrotal veins. Frequently these ameliorative techniques can result in a successful pregnancy; sometimes, however, all efforts fail and the couple must face the reality of infertility.

Couples undergoing fertility evaluations regulate their lives around temperature charts, sperm counts, office visits after intercourse, and other indignities out of their mutual commitment to having children if at all possible. Tensions in the marriage frequently develop, leading some couples to stop the testing because their marriage is more important than the constant focus on childbearing; others, frustrated and unable to reconcile their disappointment, divorce. Costs, while often high, are frequently covered by private insurance up to a certain level, but eventually the couple must decide how much of their resources will be committed to attempting to overcome their physical inability to bear their own children.

Alternatives to childlessness have always existed. Informal relationships with other couples' children satisfy many people's needs for nurturing and sharing with younger persons. For many years, the infants of teenage or single women who did not intend to raise their birth children themselves were available for adoption.

However, access to safe and legal abortion services and the increased number of young women who decide to keep their babies upon delivery have limited the number of babies available for adoption, and couples facing infertility are less likely to take in an older child or one who is handicapped or is of mixed ethnic heritage. Black market adoptions at high cost and high risk are seen by many as the only way to get a “good, healthy baby” within days of birth.

In recent years, medical developments that carry varying degrees of risk and moral ambiguity have become available to help many infertile couples have children that are biologically their own. In cases where the man has a low sperm count, ejaculant can be collected and artificially inseminated into the woman in order to maximize the chances for fertilization to occur. In cases where the man's sperm is incapable of fertilization, sperm can be obtained from a relative or anonymous donor and artificially inseminated in order to achieve conception. While a simple procedure medically, artificial insemination separates the physical act of intercourse from the conception of the desired child, creating for some a moral dilemma and charges that "laboratory adultery" is being perpetrated in the name of medical care. When the donor is someone other than the husband, there are those who question the morality of such conceptions and feel that the children by virtue of being conceived by sperm that is not the husband's are illegitimate. On a practical level, the use of donor sperm does cut off the child from knowledge of the genetic background of the biological father, which can become critical later in life.

If the woman is unable to conceive or continue a pregnancy, drug therapies, with certain accompanying risks, are available. For those who produce healthy eggs but cannot conceive because of blocked Fallopian tubes, in vitro fertilization has become possible. In these procedures, one or more ripened eggs are removed from the woman's ovary and fertilized in the laboratory with the husband's sperm. After a short period of development, the embryo is inserted into the woman's uterus where, if it implants, it develops until delivered. In other cases, where for any number of reasons, the woman cannot carry a pregnancy to term, a surrogate mother can be arranged who will, for a fee, be artificially inseminated and deliver a child for the couple.

Many of these methods go beyond traditional notions of medical "care" and become radical interventions toward the goal of conception and delivery. They have raised strident protests from some ethicists and have tended to take on sensational proportions within the media. Some are concerned about the seemingly casual treatment of the power of procreation and fear that its significance will be diminished by the availability of sperm banks and "rentable wombs." Many are concerned that these techniques, once perfected, could be too readily available, making children a commodity and enabling childbearing outside of the marriage covenant, e.g., to single persons or homosexual couples.²

4. Dilemmas Surrounding Unintentional Pregnancy

Each year, due to contraceptive or human failure, thousands of unintended pregnancies are conceived. As many families well know, an unintended pregnancy can become a wanted pregnancy and a cherished—though unplanned—member of the family covenant. In the majority of cases, this is how unintended pregnancy is handled—a decision is made to adjust and adapt and to prepare for a new human life.

Likewise, in these situations, decisions are made that to continue the pregnancy is not a responsible alternative. This choice does not arise out of a casual attitude toward childbearing or disregard for human life. Rather, women and couples who choose to continue a pregnancy, as well as those who choose to terminate one, have exercised human responsibility by evaluating their physical, emotional, and financial re-

sources—and deciding on a course of action in the particular context of a particular pregnancy.

Moral practice in the use of surgical abortion is not based on a set of categories, such as social and economic resources, emotional stress, or even rape, incest, or life endangerment of the pregnant woman. Because abortion is chosen in the exceptional case, any single rule regarding its practice by the Christian is probably not possible. Rather, as Presbyterians, we affirm the value of conscientious decision-making empowered by the Holy Spirit. While it is statistically likely that virtually all women whose lives are endangered by pregnancy will choose abortion, it is not for the church to decide for them. Likewise, victims of rape and incest frequently choose abortion, but only they know their own situation and only they can decide. It is far less common for a woman or a couple who perceive a particular pregnancy as a cause of financial or emotional stress to decide to abort. Yet statistics do not determine morality. The morality or immorality of an abortion is not contingent on the kind of problem that prompts its consideration, but on the seriousness of that problem in the particular case. The morality of abortion is a question of stewardship, not of casuistry.

There is no point in the course of a pregnancy before which the moral issue of abortion is insignificant. The morality or immorality of a decision is not determined by the gestational age of the fetus. Abortion is always a moral dilemma to be undertaken with great care.

Within this understanding, however, guidelines regarding abortion can be offered.

(1) If possible, abortion should be sought and performed during the first twelve weeks of pregnancy, not because the fetus is of less moral significance in the early stages but because the surgical procedures used in the early weeks of pregnancy are safer and the process is experienced as surgery, not as labor and delivery.

(2) There are three groups for whom second trimester abortions are needed, even with the greater risk involved in general anesthesia for surgical removal of the fetus and the experiential distress of labor and delivery. These groups include: (1) women of menopausal age who do not discover that they are pregnant until the second trimester; (2) women over 35 and others who discover through fetal diagnosis that they are carrying a fetus with a grave genetic disorder; and (3) women who did not seek or have access to medical care during the first trimester (primarily teenagers who were ambivalent about their pregnancy and fearful about disclosing it to a friend, family member, or professional who could be of aid).

The current practice of abortion in the United States is consistent with these guidelines as a result of the 1973 Supreme Court decision. By allowing states to restrict the performance of abortion to hospitals in the second trimester, the court establishes a financial incentive for first trimester abortion and continues the intent of abortion legislation historically, that is, the protection of the pregnant woman's health. The availability of second trimester abortion, though infrequently utilized, prevents those who seek it from having to face the additional financial burden of seeking court permission on a case-by-case basis. The decision can be made and carried out in the privacy of the family's relationship with its physician.

(3) The point of viability, the ability of the fetus to survive outside the womb as an autonomous being, coincides roughly with the end of the second trimester. Because we value human life, the fetus at this stage has the same moral claim as any other human, and termination of pregnancy at this stage is undertaken only in rare circumstance, usually to preserve the health or life of the mother or to terminate a fetus that is diagnosed as being unable, for genetic or other reasons, to survive autonomously outside the womb.

Long before the development of current contraceptive knowledge and the possibility of safe termination of pregnancy, John Calvin wrote of the stewardship of life:

For he who has set the limits to our life has at the same time entrusted to us its care: He has provided means and helps to preserve it; He has also made us able to foresee dangers; that they may not overwhelm us unaware, he has offered precautions and remedies. Now it is very clear what our duty is: Thus if the Lord has committed to us the protection of our life, our duty is to protect it; if He offers helps, to use them; if He forewarns us of dangers, not to plunge headlong; if He makes remedies available, not to neglect them. (Institutes of the Christian Religion, I.17.4.)

Protestants have long affirmed the use of contraception as a responsible exercise of stewardship of life. To prevent pregnancy when it is not desired is to be a responsible steward of human life. However, in the exceptional case in which a woman is pregnant and judges that it would be irresponsible to bring a child into the world, given the limitations of her situation, it can be an act of faithfulness before God to intervene in the natural process of pregnancy and terminate it.

There is frequently a tendency for those outside the decision-making process to feel that it is more virtuous to continue a pregnancy, once begun, without considering abortion. Stewardship cannot be reduced to awe of natural processes or biological determinism. A woman who considers abortion and then opts to continue her pregnancy should never be made to feel guilty that she has pondered the question of abortion. It is far better to give birth intentionally than to feel that the diagnosis of pregnancy constitutes an absolute obligation to bear a child. In most pregnancies, the question of abortion will never arise, but when it does, the choice of abortion can be an expression of responsibility before God.*

5. *Parenting as Covenant Initiation*

Life itself is a gift of God. "... then the Lord God ... breathed into his nostrils the breath of life; and man became a living being." (Genesis 2:8.) And to pass life on from one generation to another is seen as God's continuing gift. Scripture abounds with references to childbearing; in fact, in the Old Testament, images of salvation and immortality are intimately connected to the procreation of children. Even though there must have been frequent problems associated with pregnancy and delivery in biblical times, the Scriptures are largely silent about the details, for their focus is a theological one. The covenant exists from God through the generations of Abraham, and childbearing imagery is frequently used to describe the relationship between God and the people, in both judgment and joy, travail and promise.

* Dilemmas surrounding unintentional pregnancy are discussed in much greater detail in a companion paper, "Covenant and Creation," which follows.

The Old Testament references to childbearing, however, must be read in terms of the context of the nation Israel—a struggling tribal people, eking out an existence under adverse conditions. Children were needed for labor and for security in old age and were desired as a sign of God’s blessing. Not to be able to bear children was perceived as a sign of God’s disfavor and the cause of great anguish.

Contemporary society, however, finds itself in a radically different situation. For the first time in history, childbearing can be a choice, not the automatic or assumed result of sexual activity.³ Couples may choose to inhibit fertility through conscientious use of birth control medications or devices. Infertility problems can be understood and frequently addressed. Amniocentesis can reveal much about the fetus and its prospects for a healthy life several months before delivery. And in cases of unintentional pregnancy or where medical indications are present, it is medically safe and legally possible to terminate a pregnancy during the first two trimesters.

How are these developments to be understood theologically? And what insights are available from the Christian tradition to aid people in decision-making?

The hope to bear children and the decision to seek conception and childbearing are ones of ultimate importance, for they are ultimately part of a process of covenant initiation. Because life is of God, it is lived in relationship with God. Life cannot be taken lightly and should not be passed on without much thoughtful planning and preparation. First, the ability to use procreative power intentionally is a basic difference between human life and other forms of life. Second, to be responsible for our children over long years of nurture is another uniqueness. Third, to seek ways to enhance the lives of others, including the children whom we conceive, is the task of dominion. In short, human responsibility for life can be described using the imagery of birth itself: As human couples, we co-labor to give birth to our children, and we co-labor with God to fulfill the covenant of life granted to us as a gift.

Yet, to co-labor with God does not carry assurance that life will be perfect or without pain. Not all conceptions result in pregnancy that will develop to term. Not all births deliver babies who are capable of sustaining life. To seek to parent is to expose one’s vulnerability as a creature. Medical science can do many things, but it will never overcome human creatureliness and dependence on God.

Neither can medicine or new biomedical technologies create life. They can create new possibilities for life, overcome conceptive barriers, seek ways to preserve the lives of babies born with grave and threatening problems, but they cannot create life. To the Christian, life is ultimately and only a gift from God.

As gift of God, life must be taken very seriously. It must be revered and valued. On the other hand, as God’s gift, it must not be taken too seriously, lest it become an object of idolatry, a substitute for the only God, the God who gives the gift of life. Those who face reproductive problems tend to focus their lives almost totally on the desperate desire to bear children. Those who vehemently oppose abortion in the name of the fetus’s “right to life” elevate the significance of fetal life to the exclusion of any other factor or person in the particular situation of pregnancy. Physicians, confronted with a tiny premature newborn, may struggle more with competitiveness than compassion to salvage the fragile life, despite almost certain and catastrophic impairment

should they “succeed.” Life is sacred, but its sanctity lies not in its biological basis but in its source: God.

In the current highly politicized debate over reproductive choices, centered in the discussion of abortion, a polar approach is taken. The “sanctity of life” is held up by those who oppose abortion as though it were totally opposite from the “quality of life” discussed by those who support the decriminalization of abortion. It is implied, if not stated outright, that to be “pro-life” is to be opposed to responsible moral decision-making, and that to be “pro-choice” is to be against “life.” Sloganeering in this struggle has been destructive to the humanity of persons on both sides of the debate.

More helpful to persons who face decision-making at the beginning of life is a supportive concern that takes into account the difficulty of the decision. It is difficult precisely because human life is so valued: What risks are involved in fetal testing? What harm might result from a particular drug, and is the desire to conceive worth the chance of possible harm? If treatment is begun and the “premie” survives, will life outside the hospital ever be possible? What are the chances of contraceptive failure? What is my(our) situation and could I(we) establish a covenant with a child who might be conceived?

These issues are not abstract; they go to the heart of family life and affect members of every congregation. For the church to minister, it must be in touch with the anxieties, fears, hopes, and joys that persons have around beginning of life issues. Strangely, either out of reluctance to deal with sexuality or because of embarrassment, the “passages” of the childbearing years are seldom discussed openly in the church. Preaching seldom acknowledges them except perhaps peripherally on Mother’s Day, adult education does not discuss them, and there are no rituals to mark them.

Liturgy signifies importance. That which is celebrated liturgically is remembered, bears meaning, and creates community. An experimental liturgy has been developed that includes a Rite to Celebrate the Decision to Have Children. The celebration of such a ritual marks publicly and before God the transition from childlessness to parenthood, a transition of great significance for the couple, for the community, and, of course, for the children who are born or adopted in consummation of that decision. To share such a transition within the worship life of the body of Christ, which gathers weekly to share its creatureliness and its caring for one another, seems entirely appropriate.

Human life in relationship with God is the heart of the Judeo-Christian tradition. To speak either of life or of God is to speak of the covenant relationship that binds human beings to God and to one another. The issues that surround the passing of life from generation to generation are central to our self-understanding as people in relationship with God; our relatedness to God brings to our human relationships a dimension of the holy. To exercise dominion as human decision-makers in the issues that surround the beginning of life is to co-labor with God, seeking wisdom and relying in trust on God’s covenant care.

CHAPTER 3: GENETIC CHOICES AND THE ETHICS OF DOMINION

Given your medical history, Mrs. Long, I would recommend that you and your husband have genetic counseling before attempting to conceive another child and that you have amniocentesis during the pregnancy ...

• • •

They told us, “Lightning won’t strike twice, have another baby right away.” We lost our first baby and now Caroline is severely retarded. We’re angry .. upset ... and afraid to much one another for fear of risking another catastrophic pregnancy....

• • •

Let me be as honest with you as I can be. There are problems with your baby. We know something about the extent of the problems, but we don’t know everything you would like us to know. Some of the problems will be correctible by surgery, the others ... well, I just don’t know. I will answer your questions as well as I am able, but there is a lot going on inside your uterus that I just don’t know about—and won’t know about until delivery . . . if you decide to continue the pregnancy to term ...

• • •

We love Jonathan deeply; he has been the joy of our lives and adds much to our family despite his limitations. Frankly, however, if we had been able to choose, as couples can now, it might have been better if he had not been born ...

• • •

We knew we were taking a risk and we took the tests at each step of the way. Even when the results showed that David’s problem was going to be present in our son, we went ahead. His life has been a good one, and we want to share the joy of our life together with children, even if they don’t look quite “normal” to everyone else. The hardest part was explaining it to friends at church—they just didn’t seem to understand how we could knowingly have a child who wasn’t “perfect”

• • •

As we baptize with water, baptize us with Holy Spirit, so that what we say may be your word and what we do may be your work. By your power, may we be made one with Christ our Lord in common faith and purpose. *The Worshipbook*

Genetics is the study of the transmission of hereditary traits and as such deals with the very foundations of biological existence. It is also an area of science in which startling discoveries have been made in the past ten to fifteen years, with each discovery establishing new knowledge and demanding new decisions in areas that were once thought to be the province of God and thus beyond human consideration and control.

Research in genetics does not have a long history. In fact, its beginning was in the pioneering work of the Russian biologist, Gregor Mendel, in the middle of the nineteenth century. He first discovered that biological characteristics are passed on to new generations through discrete hereditary traits. Before Mendel, scientists assumed that the physical characteristics of offspring were determined by the simple blending of influence from the parents, in much the same way that colors combine. Mendel, however, by studying the reproduction of pea plants, was able to discern the es-

establishment of unique characteristics in the offspring. These hereditary elements were later identified as genes. The most significant part of Mendel's investigation was his theory that these discrete hereditary traits were found in all life forms.

With this theoretical development, the science of genetics was born. But it was slow in developing. In 1868, Haeckel, a biologist, hypothesized that the base of heredity was in the nucleus of cells, and in the same year Frederich Meischer discovered the existence of the material constituting genes, later named deoxyribonucleic acid or DNA. It was not until 1953, however, that James Watson and Francis Crick uncovered the material structure of DNA and were able to discern how it operates as a blueprint for protein synthesis. Each molecule of DNA is organized into two strands of "nucleotides" that turn around one another in helical fashion. The repeated sequence of the four different nucleotides in each strand of this "double helix" constitutes the "genetic code" and creates proteins with unique functions throughout the body.

Since the work of Crick and Watson, the field of genetic theory has developed rapidly. Scientists can now examine, identify, and manipulate specific genes and thus influence genetic processes. It is this far-reaching ability to analyze and manipulate genes that is called "the new genetics." In 1973 a major breakthrough came when scientists learned how to place a sequence of DNA into another organism and thus create new organisms that can carry desired characteristics into future generations. This ability to separate the DNA structures and then recombine them with other organisms is the basis of the recombinant DNA technology. Although there are many areas that are and will be affected by these developments, this paper will address only those related to human health and reproduction.

There are several ways in which applied genetics have been utilized in medicine in recent years and possibly will be in the future. These include: counseling and screening, fetal diagnosis, pharmacology, therapy of afflicted individuals, germ cell treatment to eliminate the affected gene, and the introduction of desirable traits.

1. *Genetic Counseling and Screening:* Genetic counseling is a rapidly developing area of medicine and is often related to social service and other departments within a hospital. Optimally, it is not so much a "service" as a process whereby an individual or a family learns about real or possible genetic problems, comes to understand the implications and significance of these problems, and is made aware of various options that are available for coping with them. According to Dr. Renata Laxova of the Waisman Center in Madison, Wisconsin, "It is a continuous process beginning with the perception of the need for counseling, through referral, diagnostic, prognostic and management procedures." Ideally the process continues indefinitely, "in the form of a lasting, supportive, informative and empathetic relationship between counselors and families." Effective counseling is evidenced, in her view, not in the reproductive behavior or decision-making of the families, but in their understanding of their own situation and all of the options, facilities, and persons who are available to help them.¹

Genetic screening is a process whereby persons are tested for the presence of a particular trait in their own genetic makeup. Persons of particular ethnic heritage, for instance, often wish to know whether they are carriers of a disease that frequently afflicts their ethnic group. By law, newborn infants are screened for certain diseases, particularly phenylketonuria (PKU). An issue, of course, is who decides who should be

screened, for what diseases, and what use will be made of the information gained. Voluntary screening is a far different phenomenon than the compulsory screening of particular groups at the insistence of others.²

2. *Fetal Diagnosis*: Fetal diagnosis is rapidly expanding the horizons of knowledge about the human fetus before its birth. At present, the normal procedure is in two parts. First, the fetus is studied through ultrasound testing, which prints a “photograph” of the fetus in the uterus, indicates certain normalities or abnormalities, hints at others, and shows the location of the placenta to lessen risk to the placenta during the amniocentesis. Second, a portion of amniotic fluid is withdrawn from the uterus (amniocentesis), and fetal cells that are present in it are cultured over a several week period. This allows various tests to be administered that can reveal several kinds of information about the fetus and its development. In certain cases, additional study can be carried out through the use of a fetoscope, which when inserted into the uterus allows the physician to examine small portions of the fetal body.

What are the genetic and congenital conditions that can be diagnosed in the uterus at present? Briefly they include:

- a. Conditions that are visible by X-ray or ultrasound. These include hydrocephaly (fluid in the brain cavity), microcephaly (abnormal smallness of the head), malformed limbs and digits, Siamese twins, cleft palate, hair lip, etc.
- b. Conditions that can be inferred by chromosomal analysis of amniotic fluid, such as a high alphafeto protein level, which predicts spina bifida.
- c. Chromosomal disorders diagnosed through analysis of fetal cells cultured outside the uterus, such as Down’s Syndrome (Trisomy 21), variant sex chromosomes, and so on.
- d. Blood system disorders diagnosed by study of fetal blood cells, such as sickle cell disease and thalassemia.
- e. Specific metabolic diseases diagnosed by analysis of the metabolism of fetal cells, such as Hunter’s disease.
- f. Fetal sex determination in the case of concern for sex-linked disease such as hemophilia.
- g. Tendencies toward polygenic disorders, those which are caused by a variety of factors, including a discernible genetic marker. Such “markers” are now available for one form of kidney cancer and one form of breast cancer. In the future, propensity to diabetes, cardiovascular disease, other cancers, and even some forms of mental illness will be able to be uncovered through fetal diagnosis.

While this knowledge is staggering, it is nevertheless fragmentary in relationship to the large number of genetically related diseases and disorders and the vast variation in severity and impact they represent. Even with frequent new breakthroughs in diagnosis, there are many severe problems that cannot be diagnosed in utero (such as cystic fibrosis). Parents and physicians thus have access to new knowledge but frequently

do not yet have enough information to answer their questions and assure well-informed decision-making. Application of recombinant DNA techniques to fetal diagnosis or the use of nuclear magnetic resonance to study the fetus in utero may provide more thorough information to families facing these decisions, but it is unlikely that it will make the decision-making any easier.

Currently, amniocentesis is performed nearly midway in the pregnancy, in the early part of the second trimester when sufficient amniotic fluid is present in the uterus. This factor, plus the length of time required to culture and test the cells, means that the pregnancy is well into the second trimester before the test results are received and the decision-making about those results is done. If a second trimester abortion is chosen, medical, as well as moral, problems are raised, since the procedure requires hospitalization, destruction of the fetus through hormone or saline injection, induced labor or delivery of the fetus by Cesarean section, and a major emotional trauma to the pregnant woman and her family who generally are losing a child they wished to conceive but have reluctantly chosen not to bring to birth.

Research is under way, particularly in the Soviet Union and England, that would permit fetal diagnosis through examination of maternal blood cells or examination of fetal cells obtained from the chorionic villi at a much earlier stage of pregnancy. Fears that these procedures would introduce infection or stimulate the uterus to miscarry seem to be unwarranted, and the success rate for diagnosis is high thus far. The distinct advantages of such earlier diagnosis are that the couple will have developed less bonding with their hoped-for child and an abortion, if one seems warranted by the diagnosis, is much less a traumatic procedure in the first trimester. Early diagnosis, however, will not lessen the moral ambiguity of abortion, which pervades the decision at every stage of fetal development.

3. *Pharmacology*: Recombinant DNA technology has been used successfully to mass-produce a number of enzymes used as treatment for disease, such as insulin. Experimentation on others, including the much-heralded interferon, continues. In these instances, DNA technology reduces the cost and brings within reach new medicines that otherwise would be prohibitively expensive.

4. *Therapy of Afflicted Individuals*: Genetic therapy or genetic engineering with persons with genetic disease would involve integrating unaffected DNA into the cells of persons with genetic disease. For instance, sickle cell disease is caused by an alteration in the gene, which manifests itself in the production of defective hemoglobin. Through genetic engineering it may be possible to introduce normal genes into the red blood cells and to displace the abnormal gene. Research on such techniques is under way and is being carefully monitored for application to human beings. Unlike drug therapy, such therapy could offer permanent cure for the person, but would not eliminate the gene; offspring of the "cured" person would have the gene and would themselves have to undergo similar therapies to overcome the disease.

5. *Germ-Line Treatment*: The ultimate genetic "fix" would involve the introduction of correct DNA into the germ (egg and sperm) cells rather than the somatic (body) cells of the affected person. This would provide for the long-term elimination of the genetic disorder in future generations as well as the affected individuals. Though not likely to be a possibility in the near future, this type of treatment, if and when it does become a

possibility, raises larger moral questions than other techniques, for it would allow humans to determine the genetic make up of persons in their own and future generations.

6. *The Introduction of Desired Traits:* Known as “positive” eugenics, this use of recombinant DNA technology would insert DNA for specific desired traits, such as increased memory ability, into the cells of persons seeking those traits. While an advanced technology would make such a program possible, the same moral questions are raised by sperm banks and other efforts to breed “selectively” in order to increase intelligence, height, and so on in offspring.

By far the most prevalent occasions for genetic choice at this time are those surrounding screening, counseling, and reproductive decisions. In many cases, it has been the very improvements in medical care that have created the problems being faced today. In earlier generations, persons with debilitating genetic or congenital disorders would not have lived long enough to reproduce. Now they do; and thus questions of reproductive choice arise. To have biologically related children is one of the most basic of human desires. Couples in which one or both are carriers of a genetic disorder, however, must evaluate several options. Previously, it should be noted, most couples probably chose not to have biologically related children; now at least there are options to consider. Sperm from an anonymous donor can be used if the male is the carrier, or the husband’s sperm could be used with a surrogate mother if the carrier is the female. They could also take their chances, depending on the severity of the disability, and choose to undergo fetal testing with the option of fetal therapy or selective abortion. While fetal diagnosis is often criticized because it leads in some cases to abortion, it also makes possible the lives of many children who would not be conceived if their parents considered the risk of genetic disease too high.

Many conditions that come about because of genetic disorders are minor or are easily corrected by surgery either at birth or during infancy. The ability to learn about offspring before their birth is indeed a wondrous gift, which leads in 95 percent of the cases to a more relaxed pregnancy, knowing that certain conditions are not present in the fetus.³ In other cases, fetal diagnosis can help parents, even those who could not morally choose abortion, to prepare for the birth of a disabled child. In still other cases, it leads to a decision to terminate the pregnancy because the family projects that it is not willing or able to extend their family covenant to include such a child.

Ethicists have raised concerns about fetal diagnosis because of this. Will this option lead to a culture of perfectionism in which those who do not fit the description of “normalcy” or “desirability” will be eliminated? To “cure” a disease by doing away with the patient is, admittedly, far different from other kinds of “healing”.⁴ Abuse could, according to some, lead to the neglect of affected newborns or a society where only particular “types” are permitted. Such idolatry was the sin of Babel. God wills and the genetic health of the human species is dependent upon diversity; homogeneity is not a “good” to be sought after at all costs. Yet it is unfair for those who would not have to care for the child to proclaim that the parents sin if they choose to abort. Genetically based abortion is filled with ambiguity as is each abortion decision, but all human choice is grounded in ambiguity.

On the level of policy, it is important to note that genetic screening should never be made mandatory, particularly in situations where there may be some question as to the purpose of the screening or the use to which findings will be put. Workplace screenings, for instance, could be used to deny certain persons access to particular jobs or to deny corporate responsibility for occupationally related disease. The current debate over the mutant effects of Agent Orange on persons who were exposed to it in Vietnam is a case in point.

Much more research needs to be done on the effects of environmental and occupational pollution on human genetics. When genetic disease is caused by corporate or governmental decision-makers who do not accept responsibility for the indiscriminate consequences of their choices, it is a far more serious moral issue than when a genetic disease is carried as a result of individual and family choice that accepts such responsibility.⁵ Dominion must not be perverted for economic gain. To deny the needs of others in human decision-making is to commit the sin of Cain.

The Theology of Creation—The Ethics of Dominion

By faith we understand that the world was created by the word of God, so that what is seen was made out of things which do not appear. (Hebrews 1:3.)

John Calvin wrote that the “skillful ordering of the universe” provides humanity with a “mirror in which we can contemplate God, who is otherwise invisible.” (Institutes, I.V.1.) Certainly through developments in genetics, more and more of the “skillful ordering” of the universe is being revealed for human knowledge. Yet the reaction of many people of faith has been to shrink away in fear, overwhelmed by the possibilities for error and corruption. Others, equally faithful to their views of creation and God’s relationship with humanity, have optimistically embraced the seemingly infinite possibilities for human endeavor that lie just beneath the surface of these new technologies, with little regard for the consequences and moral dilemmas that might be inherent in their use. A vast literature of ethical reflection has arisen over the past fifteen years that provides theological support for the full spectrum of responses, from restrictive application of the new technologies, support for cautious experimentation, all the way to enthusiastic acceptance of nearly every possible development.⁶

While Calvin and other Reformed theologians were devoted to understanding the created world as a significant source of revelation, they were also quick to point out the vast divide between God and nature, Creator and creation, which is part of the biblical tradition:

O Lord, our Lord, how majestic is thy name in all the earth! ... When I look at thy heavens, the work of thy fingers, the moon and stars which thou hast established; what is [humanity] that thou art mindful of [us]? (Psalm 8:1, 3, 4a, RSV.)

Human ability to discern knowledge of God through “the very order of nature” is limited by sin. “If Adam had remained upright,” reflects Calvin, there would be no barrier to our knowledge of nature and God’s revelation through nature. However, we live after Genesis and know that both our relationship with God and our understanding of the natural world are distorted.

Paradoxically, human life is both part of the created order—finite, part of the earth, created, and thus corruptible—and that part of the creation which is created in God's image and given dominion over the rest.

Then God said, "Let us make [humanity] in our image, after our likeness; and let them have dominion over the fish of the sea, and over the birds of the air, and over the cattle, and over all the earth, and over every creeping thing that creeps upon the earth." (Genesis 1:26, RSV.)

Scientific and medical exploration have been premised on the desire to discern God's good gift of creation and God-given freedom and creativity. Humans were given the garden to till and to keep in responsible partnership with God. Thus to intervene or to reshape creation is not forbidden; indeed humanity is called to use the raw material of nature and of life to make creation better for those who share the garden and for future generations. The notion is deep-seated in Western consciousness that people have both the right and responsibility to domesticate animals, to cultivate certain plants, to overcome disease, to prevent floods, to stop pestilence, and to alleviate suffering—in short, to alter creation by intervention. But the permission to intervene is not unlimited. Both vocation and sustenance-seeking have boundaries set by God. Dominion is not a license for exploitation and abuse; rather it is a mantle of responsibility to care for creation and to seek its enhancement.

Indeed, God is also about this task. Creation is ongoing, leading toward a day of completion.

Behold, the dwelling of God is with [humanity]. [God] will dwell with them ... will wipe away every tear from their eyes, and death shall be no more, neither shall there be mourning nor crying nor pain any more, for the former things have passed away. (Revelation 21:3,4, RSV.)

To use the imagery of the apostle Paul, God is bringing to birth a new world out of the creation. Properly limited, human participation in this newness is God's gift of vocation: to be co-laborers with God, to serve as midwife in the birthing of the new world.

Creation-based theology, drawn from the biblical foundations and medieval thought, was central to the rapid development of science, which was almost coterminous with the rise of Protestantism in Europe. Thus the Reformed theological tradition has been supportive of inquisitive investigation, creative manipulation, and responsible stewardship of the physical and natural world. The closer science comes to touching the very foundations of biological life, the more essential reverence for the created order will be. Within that reverence, however, the Calvinistic spirit would prompt present day researchers to inquire tirelessly and provide access to as much information as possible so that the human purposes of enhancement, health, justice, and fulfillment might be served.

But the exercise of scientific inquiry is not isolated in a laboratory-based holy of holies. Each development carries with it implications for use and consequences for the natural world and human society. Even if the worthiest goals could be assumed, there would still need to be moral questioning about the uses of new technologies. Who has access? Who determines use? The World Council of Churches (WCC) has been monitoring developments in the new genetics for a number of years, as have several denominations in the United States. In the first church report in this area, the WCC posited:

Church people cannot expect precedents from the past to provide answers to questions never asked in the past... Ethical decisions in uncharted areas require that scientific capabilities be understood and used by persons and communities sensitive to their own deepest convictions about human nature and destiny. There is no sound ethical judgment in these matters independent of scientific knowledge, but science itself does not itself prescribe the good.⁷

Fully recognizing the novelty of these developments and the penchant of church groups, particularly in the West, to be dazzled by such phenomena to the neglect of justice issues, a more recent WCC report precedes its recommendations with a word of caution:

Although it is certainly appropriate to give attention to specific issues of genetics practice, whether now operational or projected, such attention should not displace, but ought rather to reinforce, concern for the broader questions of justice, human purpose and the quality of life.⁸

Thus the church is confronted at this time with new questions of humanness and the ethics of dominion. New knowledge has brought about new possibilities, but these new options bring new questions and new responsibilities as well. While the fears of the recent past now seem to be largely unwarranted (DNA research is not going to unleash laboratory-created monsters on the unsuspecting suburbs), there are more subtle questions to be answered as faithful people seek to discern the boundaries of human responsibility. As with most moral questioning, there is also the issue of community. The new genetics, while based predominantly in the private realm of individual and family health, cannot be limited to a privatistic view. Both in terms of policy and resource distribution, new genetic choices raise the public questions of community. They also raise eschatological concerns of the future of the human species within the rest of creation.

A few of the questions that arise include: What are the perimeters of human life? What are we to expect in our offspring, and where do we draw the line of caution when test results raise concerns?

Is it moral for parents to knowingly destroy life they have conceived in love and yearning?

Conversely, is it moral knowingly to bring to birth a child so severely damaged physically and mentally as to preclude the possibility of anything like autonomous human existence? Is it moral to assume that society will support such a choice and absorb the cost of catastrophic medical care?

Theologically, is there an unacceptable exception? Socially, are there limits to a family's ability to bear the burden of an exceptional child?

Is there a difference between deciding at three-months gestation, six-months gestation, or at birth that the developing life should not be continued?

Is it just to preserve distorted human life for the sake of its "life" without regard for the quality of life that society is prepared to offer—too often the medical equivalent of a leper colony?

Who decides? For whom do they decide? On what criteria? With what moral guidelines?⁹

These are questions that are filled with anguish for all Christians of whatever theological persuasion, for we are all called and committed to reverence for all of God's creation. They will not be answered easily, either in the abstract or in the crisis of a medical emergency. Genetic research and fetal diagnosis search the unseen and delve into the unknown, bringing to light insights and information never before available. As a people we have eaten of the fruit of new knowledge and can celebrate that newness, but we are also burdened—burdened with new responsibility, with the need to make decisions where decisions were never before needed, with the ambiguity of decision-making without the full information we would seek to be responsible before God and our consciences, with the power of life and death over other persons and future generations. We are burdened as well with new power to define areas we would have preferred to leave untouched—What is human? What is quality in life? And too often we are seduced by an image of perfection for our fragile clayhouse-bodies.

This paper cannot presume to make decisions for individuals or for families, but it can offer guidance to congregations that more and more frequently will be facing genetically related decision-making among their membership. Pastoral leadership in the care and nurturing of families facing new decisions will be critical. By becoming knowledgeable about genetics and the new developments in diagnosis and treatment of genetic disease, pastors can guide congregations to greater understanding and support for the members in their midst who are having to deal with these questions in the realities of their own family life. Some pastors have begun to utilize a family health history in their premarital counseling in order to become aware of reproductive concerns that might be present.¹⁰ Prayer and support groups within the church can be critical both during the time of crisis and in living with decisions after they are made. Congregations can also take leadership in providing support for families who have left their own congregations and communities to travel to care centers in metropolitan areas.

“Genetics, Health and Personhood,” *Church and Society*, 73:1, September-October 1982, was prepared by the Task Force on Science, Medicine and Human Values as a resource for congregational study and reflection. Additional resources are listed in the Bibliography.

The more we know, the more we are at risk to abuse. The more we are shown the glory of God through new knowledge of the natural world and its intricacies, the more risk we stand to defile it. That is not the fault of the vision. Creation is good; the burden of responsibility is on us, not on God, and the task is to seek ways to use the knowledge available in the new genetics well, as conscientious and faithful stewards of the gifts of new life it offers.

CHAPTER 4: THE PROVISION OF HEALTH CARE: OBEDIENCE TO DIVINE PURPOSE

The only way to keep your health is to eat what you don't want, drink what you don't like, and do what you'd druther not. (Mark Twain¹)



Health is personal fitness for survival and self-renewal, creative social adjustment and self-fulfillment. The most exacting test of one's health is to stay alive and to retain the capacity for self-repair and self-renewal. (Howard S. Hayman²)

• • •

Healing is restoration to proper use. We are engaged always rehabilitation work, of course. But that is more subtle than it might seem. Restoration to proper use does not always mean restoration to former use. Because former use may have been inhuman and improper use. (Walter Brueggemann³)

• • •

Justice is the first virtue of social institutions, as truth is of systems of thought. A theory however elegant or economical must be rejected or reversed if it is untrue; likewise laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust. Each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override. (John Rawls⁴)

• • •

Be glad and rejoice forever and ever for what I am creating, because I now create Jerusalem “joy” and her people “gladness”. I shall rejoice over Jerusalem and exult in my people. No more will the sound of weeping or the sound of cries be heard in her; in her, no more will be found the infant living a few days only, or the old man not living to the end of his days. To die at the age of a hundred will be dying young; not to live to be a hundred will be the sign of a curse. (Isaiah 65:19–20.)

• • •

Alas for you, scribes and Pharisees, you hypocrites! You who pay your tithe of mint and dill and cummin and have neglected the weightier matters of the law—justice, mercy, good faith! These you should have practiced, without neglecting the others. You blind guides! Straining out gnats and swallowing camels! (Matthew 23:23–24.)

• • •

We believe that the value of persons requires that each person have full access to essential services without regard to ability to pay and on terms that enhance the dignity of individuals. ... We believe that only with a continuity of personal relationships in a health-providing community and a continuity of access through comprehensive health services will adequate care be achieved. (*Minutes*, UPCUSA, 1971, Part 1, pp. 588–589.)

Christians in general and Presbyterians in particular must play a crucial role in seeing that health care is provided justly to persons in an increasingly complex society. Within the Reformed-Presbyterian tradition we bear witness that health and peace are God’s will for all. This affirmation must take form in the distribution of the best health care for all people regardless of race, gender, or economic standing. That is at once the calling of God and the demand of fellow human beings upon us. In this way we try to fulfill the two great commandments to love God and to love our neighbors. No longing for a simpler model will allow us who profess this faith to ignore this clear summons. Our duty and privilege seem simple enough, but fulfillment of that duty is neither simple nor is it always clear exactly what the extent of the duty is.

Consider the issues under debate and discussion today among health care professionals and providers as well as by ethicists. There are five major issues that keep surfacing in the discussions:

1. Is health care a right or a privilege? In the past, most have considered health services a privilege, but increasingly there are those who say it, like education, is a right.

2. How much health care do we have to distribute? Here the elements of limitation and possible scarcity come into play. If health care services are not unlimited, where are the limitations—not just in exotic frontiers of medical science but in day-to-day health care situations and needs?

3. Within the present health care system, with so much money coming from the federal government, who gets the available dollars and for what purposes? How much of the public resources, for example, should be used on heart transplants and kidney dialysis as over against preventive medicine and health education?

4. Having recognized that there are limitations, allocations of resources must be made. Who will decide what resources go where and to whom? On what basis are such decisions to be made?

5. Within this massive health care system where decisions for the individual are often made by others, how are individual rights and values protected?⁵

Solomonic wisdom is needed to grapple with these issues, which are illustrated daily in various medical centers around the land. The following case is not extreme:

A poor, black, unemployed man in his early thirties came into a cardiology clinic in a state of desperation because his heart was failing. Technically his condition was called cardiomyopathy—a failing heart. This condition could have come from genetic problems or a viral infection or simply from unknown causes (referred to in medical settings as idiopathic cardiomyopathy). He had two possible choices of therapy, if indeed he was given a choice: (1) medication to minimize symptoms and perhaps to slow down heart failure; (2) surgery, perhaps with total replacement of heart by transplantation or by implantation of an artificial heart. The medical residents asked if the young man should be made aware of these options since the option of transplantation was not real for him because he could not afford it financially. (Such procedures are available only in a limited number of medical centers and at great expense.) Moreover, the additional question was raised: Should his life style and frequent use of drugs and alcohol as well as chronic unemployment weigh against his being chosen for a transplant if it were available?

This is but one case that raises many of the difficult questions that must be faced in the provision of health care. How does one judge the case without becoming judgmental of the person? All are equal before the law and in the sight of God; there is, however, a real, present danger of unequal treatment in this case and others like it. Unfortunately, the issues will not become more simple with the passage of time. Fortunately for those of us who have been shaped and directed by a vital tradition, there are some directives to guide both thought and action. Indeed the Presbyterian-Reformed faith confronts a number of the five issues that have been enumerated above. For it is the historic assumption that there is one sovereign God who rules over all life and history, and faithful people must keep faith with God in all of life. There is no separation between the secular and the sacred. Christians are, therefore, involved with God in social policy as well as in private life and are ready to engage in the social arena where God has put them to bear witness and to make a difference.

Briefly and succinctly, the ground out of which the Presbyterian-Reformed tradition grows is the Bible, both the Old Testament and the New Testament. According to this biblical record, God called Israel into covenant. The Hebrews were called to service, not to privilege. The covenant between God and the people was based on God's unmerited goodness (*hesed*), in God's freeing them from bondage and leading them to

a land of promise. The response of the people was to show loyal love (*hesed*) to God by the way in which they treated one another. As God had done to them so they were to do to one another. The community thus formed was a covenant community where people bound to God were also bound to each other. Each individual had value conferred by God, and it was the duty not only of the community but of every individual within it to protect and enhance that value. Health, peace, and justice became the hallmarks of the new society called to be an example and a prod to other nations and societies. The “Golden Rule” later came to summarize these basic concepts.

The Old Testament prophets relied on this covenant theme to call the people back to a just society as the embodiment of the covenant relationship. Prophetic faith called for the manifestation of the same kindness and care toward others as God had shown to the people. Such attitudes and actions included refusal to harm and willingness to enhance the life of the other. The laws of hospitality and social responsibility in Deuteronomy and elsewhere illustrate this point. Included in such care and concern would be the health and well-being of others.

The righteous Kingdom failed to materialize in historic Israel and Judah. But out of this failure comes the promise of the Messianic Kingdom. The “expected Kingdom,” like the covenant idea, has been a shaping concept in our history. To be sure, the Kingdom would finally be brought to completion by God; but, meanwhile in this world, obedience to God required that the faithful work to approximate the Kingdom not yet fully come. We are to work to bring the Kingdom we wait for. This prophetic view of hope and action was redefined and refined in Jesus of Nazareth.

These covenant and Kingdom traditions were streams that flowed into the life and ministry of Jesus. His purpose was to bring salvation and peace (wholeness) to life. To this end, his was a healing ministry. Several of the signs in the Gospel according to John are miracles of healing (e.g., the nobleman’s son, John 4:46–54; the invalid man, John 5:1–9; healing the blind man, John 9:1–41; and the raising of Lazarus, John 11:1–44). Additionally, Luke is known, according to the strongest tradition, as a physician. The Gospel of Mark is crowded with sick people in a sick world where Jesus comes to make the broken whole again. Not to the same extent, but of equal importance, the healing power and purpose of Jesus is reflected in the Gospel according to Matthew. That healing theme, so attached to the ministry of Jesus, was also a strong motif in the early church (cf Acts 4–5).

Concern with health, wholeness, and peace are woven into the very fabric of biblical tradition. The apostle Paul uses the figure of the body to depict the interdependence of members within the church. When one is hurt, all hurt; when one rejoices, all rejoice. Health then becomes a kind of community experience and responsibility. Our lives are tied together; we are affected by each other. In loving and caring for the other, we love and care for ourselves. So in the early church there was concern and special attention for the sick, the weak, and the powerless.

Covenant theology, thus, will not let persons become primarily individualistic, but constantly recalls each one to play a role in creating a just social order. While Christians are drawn together by common faith in God, they are in the world to show the love of God in word and deed, not only among themselves but to all. There are not “two

kingdoms” in the Reformed approach, but only one: God’s Kingdom. All who have faith must respond in the common place to God. For Calvin, Zwingli, and Knox, that calling and election clearly involved care for the sick, usually by a neighbor or Christian friend. Each Christian was, according to this tradition, called to serve God in the ordinary. Provision of health care as part of self-forgetting love was, and remains part of, the thankful response to God’s grace.

This understanding was manifested in Zwingli’s Zurich and among the Puritans (through the influence of Heinrich Bullinger and others) in concern with education and care for the sick. In Calvin’s Geneva and in Knox’s Scotland, the delivery of service to the sick was an important part of life in the community of faith. That idea persisted in the early days of the American colonies despite some dark theories and superstitions about illness.

Presbyterians have been involved in and committed to education, to health care, and to politics. The knowledge that we may not reach the ideal or attain the final Kingdom does not prevent our seeking to make progress in establishing such a kingdom on earth, in which health, wholeness, and peace characterize the citizenship and the atmosphere.

There is a given within our tradition that life, though flawed, is still a good gift from God. It is to be valued in ourselves and in others, and it is to be protected from sickness and death. Within this robust tradition there is, at its best, an acceptance of life not as a dreadful burden to be escaped but as a joyous gift to be enjoyed. While there have been constraints and restraints on life, our tradition sees life in this world as good, having basic and enduring value.

Increasingly the Reformed-Presbyterian position has been that we are co-laborers with God in the continuing processes of creation and redemption. While the idea that God works only through our lives has been disclaimed for its arrogance, still we affirm with wonder that God does work through us. We are involved, inasmuch as possible, in what God is doing. Many in the health care field assert that they are God’s servants as they bring comfort, care, and healing; but the real healer is always God.

Finally, as Presbyterians we have recognized that persons are corruptible and that all organizations are temporal and imperfect; thus no social order or system is ever to be equated with the Kingdom of God. All are subject to the judgment and the correction of God who alone is sovereign. Every kingdom and all organizations are to be re-assessed and judged according to how well they have measured up to the ultimate Kingdom which is yet to come.

While the material just cited is general and is in summary form, it provides groundwork and guidance for persons who face decisions about health care delivery. Our mandate is clear as those elected by God to serve and as the covenant community ready to manifest in our life and action the grace and goodness of God. Health care is a biblical mandate reflected in our Presbyterian-Reformed tradition. It is a wonderful and unavoidable calling.

Now the urgent issues of the day noted at the beginning of this section must be addressed in light of four affirmations. No matter how pious our affirmations, however,

they are empty and meaningless if they do not lead to action. We are in the world not just to be, but to do. The fact that the issues and decisions are seldom clear-cut does not exempt us from making decisions.

(1) Under God, health care is a basic right of every person just as safety and education are basic rights. Without assured basic health maintenance, other rights have little meaning. Good health care is vital to the community; it is essential to human dignity and freedom. In sum, it is the will and purpose of God. As a church we must not only seek this for our own but for others as well.

The debate whether health care is right or privilege has grown more heated in recent times, partly because it has been politicized. However, the fact that it has become a political question must not divert us from the more basic fact that it is a moral issue. To say that health care is a privilege rather than a right raises the question of who are the privileged. Moreover, to say it is privilege may mean it is to be given to the so-called “deserving” and to the “more valued” in society. Either of these possibilities is frightening. While the individual must continue to have the right to refuse health care, still he or she should have the right of access to that care as part of citizenship. Therefore the widest possible distribution of health care services without discrimination ought to be a goal of the church within American society. This leads to the inevitable conclusion that there is a need to revamp our present health care delivery system.

It is time, therefore, that Presbyterians take a hard look at the current health care system, which is largely fee-for-service and not cost-effective. It is time to give serious consideration to proposals that are potentially more cost-effective and more fair. One of these recent proposals presented to the American Public Health Association Meeting, November 1982, by Milton Terris, M.D., M.P.H., includes four basic elements: (1) preventive service, (2) community health centers and group practice prepayment plans, (3) facility resource area plans, and (4) home health services. This proposal incorporates a much-needed emphasis on preventive medicine and public health measures. It also suggests decreasing—if not virtually eliminating—fee-for-service payments to solo practitioners while increasing community health centers and group prepayment plans that tend to

(a) emphasize health maintenance and preventive services; (b) improve the quality of care by bringing general and specialty physicians and other health personnel together, thereby facilitating consultation, collaboration, and more effective use of modern technology; (c) avoid the paperwork, bureaucracy and high administrative costs associated with fee-for-service payment; and (d) reduce the incidence of surgical operations by about 30 percent. This last advantage results primarily from the fact that the physicians in community health centers are paid by salary, and those in group practice prepayment plans (health maintenance organizations) by salary or by capitation, i.e., a fixed amount per person served by the plan. There is therefore, no incentive to perform unnecessary surgical operations or other procedures, an incentive which is characteristic of fee-for-service payment to providers.⁶

Facility resources area plans would allocate and monitor hospital and long-term care resources. Terris concludes by advocating the use of home health services to replace less than adequate services offered by many nursing homes and mental institutions.

(2) Though there are limits to what our nation can spend on health care, both the amount of money and the resultant contribution to health can and should be ex-

panded by a reordering of national priorities, containment of health care costs, more efficient organization of services, and greater focus on prevention and health maintenance.

Even after constructing and adopting a more effective and fair system for health care delivery and utilizing personnel and facilities more wisely, there still are scarcities and limits requiring priority decisions. We do not have even in this wealthy land, adequate resources—including personnel—to do everything we would like in health care. There are limits to financial resources and to developed institutions.

There are several steps that should be taken to deal with some of the limitations: (a) We should have a regional and national dialogue about priorities in the national budget and the place of health care in that budget. The church must be visible and vocal in advocating that a greater proportion of the national budget be used to save lives, i.e., through efficient and effective health care, school lunches, etc., than to kill, i.e., stockpiling weapons that have the capability of destroying the world many times over. The church must state clearly and loudly the marginal cost versus the marginal benefit in using resources to build one new bomber versus providing nutritional programs for children and the elderly. (b) There should be critical scrutiny of the escalating costs of health care. In 1982 the Consumer Price Index rose 3.9 percent but medical care costs increased 11 percent, which substantiates the need for examination of our present system. (c) Young people should be encouraged to enter the medical and paramedical fields as those who serve. (d) Organizations of medical delivery systems should be revised so that minor medical needs can be quickly met on an outpatient basis without tying up facilities and personnel needed for more urgent service.

Escalating costs have moved medical funding away from private pay to third-party payers. (Private insurance and medicare-medicaid have been the major third-party payers.) This has tended to allow costs to rise, since the two primary parties, patient and doctor, do not seem to be in charge or responsible for the economics of care. There has been little evidence of stewardship or responsibility for the runaway costs. Critical evaluation and judgment are required by medical professionals and by more objective analysts.

A very large amount of available health care resources has been devoted to the development of exotic technology and the widespread acquisition of these expensive status symbols, as well as to the development and use of expensive procedures that benefit a relatively small number. Though bombers may be an appropriate trade-off for large-scale kidney dialysis of the elderly, malnourished children are not. The church must insist that the first call on available health resources, whatever their level, be for the provision of basic health care for all in the holistic terms described in this report.

(3) Decisions about the general distribution of health care resources should be made with the full and informed participation of the public whose health is the objective. Decisions about the specific allocation of resources, particularly for treatment, should be made by a process that is fair, provides for the involvement of consumers, and protects the weak and powerless.

Who is to decide how and where resources are to be allocated? Will the government decide how funds and personnel are to be distributed or should politics and govern-

mental process give way to economic factors as they affect and direct health care? Other values, such as the dignity and worth of the individual, ought to come into play in deciding resource distribution. Hopefully there can be a greater openness about the dynamics of such decision-making so that the values of the person and the needs of society can be weighed and kept in balance. The ultimate values are the worth of persons and the importance of community under God.

Will allocation be by community consensus? A board established for such decisions? Or will the decision continue to be made *in situ* by medical professionals? Consumers should have a voice in how available resources are to be distributed, since they will be the beneficiaries of such policy decisions. Boards and commissions can be useful in determining priorities, particularly if they contain a reasonable proportion of lay-consumers as members. Decisions made *in situ* may or may not be fair. In any case the politics of such decisions ought to be closely monitored.

The next step then is to face the question, “who gets what?” Much has been written about methodology trying to answer this question along lines of merit, or by lot, or according to utility. Many ethicists prefer the drawing of lots or the “chance” approach to decision-making. Most decisions involve more than one of these approaches. Some decisions about treatment are made largely on the basis of viability of the patient and his or her usefulness to society. At other times, priorities are determined in keeping with the interests and enthusiasms of the medical team, which is oftentimes the case with organ transplants. Much more conscious thought must be given to how such decisions are made.

As Christians, we know we must be concerned for the weak and the helpless, because Jesus gave us that example. Moreover, a society, according to prophetic tradition, is judged largely by the way it treats the powerless. The weak may not be truly weak and may, in fact, be more sensitive and “useful” than the strong. Paradoxically, God has set his love upon those whom society might deem to be of little value. The church must insist that the weak and nonproductive in society receive health care along with others; to do less would be to neglect our calling by Him who was poor for our sakes.

(4) In any system for health care delivery, the value of the person qua person must be protected. Rights of the individual to choose must not be neglected. The traditional paternalistic and authoritarian model of medical practice must continue to move toward cooperative decision-making by doctor and patient. The autonomy or right to self-determination of the individual who is ill must be preserved.

The church must protect individual rights and values at all times. Admittedly, there is a delicate balance to be maintained between what is best for the individual and what is best for the larger society. Efforts must continue to be directed at increased participation by patients and their families in decision-making. Patients’ rights and values can be further protected by a team approach to decision-making, especially if the patient is comatose or unable to make decisions for himself or herself. The team might consist of patient, immediate family member, physician, nurse, clergy-person, and possibly a social worker. The church must continue to urge its members to discuss their wishes during the dying process, i.e., the limits to treatment that they would want, with a family member or their pastor or other designated agent.

What, then, can we say about the system of health care delivery that we envision? As stated earlier, the system ought to move away from fee-for-service to community health centers and group practice prepayment plans, making health care available to every citizen. Within this system the patient must have the right to choose his or her physician and institution within the area where he or she lives. Such a public health delivery system must always be subject to scrutiny and to criticism leading to change and improvement. No system is God's doing; all systems are of human devising. Therefore no system is permanent or perfect; systems must never become idols to worship. Within such a system great care must be given to cost containment, and the present inefficiencies and overlaps ought to be eliminated. Not to be good stewards will mean that the system, however devised, will not deliver. Cost accountability is not only desirable; it is essential.

The present health care system in the United States is a mixture created by the evolution of the system itself. Through a number of circumstances, health care has been developed into an industry with a product to deliver for a price. Thus, much caring has gone out of health care. The personal and covenantal relationships between patient and doctor or nurse have diminished to the detriment of both. The Christian emphasis on the dignity and worth of persons should be vigilantly emphasized when subjects are becoming objects.

Under the sovereignty of God, the social order prompted by the church and others must be just and show mercy in the health care delivery system. Discussions about comparative and distributive justice may well be of scholarly value; but, more basically, we are called to uphold the value and life of the other as we have been upheld by God. That is simple justice. Unfortunately, when we get into discussions of philosophical or political theory, we often lose sight of simple justice through the conflict of ideologies. Labeling opponents as communist or socialist or capitalist obscures the issue and the discussion gets bogged down in ideological debate. What the Lord God requires is that we work to bring about justice and show mercy; failures to live up to this call for simple justice, summarized in the "Golden Rule," mean that any society is under the judgment of God.

Within the process of distributing health care there must be a careful avoidance of moralism and retribution. In a health conscious era, more and more persons have come to believe that health is a personal responsibility and it follows, therefore, that sickness is usually caused by the patient. Some persons within medicine and other professions have set themselves up as judges to decide whether the individual deserves treatment. The position that the church must espouse is that we cannot be certain to what extent illness is caused by the habits of the patient;⁷ therefore all patients must be treated alike. God alone is the final judge in this as in other areas of living.

There must be more to the health care system than therapy for those who are ill. The fact that the environment in which we live has become increasingly toxic must be addressed as part of any general health care system. More health education, including a better understanding of diet and hygiene, is needed. Attention ought to be given to the psychological environment of our society so that anxiety and tension, often generated by the threat of a nuclear holocaust, can be alleviated.

The Presbyterian Church has a major role to play in revising the health care system in the United States. First, there is the prophetic role, which calls attention to the wide disparity in health care for the wealthy and middle-class on the one hand and the poor on the other hand. There is a two-tiered system of health care quality in this country that must be changed.⁸ In addition to the prophetic role, the church must constantly point to the reality of life and death. Life has its limits. We are mortal. The denial of death and the desire to gain immortality through medical means is foolish, if not blasphemous. Death is a part of life. Christians should never idolize bodily life, but accept it as a stewardship for a limited time; nor should Christians seek to prolong life beyond all bounds as if there were no hope of resurrection. We should do all in our power to help people accept mortality and face inevitable death, not as the ultimate annihilation but as the beginning of fuller life.

The Presbyterian Church can play an additional role by being supportive of physicians who are struggling with ways to deliver better medical care and who are motivated by a sense of justice and caring. Physicians should be supported in times of difficult decisions and as they attempt to uphold the values of their patients while maintaining their sense of integrity. Physicians require support, care, and education within the covenantal community, as do the other members.

Health care offers an opportunity for service and glory. It is God's call to do justice in relationship to others by treating them as we think they would want to be treated and as we would be treated. Health care is also part of fulfilling the human potential, which is our calling by God's grace. As we seek to do justice and to show mercy unto the lowest or greatest we, thereby, glorify God. In such effort, we begin to fulfill God's ancient promise of health and peace, which lead to hope.

This area of health delivery is a clear opportunity to fulfill justice and to show mercy and in our effort we begin to fulfill the ancient promise of health and peace, which lead to hope. Under God's sovereign care, we are called freely to serve God by showing mercy, doing justice, and providing care.

CHAPTER 5: DECISION-MAKING AT THE END OF LIFE

Do not seek death. Death will find you. But seek the road which makes death fulfillment. (Dag Hammarskjöld)

• • •

Never harm (*primum non noeere*), cure sometimes, comfort always! (Medical Maxim)

• • •

The primary factors in decisions about life or death should be the individual's wishes and needs, but decisions of this magnitude ought also to occur within the context of community. Since individuals differ in their understanding and acceptance of death, their decisions regarding care at the end of life will also differ. Those views must be considered. In Christian perceptions the believing community is the body of Christ, so we must be concerned with the whole body and also with the individual members. As a body sensitive to corporate as well as personal needs and desires, the

Christian community should provide a model to guide others in society. But this is no easy task since individuals differ, as is illustrated by the following case studies.

Fourteen year old Tim Clark said good-bye Wednesday night to his friends during a prayer meeting at Abbots Creek Baptist Church. Weary of three and a half years of dialysis treatments and three unsuccessful transplant attempts, Tim finally chose to die having received a sign from God to “come home” to live. Mrs. Clark said Tim had discussed going off dialysis for more than a month. “On Tuesday night after reading his Bible and saying his prayer, I heard him say, ‘God, if you want me to come home and live with you, give me a sign.’ A little later, I heard him get up and he came down the stairs. He was aglow. He showed me his arm. It was bleeding where the dialysis needles had been nine hours before. He interpreted this as a sign that God wanted him to come home.”¹



When Jane Gahagan, a young woman from Evanston, Illinois read the story, she was not moved. Having struggled with dialysis treatments for 8 years, “. . . I thought of all those who are struggling to hang on, who give everything they’ve got to be alive.” Gahagan wrote an open Christmas letter to her fellow dialysis patients. “Life really begins when we know we might lose it. Suddenly, all the little things become important again, as they were when we were children. The sun on the lake, the flow of the seasons, the sting of wintry air on our faces, the sound of leaves falling . . . Most of us know that time in the middle of the night when we are very much alone. That hour of truth, the one in which we have no voice but our own echo... Still, that moment becomes a triumph. There is always rising an instinct toward another day and the desire to make it count. And that is life, burgeoning in the midst of death, defiantly saying, ‘I will not give in.’”²

The vignettes above briefly describe two inspiring and courageous perspectives on chronic illness and ways of accepting death: two theologies of death and eternal life. These two stories frame the single human experience that most invites, indeed mandates, that biomedical and theological reflection be joined: that of dying and death. Our attention now turns to biomedical developments that affect the end of life and then to theological and ethical analysis of those developments.

A. The Biomedical Assault on Death

Life expectancy has changed dramatically in the last forty years due to the discovery and use of vaccinations and antibiotics, in addition to improvements in sanitation. In the typical deathbed scene of the nineteenth century, the physician looked on helplessly as infection carried the person away. At the present time infections remain a frequent cause of death, especially in the developing countries; but in Western culture, other factors such as renal failure, toxemia, or cardiopulmonary collapse are more likely to be its cause.

A major changeover. The past fifty years have brought a major change in the place where death occurs. Today this event takes place more often in institutions, namely, in hospitals and medical centers. In 1937, 37 percent of Americans died in hospitals; in 1958, the percentage had increased to 73 percent. Today over 80 percent of deaths occur away from home in hospitals or other institutions. This statistic underlies two primary characteristics of death in the modern world: (1) Death most often occurs in the presence of powerful technology. (2) Death most often occurs at a time, place, and manner outside of one’s control.

Most people die in centers where advanced technologies capable of prolonging life, and thus the dying process, are available and often used. In a clinical consultation at

a university teaching hospital, the question was raised whether emergency dialysis should be used for a patient who was refusing therapy. "Of course," the dialysis team claimed, "that's what we're here for." When the services are available and highly trained teams are on hand to initiate these efforts, it is virtually assumed they will be used. This is also true for resuscitation efforts and a wide range of emergency measures. The modern hospital is well equipped with a number of specialty teams who are always on call to do all they can to stave off inevitable death.

As a result, many persons now die in institutions under intensive care, at a much older age, surrounded by an impressive battery of devices and machines. Under these circumstances, dying takes much longer and costs far more. Our technology may be capable of rescuing an individual from death but may not be able to save the person from existence in a vegetative state with high social costs. Severely ill or injured persons are often stabilized in conditions of permanent impairment, which raises questions about the long-range efficacy of these technological efforts.

Modern technology has forced us to reexamine the question, "When does death occur?" This questioning has been made more urgent by economic and organ transplant considerations. The older definitions of death: "when a physician declares death," or "when heart and lung function cease," have in recent years yielded to the criterion of cessation of brain function as the decisive factor in determining death. The Harvard ad hoc committee's definition of irreversible coma (or some modification thereof) has been widely accepted as the best objective standard by which to determine death and has been adopted into legislative statutes and hospital policies.³

The great Puritan physician, Sir Thomas Browne, summarized the plight of modern society seeking both to assault death via biomedical skill and yet to retain the grace of acceptance, even victory, in the face of the inevitable.

With what shifts and pains we come into the world, we remember not; but 'tis commonly found no easy matter to get out of it. Many have studied to exasperate the ways of Death, but fewer hours have been spent to soften that necessity.⁴

Many people today fear that they will lose control over their lives when they approach death; that things will be done to them that they would not want; and that they will not be given a choice to accept or refuse contemplated therapies. This fear has given rise to two movements in public policy that have import for our consideration of death and dying, particularly as the church contemplates its own policy and its counsel to the secular society on these issues. Some persons have signed a "living will." This is a document that attempts to clarify a person's wishes about time, manner, and condition of his or her own death and what he or she insists not be done.⁵ It is limited in its usefulness because of its lack of specificity. Various religious bodies have formulated versions of a living will. The Roman Catholic affirmation of life and Sissela Bok's "Personal Directions for Care at the End of Life"⁶ are more specific and thus are helpful examples. Both are included in the Appendix along with text examples from the Euthanasia Educational Council (name now changed to Concern For Dying).

The "living will" movement is both tragic and encouraging. It is tragic in that it is necessary. Individuals and families should, under optimal conditions, have discussed

these issues fully and made their wishes clear to physician, family, and designated agents before the final days of life. In an earlier time, when one's pastor, physician, lawyer, and mortician were personal friends, these convictions could be voiced and arrangements made, so that formal documents were unnecessary. Now, one may die in unfamiliar surroundings in the presence of strangers where one's wishes are not known. People are therefore beginning to take initiatives so that guidance is given to loved ones in the event that he or she lapses into coma or in some other way is unable to control medical decisions through personal consent. Thus, proxy judgments can be made according to the patient's desires. This, of course, confronts the proxy with new responsibility and burden as a maker of moral decisions.

An increasing number of states have enacted into law "natural death acts." This type of legislation seeks to give legal authority to a person's wishes and at the same time protects health professionals and institutions from litigation arising out of an accusation that they failed to do all that could be done to prolong life. An interesting philosophical and theological concept underlies these laws. They suggest that there are "natural" and "unnatural" ways to die and that ethical and legal sanctions should apply to safeguard persons from unnatural deaths and assure that their rights to "natural deaths" are sustained.

The experience of death has not changed dramatically since the dawn of human history. It is terrifying because it is either the end of everything, or it leads to the unknown. In theological language it portends salvation or damnation. To a large measure death remains out of human control. As Sissela Bok, the Harvard philosopher, has argued, it is not the fear of being dead that brings dread to modern people; it is the fear of dying, fear of long and hard suffering and pain, fear of losing contact with loved ones, and fear of "physical debilitation, senility ... the loss of freedom and the loss of knowing what's going on."⁷

How does theology reflect on these developments in the experience of death and what ethical wisdom does that theology present?

B. The Christian Theology of Life, Death, and Eternal Life

We seek good deaths, natural deaths, explainable deaths in the same way that the ancients did. In his study of primitive cultures, Frazer shows that all people stand in awe of death, seek to avoid it, and propose all manner of rationalizations and escapes from it.⁸ Death was sometimes likened to a dream in which a person enters another world. Reverence for the dead is evident at the prehistoric burial sites in Africa, the Near East, and Europe. This reverence in part arose from the belief that the dead still had contact with and could influence for good or ill the lives of the living.

Whether death is seen as natural (a part of life) or unnatural (provoked by evil spirits) by primitive persons is disputed by the anthropologists. It is likely that people from earliest times saw death as it is seen today—with a mixture of emotions. On the one hand it is natural, a part of life and inevitable. On the other hand, it is unnatural and an intrusion, an evil to be explained, a problem to be solved. The early Christians were divided over the question whether death was part of the original creation. Would our progenitors have died even if they had not disobeyed God? Or is immortality the primal natural state? In some cultures infanticide and senilicide are practiced in order to

hasten or facilitate natural destruction. In other cultures childhood and old age are revered and protected from assault. The seeds of the modern impulses of both accepting and fighting death seem to have existed since the beginning.⁹

The Hebrews in biblical times began to reflect on death in a new way. Taking these primitive precedents, they found several explanations of the meaning of death. On the one hand, death was natural. Death was the normal end of life. When a human life, like a fruit, is full grown, it is harvested. (Job 5:25.) “Full of years,” one is gathered to one’s people. (Genesis 15:15.) We are like the grass that flourishes, then dies, our days are a fragile breath that will soon be over. (Psalm 39.) In another understanding, life continues through the offspring into the next generation. Thus, to die without children was to be completely dead. Also there is the question of the fullness of one’s life. Jephthah’s daughter wept about her unfulfilled maidenhood. (Cf. Judges 11.) The prophetic tradition found a primal transgression as the root cause of human death. Thus even at this early intuitional stage, death was separation from the source of life.

In the first tradition, death is merely the cessation of life. Vital power (*nephesh*) is exhausted from the body when breath leaves, and the body lapses into corruption and impurity. (Numbers 9:6.) In the complementary tradition, death is a force controlled by God. Premature death was seen as a punishment allowed by God but delivered by a hostile power. This strain in Hebrew thought became the basis of Paul’s doctrine that death is the “sting” which is the just wage of sin. (Romans 6:23.)

Superseding both of these notions, in which death is seen either as natural or as evil, is the confidence that God contends against death with humanity. God snatches believers from the hand of death. (Psalm 18:6, 116:3.) God accompanies persons in the valley of death and allays their fears, sustaining them forever. (Psalm 23.) God holds power over death. For those who have turned against God, death is the instrument of isolation and condemnation. For God’s own, death is an instrument of deliverance and salvation. Thus the meaning of death, like the meaning of life, is determined by the covenant relationship.

The essential Christian teaching that bears on death is centered in the death and resurrection of Christ. In Christ’s crucifixion, God has decisively conquered the powers and dominions of this world, especially the power of death. (Acts 2:24, I Cor. 15:45–46, Rev. 6:8.) The “last enemy,” whose fate is sealed in Christ’s atoning death, is death itself. In its fellowship with the Living Christ, the Christian community has already been transported in anticipation to the other side of death. New life in Christ, which is resurrection, can look back at death from beyond. (Colossians 3:2 cf. Col. 2.) The Gospel of John uses eternal life as both experience and promise for Christians. (Cf. John 5–6.)

To set the stage for an ethical response to the biomedical issues of dying and death, it is necessary to review briefly the evolution of Christian thought about death and resurrection. Early Christians believed, as did the Jews of the first century A.D., that a universal bodily resurrection of the dead was forthcoming in the Messianic age. This belief informed their understanding of the destiny of Jesus, then dead, now vital to their faith. This resurrection belief was further intensified by the experience with Jesus. The earliest Christian burial customs and tests, and the abandon with which first and second century disciples went to their deaths, exemplify in behavior their

faith in bodily resurrection. It is clear that the apostolic community knew that Jesus, alive and powerful, was with them. They expected his imminent return, which would mark the final victory over the grave. Thus, there was watchful waiting and a call to be faithful unto death.

In the first and second centuries a great struggle ensued over the manner and meaning of Christ's death and resurrection. Generally, Hellenistic Christians, especially gnostics, emphasized a spiritual resurrection and the derivative doctrine of the immortality of the soul, while Jewish Christians ordinarily held a more apocalyptic belief in the resurrection of the body. These two ideas framed the theology of human death in early Christian history and were crucial as individual persons and the community came to terms with physical death. Oscar Cullmann writes:

Only he [or she] who apprehends with the first Christians the horror of death, who takes death seriously as death, can comprehend the Easter exultation of the primitive Christian community.. Belief in the immortality of the soul is not belief in a revolutionary event. Immortality, in fact, is only a negative assertion; the soul does not die, but simply lives on. Resurrection is a positive assertion: The whole person, who has really died, is recalled to life by a new act of creation by God. Something has happened—a miracle of creation! For something has also happened previously, something fearful: Life formed by God has been destroyed ¹⁰

The biomedical implications of the theology of death and eternal life reflected in contemporary theologians are several. (1) We fight with God against the power of death; (2) we hope for a time in history when disease and untimely death will be overcome; (3) we accept death as a part of life experience; (4) we do not live under the dominion of death but live toward the promise of life; (5) we trust the details to God; and (6) in life and death we are with God.

C. The Ethics of Life and Death

Reformed theological ethics lift up several points about death that are moral issues of life and living.

(1) The direction of biblical ethics is against taking the life of another, even for benevolent reasons. Persons should not be deemed worthless, too old, too weak, unproductive, sociopathic, or a burden, thereby justifying some act of positive "mercy killing," or the more fashionable slow killing by neglect. When persons fall into deep sickness, pain, suffering, unconsciousness; when they lie helpless under deep sedation or at the brink of danger in intensive care, they must know that they will not be abandoned.

While the direction of biblical ethics is against taking the life of another, it in no way claims that it is necessary to prolong the life—or the dying process—of a person who is gravely ill with little or no hope for cure or remission. Persons who are terminally ill must be able to trust that their dying will not be prolonged by unrequested technological interventions. As theologian Paul Ramsey has stated, "We need . . . to discover the moral limits properly surrounding efforts to save life. We need to recover the meaning of only caring for the dying, and the justification—indeed the obligation—of intervening against many a medical intervention that is possible today."¹¹ The existence of specific medical technology does not require that it be used.

Admittedly, it is often difficult to know or to acknowledge when a person is dying. It is equally difficult to stop aggressive, curative types of treatments and therapies or to say that ordinary types of therapy have become extraordinary. Sometimes the person will know that he or she is dying, will try to communicate that knowledge to family and caregivers who prefer not to hear and keep busy trying to cure, rather than sitting quietly by, showing care and concern. Ramsey admonishes readers to be aware of “the duty only to care for the dying, simply to comfort and company with them, to be present to them.”¹²

(2) Most discussions of ethics in health care address the issue of autonomy (i.e., a person’s right to make—or at least participate in—decisions related to his or her own body), primarily when discussing death and dying. The popular clichés related to this issue are: “the right to die,” “death with dignity,” and the “right to refuse treatment.” Although cases (Quinlan, Fox, Saikewicz) that have been prominent in the mass media and that have focused on these extraordinary issues are more dramatic than commonplace, they still necessitate a moral response. In a pluralistic society where people have different beliefs about life and death, basic Christian respect for persons demands that a person’s decisions about death be honored in most instances.

The choice of whether or not to undergo further treatment, whether or not to consent to experimental therapy, or to donate tissue should be a personal decision. Since the atmosphere of critical care medicine is highly charged with values such as medical authority, vested interest, and patient submission, care should be taken by the physician to converse freely and candidly with the patient. The patient ought to know the options, the pros and cons of each option, the thoughts of the attending clinicians, and then be encouraged to make his or her own decision. Two extremes must be avoided. The first extreme position paternalistically decides for patients what is best and then announces that decision. This view holds that it is unkind or unreasonable to invite the patient into the debate over options (and that the physician knows best), and so the physician proceeds to make proxy decisions for the patient. The second unfortunate course sets the options and scenarios before the patient like a computer. It gives the probabilities and statistics and then says, “There you are, now decide!” Both of these approaches shrink from the pain and reward of cooperative judgment. The best course is one that involves coming to a thoughtful medical judgment, sharing this with the patient, reviewing the alternative courses, and inviting the patient’s response. The tragedy of patient refusal—or thoughtless acceptance—of procedures and the increased possibility of legal action often arise from failures to respect the patient’s humanity and enter into responsible dialogue with him or her.

Another variation on paternalistic decision-making involves the externally imposed judgment about a patient’s quality of life. If a patient’s quality of life is deemed unsuitable or intolerable by members of the health care team, treatment may be terminated—or not initiated—and the patient allowed to die. This judgment about a person’s quality of life made by someone other than the patient is far different from an individual’s making such a decision about his or her own life quality. While members of the health care professions are called upon to make quality-of-life decisions at many levels—and it is unrealistic to deny that such decisions are not necessary—a word of caution is in order to those who make such decisions and to all who may be patients at some point in time. We must take great care not to denigrate the worth or life of

others and impose a judgment of poor quality that might provide justification for stopping treatment or avoiding the patient.

For the time being, given the complexity of the modern medical center, the anonymity of doctor-patient relationships, the tendency to do things to and for other people, and conflicting interests, it is best to safeguard autonomy in medical decision-making by whatever means. Patient review boards, hospital ethics committees, institutional review boards for research protocol, patient advocates, and a patient bill of rights all serve the function of safeguarding personal freedom. None of these can take the place, however, of honest, fair, and compassionate human relations and communication.

(3) The real, almost inevitable danger of reducing human lives to statistics or mechanical processes must be acknowledged. The influences of economic factors, often unspoken, loom large. The efforts to place economic values on patients' lives or determine how many treatments an individual deserves, while reprehensible, nonetheless occur. If medical care must be rationed (e.g., no dialysis after 60 years of age), policies should be made following public deliberation so that those affected will have had a chance to participate.

Impulses to quantify or stage the experiences of moving toward death or beyond death should be stifled. The thought of nurses or others with handbooks trying to assess whether the patient is in the "denial" or "acceptance" stage of dying is frightening. To reduce a person to a stage, a disease ("the ulcer in Room 210"), or a statistic is to wish that person dead. The awesome mystery and unpredictability of life and living, to say nothing of an enduring respect for persons, should be sustained in I-Thou rather than I-It relations.

(4) There is the danger and temptation to idolize bodily life by making retention of physical life the only good and primary goal. Jesus touches this subject when he says that "Whoever would save his life shall lose it." Too much effort to defend one's own life, to bury it in a safe place like the one-talent man, to refuse to give life away, or to fail to use it up goes against the grain of Christian calling. It is indeed idolatrous to try to keep a person's body alive no matter how empty that life may be. Human beings are transcendent creatures. Real life comes from beyond bodily function. Jesus asks: "Is not life more than food, and the body more than clothing?" (Matthew 6:25b.) Often hospitals and medical personnel are simply engaged in a contest to preserve "life," with little concern for quality or expectation. Sometimes they win the battle, but the patient loses. Clinging to life rather than reaching out to life compounds the tragedy.

(5) The affirmation about eternal life that is woven into the Gospel according to John should be emphasized. Eternal life is here and now. According to the apostle Paul, the light of promise shines in the present moment. Eternal life, not death, is the ultimate reality. That assurance keeps Christians from living all of life being afraid of death. For Christians the adventure is never toward an end but toward new beginnings. Elizabeth Kubler-Ross has written that death is the final stage of growth; it would be more appropriate to affirm that death is another stage of becoming. For Christians, death can be understood as the next chapter in the surprising story of life.

(6) Decision-making is never sure; deciders are seldom secure. Persons are ambivalent about whether to approach death with dread or hope, whether to resist or to accept. Possibly this ambivalence comes from the built-in will to live and the corresponding will to die. Whatever its origin, ambivalence is woven into the fabric of being itself, and decisions of life and death are met with a kind of frustrating ambiguity. Since life-death decisions can rarely be made with certainty, even when all the evidence is in, decisions must be made with humility and with a posture of seeking God's forgiveness and acceptance.

(7) Finally, the church is in the world to be an example, not to impose values or beliefs. By its life and its attitude toward life, it can and should bear witness to the faith. The church in this area, as in many others, must be the community of care, protection, and nurture. In this way, the church can be a model in a pluralistic society for how these decisions ought to be made while preserving and enhancing human dignity and worth.

THE COVENANT OF LIFE AND THE CARING COMMUNITY

What Are We to Do as Responsible People of Faith?

Policy Statement and Recommendations

God is the God of history and historical events are vehicles for divine revelation. Grace involves obligation; experience requires response. The rapid expansion of scientific and medical knowledge, together with the recent explosion of technological skills, presents a challenge and an opportunity of seemingly unending magnitude to the church. In responding to these developments, the Presbyterian Church must remember not only that events shape faith but that faith also shapes and directs events. The church is called to be a corporate interpreter of events from the perspective of faith and has an obligation both to be informed and to speak out with a strong voice either in favor of current developments or in urging caution.

A strong commitment to the value of and responsibility for life underlies these policy recommendations. Options for human choice-making at the beginning of life are many, offering persons the opportunity to be co-laborers with God in the development of their families. The potential for abuse and dehumanization is also present, challenging Christians to thoughtful decision-making. Genetic research brings promise for relieving suffering and enhancing life, but it also raises the threat of idolatry in the search for the "perfect human being." While abortion may be a morally responsible choice and must remain available, it cannot become ordinary. In times when funds to programs that provide services to the poor and underprivileged are being slashed, the church must speak out against these cuts. The church must challenge the abuses of justice in access to medical care, which it sees in cuts in Medicare, Medicaid, and policies that deprive the poor, the very young, and the elderly of programs that provide nutrition and basic services designed to prevent disease. Great care must be given to decisions at the end of life so that the wishes of persons who are dying are heard and respected. Caution must be taken so that prolonging life does not become idolatrous. In all these areas, the church must defend life as God's good gift, affirm the responsi-

bility of persons to make decisions about its quality and use, and recognize that each individual life is finite in its earthly tenure.

As Presbyterians, we welcome the challenges that cause us to reexamine the boundaries and descriptions of our faith. Scientific research has revealed to us that creation is not fixed, but ongoing; God calls us to be involved in the process. We behold God as the initiator and director of the process of continuing creation. Old securities are gone; new insecurities appear; hope and faith remain.

These recommendations are a call to venture forth with God out of the “already” into the “not yet.”

Even though ambiguity abounds and little appears certain, decisions have to be made, for that is the essence of our humanness. **Acting with prayerful concern for the value and quality of life as a gift of God, our Creator, the 195th General Assembly (1983) therefore proposes the following recommendations to the church.**

OPTIONS AND INTEGRITY AT THE BEGINNING OF LIFE

1. The intricate relationship between maternal health and nutrition and the birth of healthy babies has long been established. In order to assure the vitality of all infants, the 195th General Assembly (1983):

a. Urges full access to adequate prenatal care for all pregnant women, regardless of age, race, or economic standing.

b. Urges the United States Congress to assure adequate funding for the Women, Infants, and Children Program and others that provide medical and nutritional services for women and children in need.

2. Childbirth is not a disease, and while medical care and monitoring are critical to assure that all goes well, in the vast majority of cases delivery need not be seen as a time of crisis. Therefore, the 195th General Assembly (1983):

a. Encourages active partnership by couples in determining the extent of medical intervention during pregnancy and at birth.

b. Affirms trends toward family-centered birth, including alternative birthing centers and birthing rooms in hospitals.

c. Recognizes the option of home delivery in certain cases but urges careful monitoring of the birth by trained personnel and arrangements for backup hospital care in the event it becomes necessary.

3. Even with the best of care, crises in wanted pregnancies occur, thrusting the family into sudden grief and the need for thoughtful decision-making. These are crises families cannot meet alone, but neither are they exclusively medical decisions; therefore, congregational and pastoral support is essential in these moments of crises and the weeks and months that follow. Therefore, the 195th General Assembly (1983):

a. Urges a team approach to decision-making in cases of neonatal crisis whereby the family, the physician(s), clergy, nurse, and social worker participate in the determination of the extent of treatment.

b. Urges that the courts be used as a last resort in making decisions regarding care or its discontinuation.

c. Urges careful projective analysis of all the implications of a decision to initiate care that would create irreversible dependencies and would cause more harm than benefit to save the lives of extremely premature infants or those born with massive health problems.

d. Affirms trends toward home care for children with medical problems who once required hospitalization to insure survival, while continuing to exercise emotional support for the families for whom such hospitalization or institutionalization offers the only viable alternative.

4. The church must be the embodiment of covenant care for its members in times of joy as well as in times of grief. Therefore, the 195th General Assembly (1983):

a. Requests the Joint Office of Worship to develop appropriate optional liturgies to aid families in the various rites of passage of the childbearing years, including grieving in the event of miscarriage, stillbirth, neonatal death, and handicapping conditions.

b. Urges the development of support groups through partnership between hospitals and congregations for families who have experienced stillbirth, neonatal death, frequent miscarriage, and handicapping conditions.

c. Urges training for congregational members to aid in pastoral support of families facing long hospitalization or enduring home care for children with handicapping conditions.

5. Advances in the enhancement and control of fertility have created many new options for families. The 195th General Assembly (1983), while recognizing that all human undertaking is open to abuse, affirms these advancements. To parent or not to parent is a decision of utmost concern, with clear implications beyond individuals and families to the community, society, and even the species. While the option of bearing children should be available as universally as possible, to bear a child should not be undertaken without clear intentionality. The choice should not be determined for voiceless minorities or disenfranchised groups, including the physically disabled and the mentally retarded. Within this area of concern, the 195th General Assembly (1983):

a. Urges compassion and sensitivity for those who face fertility or conceptive problems; and

(1) Affirms the use of drug and surgical therapies to overcome anovulation, hormonal disorders, and other problems that lead to infertility;

(2) Affirms the use of artificial insemination by husband as a responsible means of overcoming certain fertility problems;

(3) Affirms in vitro fertilization as a responsible alternative for couples for whom there is no other way to bear children.

b. Urges couples who cannot conceive to consider adoption as an alternative to childlessness, even if available children are beyond infancy or handicapped; and condemns efforts to procure infants for adoption through illegal means.

c. Urges that the high standards of the initial in vitro fertilization programs be maintained as the procedure becomes more widely available; and

(1) Opposes state or local legislation that would prohibit in vitro fertilization and urges church advocacy against such legislation where it exists (Illinois) or maybe proposed;

(2) Discourages development of human embryos and their use for experimentation except in those cases of clearly demonstrable benefit where no other substitute could accomplish the same end;

(3) Opposes legislation that, while attempting to curtail abuse, would serve to prohibit amniocentesis and beneficial fetal therapy.

d. Urges that informed consent be required from all participants in contraceptive and fertility drug experimentation and states emphatically that racial-ethnic, poor, and Third World women should not be used as guinea pigs for drugs deemed too risky for testing in affluent United States communities.

e. Urges further study on the psychological, ethical, and legal ramifications of surrogate motherhood and anonymous artificial insemination donors for all parties, including the child.

GENETIC CHOICES AND THE ETHICS OF DOMINION

1. The church is being challenged by medical advances to look more carefully at its heritage of healing in the light of treatment made possible through newly developed technology. The church should prepare pastors and members to understand the basic facts and implications of genetic diseases and reproduction so it can be a haven and a resource for its members and others in the community who are tormented by the agony of decision-making. The 195th General Assembly (1983) calls upon:

a. The Vocation Agency, working with synods, presbyteries, and seminaries, to consider ways to equip clergy, chaplains, and theologians to assist persons seeking to make responsible decisions related to new options in medical care.

b. The Joint Office of Worship to develop liturgical materials to aid the church in observance of grief and celebrations of healing occasioned through biomedical advances.

c. The Program Agency, United Presbyterian Men, United Presbyterian Women, and persons with program responsibilities in governing bodies to identify opportunities for interpreting recent biomedical advances, identifying new kinds of decisions that arise from the new technologies and the values related to those decisions.

d. The clergy to seek opportunities to meet with genetic counselors in order to explore ways in which each can support the work of the other and to explore with their congregations recent developments in biomedicine, identifying those which present ethical dilemmas and seeking ways as a community of faith to respond to them.

2. In the area of medical genetics, priority should be given to the prevention of disease via family planning, genetic counseling, and fetal diagnosis. Genetic counseling provides a helpful resource, particularly to those families with a known heritage of genetic disease and to those parents who experience a pregnancy after age thirty. Genetic counseling should be encouraged, with concern expressed about the easy designation of some traits as deleterious. The pursuit of "superior" human beings through genetic manipulation should be explored only with great caution, if at all. However, the possibility of this abuse should not discourage couples from seeking advice regarding the health of their unborn children. Therefore, the 195th General Assembly (1983):

a. Urges hospitals and medical centers with genetic counseling programs to work with churches and community agencies so that all who need such service will know of its availability.

b. Affirms the increased safety of surgical abortion as a procedure; urges continued training and research on methods for safe abortion; and urges the development of more humane policies and practices for those persons who undergo second trimester abortions.

c. Affirms research on alternative methods of fetal diagnosis that will make possible earlier determination of defect or disease and thus lessen the need for late abortion.

3. The church should be a community of faith, strong in mutual support in time of grief and anxiety provoked by stressful decision-making or the burden of genetic affliction. Therefore, the 195th General Assembly (1983):

a. Urges the Use of "Genetics, Health and Personhood," *Church and Society*, September–October 1982; *Genetics, Ethics and Parenthood*, The Pilgrim Press, 1983; and other resources for congregational study and for working with couples facing reproductive decisions.

b. Urges clergy to become well-informed on genetics issues in order to counsel couples in distress and to provide preventive counseling prior to marriage or reproduction.

c. Urges clergy to preach on the moral dilemma of biomedical decision-making in order that congregations may become better equipped to undertake their supportive and prophetic responsibilities and that persons may be aided in their moral decision-making.

d. Urges clergy to include a family health history segment in their premarital counseling procedure.

e. Urges congregations, working ecumenically wherever possible, to provide support groups for persons facing needs with regard to genetic disorders and other handicapping conditions, so that involved individuals and affected families do not suffer in isolation.

4. Inasmuch as technology or science impinges in so many ways on the everyday life of all persons, it is imperative that the general public have a far greater understanding of science. Therefore, the 195th General Assembly (1983) calls upon:

a. Scientists and the news media to make increased efforts to educate the lay public on the nature of scientific investigation per se, as well as on new discoveries in specific areas of science.

b. Educators to place greater emphasis in grade schools and high schools on science education and the process of scientific investigation as an expression of human activity.

c. Every governing body, pastor, and congregation to instill in the community of believers the realization that scientific undertakings are imbued with moral and ethical values and are central to living under the Word of God in contemporary society.

5. The application of science is the rightful concern and responsibility of nonscientists, particularly in determining the appropriate applications of science to the problems of society. Therefore, the 195th General Assembly (1983) affirms that:

a. Decisions concerning the pursuit of science and its practical application should have a significant input from the public; decisions concerning funding of research should be made by committees that are constituted of both scientists and laypersons.

b. Wherever scientific techniques are applied, including health care delivery, decision-making and review groups should include representation from both scientists (physicians) and laypersons.

6. As society looks to the benefits of biotechnology, there must be more serious social and ethical discussion about its application, especially human application. Abuses in eugenics programs in the recent past make the establishment of guidelines for the application of biotechnologies to human beings mandatory. The deepest issues of life and its meaning must not be obscured in the rush to profits and benefits promised by new biotechnologies. Therefore, the 195th General Assembly (1983):

a. Instructs the Advisory Council on Church and Society to circulate the study paper prepared by the National Council of Churches, to gather comments, and to forward these to the National Council of Churches.

b. Requests the Program Agency, through its Washington Office, to monitor proposed legislation that affects the application of biotechnology to human subjects, particularly those least able to defend themselves, such as the retarded and the poor.

c. Calls upon society in its role as guardian of persons' welfare to Institute rigorous human protections in medical research.

7. The goals and practice of science shape its impact upon each person and profoundly affect the values of human culture. Research can be guided by the desire for profit and fame as well as by compassion and a sense of justice. Biomedical advances can be harnessed in the service of war or in the service of a life-giving society. Thus the 195th General Assembly (1983) calls upon scientists, institutions of scientific research and instruction, Congress, and all Presbyterians to advocate that:

a. Research and development in science be guided by the following human values: survival, enhancement of life, Justice, and equity in access.

b. Research endeavors involving the natural world be undertaken only with ecological consideration and care; that animal subjects be treated humanely; that human subjects be given the strongest human protections, including full information about the research, and that their consent be obtained without coercion; that fetal and embryonic research be undertaken with caution and sensitivity.

c. Science place priority on supporting the basic life possibilities and needs of everyone rather than enhancing (prolonging, beautifying, etc.) the lives of a few, and that research and development allocations be made so as to reflect these goals.

d. Biomedical policy be formulated with participation by centers of value exposition, including the church.

THE PROVISION OF HEALTH CARE: OBEDIENCE TO DIVINE PURPOSE

1. The church is called to seek justice in the delivery of health care in our increasingly complex society. At the same time, injustices in the current system

that are being exacerbated by deep cuts in federal funding must be challenged. Therefore, the 195th General Assembly (1983):

a. Urges that access to a basic, minimal level of health care be available to all persons regardless of race, gender, age, or economic standing.

b. Urges Congress to pass legislation that would enable a cost-effective, yet fair, health care system to be established:

(1) This system should include preventive services, emphasis on community health centers, and group practice prepayment plans to eliminate or at least decrease the abuses of fee-for-service care.

(2) It should also include an effective system for monitoring medical resources and an emphasis on home health services, ranging from public health nursing to hospice home care.

c. Affirms trends toward increased use of outpatient facilities for minor medical procedures, and affirms the trend toward coverage of procedures done as an outpatient by third party payers.

d. Notes with concern the emphasis by private hospitals on provision of profitable services, leaving public hospitals and clinics burdened by more costly services.

e. Urges monitoring of decisions about allocations of resources (1) to determine who the primary decision-makers are and (2) to determine if decisions are fair and beneficial to large numbers of individuals and groups, not just to a privileged few.

2. Decision-making regarding treatment and health care delivery is imbued with values. The deeply held values of patients as well as caregivers are often tested, particularly in times of crisis. Recognizing this often overlooked factor, the 195th General Assembly (1983):

a. Urges young people to enter medical and paramedical fields with a view toward service and care, as opposed to increased financial gain.

b. Affirms physicians who do their best to be fair and show genuine care and concern for their patients and who try to uphold their patients' values without compromising their own integrity.

c. Urges regional and national dialogue about priorities in health care and the place of health care in the national budget.

3. The church should be a force for health maintenance. While acknowledging that health is more than absence of disease, the church should encourage congregations to sponsor information dissemination on prevention of disease, understanding the realities of genetic diversity and adapting to the process of aging. Therefore, the 195th General Assembly (1983):

a. Calls upon the Program Agency to encourage additional program development in health care delivery in Presbyterian congregations and to provide opportunities for models of ministry to be shared.

b. Urges congregations and governing bodies to explore the possibility of participating in or encouraging the formation of health maintenance organizations or other alternative health care programs, e.g., hospices.

c. Calls upon the clergy to become more aware of health care resources within their communities and seek more aggressively the opportunity to inform both the congregation and the community of those services.

d. Urges congregational study of scriptural themes such as healing, suffering, acceptance, and forgiveness as they pertain to health and illness.

e. Urges members, governing bodies, and agencies of the Presbyterian Church (U.S.A.) to monitor the accessibility of health care delivery, particularly for the poor, in their communities and to identify ways in which they can address inequities in health care delivery and apply themselves to repair injustices.

f. Recognizes and appreciates the role of the Presbyterian Health, Education and Welfare Association in providing Presbyterians in health ministries with a network for both mutual support and advocacy for justice.

g. Encourages congregations located in the vicinity of medical centers to provide hospitality for persons who have traveled a distance in order to receive treatment or for family members who are accompanying loved ones receiving treatment.

4. Biomedical advances have had implications for the role of those whose lay or ordained ministry is located in the hospital or clinic. Out of concern that the patient be responsible for his or her own care insofar as possible, the 195th General Assembly (1983):

a. Calls upon chaplains and all clergy who minister in health care settings to recognize that their responsibilities go beyond traditional spiritual support and include recognizing when a patient's beliefs and values clash with those who provide care and intervening on behalf of the patient.

b. Encourages the team approach to decision-making in times of serious medical problems and affirms participation of the chaplain or pastor on the team.

c. Affirms the value and importance of nurses in providing care to patients.

d. Urges individuals to assume more responsibility for their own health through education and healthful living; and

(1) Discourages a moralistic approach to health care distribution based on merit according to preset criteria (e.g., nutrition, rest, exercise, and habits such as smoking);

(2) Discourages punitive attitudes and actions against persons who do not take care of their health.

5. The 195th General Assembly (1983) affirms that the benefits of science, particularly those related to biomedical advances, should be made available to all persons irrespective of sex, race, or nationality. The prime goal of all persons concerned with advances and applications of biomedicine should be the health and well-being of humankind, and not the selective use of these applications for specific subgroups or the financial gain of individual scientists or corporations. Therefore, the 195th General Assembly (1983) urges the legislative bodies of the United States to alter tax and patent laws to insure that the fruits of science generally, and the biomedical sciences specifically, are equitably distributed.

DECISION-MAKING AT THE END OF LIFE

1. Many members of the Presbyterian Church (U.S.A.) will face health care decisions toward the end of life that they could not have anticipated, and many of those decisions will require judgments that relate to values held by the patient. Therefore, the 195th General Assembly (1983) calls upon its members to:

a. Select their physicians with regard not only to the skillfulness of the medical care that they can provide but also for their values regarding human life and community, whenever such a choice is available.

b. Take time to reflect on their own values and discuss these with family members, close friends, and their clergy.

c. Speak with their physicians about their concerns regarding care and become educated about their conditions in order to permit informed decision-making.

d. Provide instructions (and designate two agents to carry out instructions) with regard to extraordinary therapies and treatments to prolong life.

2. The church should be a place where individuals and families can make plans about death, manner of death, living wills, etc. Therefore, the 195th General Assembly (1983) calls upon the church to:

a. Request the Program Agency to make available information and study tools for use by congregations regarding options available at the end of life and means of informing health care professionals of these wishes.

b. Hold seminars utilizing the aforementioned materials and qualified resource persons whenever possible.

c. Advocate that human need and benevolence replace the opportunism and exploitation that so often surround the death experience presently.

3. Harmony and integration should be sought between intensive care, curative hospitals, and hospices so that end of life care can be free from jurisdictional conflict and that therapeutic and palliative care are available to all.

APPENDIXES

APPENDIX A

DIRECTIONS FOR MY CARE

I, _____, want to participate in my own medical care as long as I am able. But I recognize that an accident or illness may someday make me unable to do so. Should this come to be the case, this document is intended to direct those who make choices on my behalf. I have prepared it while still legally competent and of sound mind. If these instructions create a conflict with the desires of my relatives, or with hospital policies or with the principles of those providing my care, I ask that my instructions prevail, unless they are contrary to existing law or would expose medical personnel or the hospital to a substantial risk of legal liability.

I wish to live a full and long life, but not at all costs. If my death is near and cannot be avoided, and if I have lost the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible, I do not want to have my life prolonged. I would then ask not to be subjected to surgery or resuscitation. Nor would I then wish to have life support from mechanical ventilators, intensive care services, or other life prolonging procedures, including the administration of antibiotics and blood products. I would wish, rather, to have care which gives comfort and support, which facilitates my interaction with others to the extent that this is possible, and which brings peace.

In order to carry out these instructions and to interpret them, I authorize _____ to accept, plan, and refuse treatment on my behalf in cooperation with attending physicians and health personnel. This person knows how I value the experience of living, and how I would weigh incompetence, suffering, and dying. Should it be impossible to reach this person, I authorize _____ to make such choices for me. I have discussed my desires concerning terminal care with them, and I trust their judgment on my behalf.

In addition I have discussed with them the following specific instructions regarding my care:

(Please continue on back.)

Date _____ Signed _____

Witnessed by _____ and _____

(Source: Sissela Bok, "Personal Directions for Care at the End of Life," *New England Journal of Medicine* 295 (August 12, 1976), 367-369.)

Appendix B

CHRISTIAN AFFIRMATION OF LIFE¹

To my family, friends, physician, lawyer, and clergyman:

I believe that each individual person is created by God our Father in love and that God retains a loving relationship to each person throughout human life and eternity.

I believe that Jesus Christ lived, suffered, and died for me and that his suffering, death, and resurrection prefigure and make possible the death-resurrection process which I now anticipate.

I believe that each person's worth and dignity derives from the relationship of love in Christ that God has for each individual person and not from one's usefulness or effectiveness in society.

I believe that God our Father has entrusted to me a shared dominion with him over my earthly existence so that I am bound to use ordinary means to preserve my life but I am free to refuse extraordinary means to prolong my life.

I believe that through death life is not taken away but merely changed, and though I may experience fear, suffering, and sorrow, by the grace of the Holy Spirit, I hope to accept death as a free human act which enables me to surrender this life and to be united with God for eternity.

Because of my belief:

I request that I be informed as death approaches so that I may continue to prepare for the full encounter with Christ through the help of the Sacraments and the consolation and prayers of my family and friends.

I request that, if possible, I be consulted concerning the medical procedures that might be used to prolong my life as death approaches. If I can no longer take part in decisions concerning my own future, and if there is no reasonable expectation of my recovery from physical and mental disability, I request that no extraordinary means be used to prolong my life.

I request, though I wish to join my suffering to the suffering of Jesus so I may be united fully with him in the act of death-resurrection, that my pain, if unbearable, be alleviated. However, no means should be used with the intention of shortening my life.

I request, because I am a sinner and in need of reconciliation and because my faith, hope, and love may not overcome all fear and doubt, that my family, friends, and the whole Christian community join me in prayer and mortification as I prepare for the great personal act of dying.

Finally, I request that after my death, my family, my friends, and the whole Christian community pray for me, and rejoice with me because of the mercy and love of the Trinity, with whom I hope to be united for all eternity.

Signed _____

Date _____

Appendix C

A LIVING WILL

To My Family, My Physician, My Lawyer, My Clergyman; To Any Medical Faculty In Whose Care I Happen To Be; To Any Individual Who May Become Responsible For My Health, Welfare, Or Affairs:

B. In the event of my suffering from any of the conditions specified above, I request that no active steps should be taken, and in particular that no resuscitatory techniques should be used, to prolong my life or restore me to consciousness.

C. This declaration is to remain in force unless I revoke it, which I may do at any time, and any request I may make concerning action to be taken or withheld in connection with this declaration will be made without further formalities.

I WISH it to be understood that I have confidence in the good faith of my relatives and physicians, and fear degeneration and indignity far more than I fear premature death. I ask and authorize the physician in charge of my case to bear these statements in mind when considering what my wishes would be in any uncertain situation.

SIGNED

[SIGNED ON RE-EXECUTION]

WE TESTIFY that the above-named declarant ²[signed] ²[was unable to write but assented to] this declaration in our presence, and appeared to appreciate its significance. We do not know of any pressure being brought on him to make a declaration, and we believe it is made by his own wish. Insofar as we are aware, we are entitled to attest this declaration and do not stand to benefit by the death of the declarant.

Signed by _____

Signed by _____

of

of

Signed by _____

Signed by _____

of

of

on re-execution]

on re-execution] Notes

Notes

Chapter 1

1. This interpretation draws heavily on the work of Walter Brueggemann in his book, *Genesis: A Bible Commentary for Teaching and Preaching* Atlanta: John Knox Press, 1982.
2. Cf. Lynn White, "The Historical Roots of Our Ecological Crisis," *Science*, 155:1203-07, 1967.
3. *Op. cit.*, Brueggemann, pp. 32-33.
4. *Ibid.*, p.58.
5. *Ibid.*, p. 99.

Chapter 2

1. *When Pregnancy Fails*
2. *Genetics, Ethics and Parenthood*, edited by Karen Lebacqz (New York: The Pilgrim Press, 1983), explores these issues in greater depth and is recommended to groups wishing to do more study in this area. Of particular interest is a discussion tool that sets out several alternative scenarios utilizing new procreative methods (Chapter 4, "Testing the Limits," pp. 24–28). It has been noticed that many Christians become increasingly uncomfortable the further the scenarios go from a covenanted family context.
3. "A Congregational Perspective" by Bobbi Wells Hargleroad, unpublished, prepared for the Task Force on Science, Medicine and Human Values. A longer paper describing the rite, *Passing Into Parenthood: A Rite to Celebrate the Decision to Have Children*, is available from the author, 6320 Crescent Drive, Huntley, IL 60142.

Chapter 3

1. Laxova article, *Church and Society Magazine*, September-October 1982.
2. Langella, *Ibid.*
3. Cf. "A Personal Perspective," by Bobbi Wells Hargleroad, *Ibid.*
4. Cf. "Who Then is Normal?" by Jan van Eys, *Ibid.*
5. Bentley Glass, in his article "Genetics, Evolution & Human Values," in *Church and Society Magazine*, September-October 1982 raises this concern. "People cannot continue to exist except in a carefully ordered environment of a particular kind, nourishing, wholesome, balanced. . . We do not stop with our skin; rather, social relationships are in truth a part of each person, for no human being is entirely self-sufficient. And this ethic of interdependence and concern is not limited to others of one's own species. The human biome is in fact a part of and necessary to each person, and each person thereby assumes a need to preserve and a responsibility to defend the biome that is a part of us." (C&S, p. 72.)
6. This literature is summarized in "Ethical Options in the New Genetics" by Peter Browning in *Church and Society*, 73:1, September-October 1982.
7. *Genetics and the Quality of Life*, Birch, Charles and Paul Abrecht, Pergamon Press, 1975, pp. 200–223.
8. *Manipulating Life: Report on Ethical and Social Issues in Genetic Engineering and the Ownership of New Living Organisms*. *Church and Society*, 3:1, September-October 1982, p. 40.
9. The second section of *Genetics, Ethics and Personhood*, edited by Karen Lebaeg, (NY: The Pilgrim Press, 1983) is devoted to questions of "quality control" in human offspring. The third section outlines an approach to ethical decision-making.
10. *Coping with Genetic Disorders: A Guide for Clergy and Parent*, Fletcher, John C. (Harper & Row, 1982.)

Chapter 4

1. Quoted in Strauss, *Familiar Medical Quotations*, Maurice B. Strauss, Ed., *Familiar Medication Quotations*. Boston: Little, Brown and Co., 1968, p. 206.
2. "The Spiritual Dimensions of Man's Health in Today's World," in David Belgum, ed., *Religion and Medicine*, Ames: Iowa State University Press, 1967, p. 189. [Cited in Robert Lanon White, *Right to Health: The Evolution of an Idea*. Ames: Iowa State University Press, 1971, pp. 12–13.1
3. "Health Care in the Church's Ministry: A Biblical Perspective," p.15. (Paper delivered at Elmhurst College, October 1981.)
4. *A Theory of Justice*. London: Oxford University Press, 1973, p. 3.
5. A right to health care is different from a right to health A right to health care usually refers to access to health care while right to health requires agreement on a minimal definition of health and then providing what is required to maintain the required level of health. A right to health is a utopian dream which depends on perceptions and factors far beyond the scope of a right to health care.
6. Milton Terris, M.D., M.P.H. "A Cost-Effective National Health Program," paper presented APHA, Montreal, Canada, November 1982.
7. Even in a situation where individuals may have caused their poor health (e.g., substance abuse), underlying causes within society may have led the individual to drink, smoke, or eat too much. Thus the individual may not be entirely to blame for his or her situation.
8. Generally speaking, the wealthy and the poor in the United States have had greater access to medical care than the middle class. This situation may be changing, however, with the withdrawal of funds from Medicare and Medicaid, thus leaving the poor with inadequate access to medical care.

Chapter 5

1. "Boy Needs 'Signs,' Makes Choice to Die," *Chicago Tribune*, Thursday, June 22, 1982, p. 1.
2. "Her Choice: Don't Give in to Death," *Chicago Tribune*, Friday, July 30, p. 4, Sec. 1.
3. "A Definition of Irreversible Coma," *Journal of the American Medical Association*. 205 No.6, August 5, 1968, pp. 85–88.
4. Sir Thomas Browne, *Christian Morals*, Park II, Sec. XIII, Works IV, Ed., S. Wilkon. London: William Pickering, 1835, p.170.
5. See versions of "Living Wills" in Kenneth Vaux, *Will to Live/Will to Die*, Minneapolis: Augsburg Press, 1978; Marvin Kohl, Ed., *Beneficent Euthanasia*, Buffalo, NY: Prometheus Books, 1975; "Death" *Encyclopedia of Bioethics*. New York: MacMillan Free Press, Vol. 1, 1978, p. 221.
6. Sissela Bok, "Personal Directions for Care at the End of Life," *New England Journal of Medicine*, Vol. 295:7, p. 367–69, August 12, 1976.
7. Sissela Bok in "Death and Dying," *Hard Choices*, produced by KCTS/9, Seattle, Washington, p. 4.

8. James George Frazer, *The Belief in Immortality and the Worship of the Dead*, 3 Vols. (London: Macmillan, 1913–22.)
9. “Death: Anthropological Perspective,” *The Encyclopedia of Bioethics*, *Op. Cite*, p. 225 ff.
10. Oscar Cullman, “Immortality of the Soul or Resurrection of the Dead?” in *Immortality and Resurrection*, ed. Krister Stendahl. New York: MacMillan, 1965, pp. 26–27.
11. Paul Ramsey, “The Patient as a Person.” Yale University Press, New Haven and London, 1970, p. 118.
12. *Ibid.*, p.125.

Appendix B

1. This document was approved by the Board of Trustees of The Catholic Hospital Association in June. Reprints of the Affirmation will be available soon. For quantity prices, contact the Publications Department, The Catholic Hospital Association, 1438 S. Grand Blvd., St. Louis, Mo. 63104.

Appendix D

2. Strike out whichever words do not apply.

COVENANT AND CREATION: THEOLOGICAL REFLECTIONS ON CONTRACEPTION AND ABORTION

A. Introduction: Responsibility in Creation and Covenant

When I look at thy heavens, the work of thy fingers,
the moon and the stars which thou hast established;
what is man that thou art mindful of him,
and the son of man that thou dost care for him?
Yet thou hast made him little less than God,
and dost crown him with glory and honor.
thou has given him dominion over the works of thy hands;
thou has put all things under his feet,
all sheep and oxen, and also the beasts of the field,
the birds of the air, and the fish of the sea,
whatever passes along the paths of the sea.
O Lord, our Lord, how majestic is thy name in all the earth!
(Psalm 8:3–9.)

The psalmist sings of the honor given to humankind, the honor that reflects human dominion over all that has been created. The very first chapter of Genesis sets forth this honor as a responsibility: “Be fruitful and multiply, and fill the earth and subdue it; and have dominion over every living thing that moves upon the earth ... (Genesis 1:28.) Our stewardship of creation is our exercise of that dominion. We are called not to dominate, to exercise power for its own sake, but to care for that which God has made.

John Calvin, in the *Institutes of the Christian Religion*, describes the combination of providence and stewardship that forms the basis of our analysis. While we would today reject Calvin’s exclusively masculine language in reference to God, we are grateful for this clear and strong affirmation of human freedom and responsibility in God’s provision for us.

For he who has set the limits to our life has at the same time entrusted to us its care: He has provided means and helps to preserve it: He has also made us able to foresee dangers; that they may not overwhelm us unaware, he has offered precautions and remedies. Now it is very clear what our duty is: Thus if the Lord has committed to us the protection of our life, our duty is to protect it: if He offers helps, to use them; if He forewarns us of dangers, not to plunge headlong; if He makes remedies available, not to neglect them. (1.17.4)

This paper will examine the issues related to contraception and abortion as an aspect of our care for creation. It will do so out of a profound respect for human life. Like the psalmist quoted above, we know that the value and dignity of human life are bestowed by God our Creator who calls us into a covenant relationship with him and with each other. Our study is based on a deep appreciation for the human family, for the ties that bind people together into long-term commitments and through which joys and sorrows, blessings and burdens may be shared. This study reflects an attitude of respect for the values and teachings of other religious groups. It was developed by the

Task Force on Science, Medicine, and Human Values of the Advisory Council on Church and Society. The task force examined many different theological statements on abortion and contraception, interviewed physicians and researchers, and searched for a way it could best serve the church through a paper on contraception and abortion.

We affirm that the decision to bear a child may be described as being a decision to initiate a covenant with that child. Through this covenant the parent(s) commit themselves to providing those resources of nurture and protection needed to bring that child to maturity. The covenant, begun in the decision to become pregnant (or to continue the pregnancy), is shared in baptism when the child is brought into the fellowship of the covenant community.

The Use of Contraception and Abortion

For the most part, Protestants have affirmed the role of contraception as a responsible exercise of stewardship vis-a-vis natural processes. Limiting the size of a particular family or limiting population growth in a whole population is generally understood to be a kind of caring for the next generation. The most desirable means of limiting natural human fertility is being able to prevent pregnancy. However, in the exceptional case in which a woman is pregnant and judges that it would be irresponsible to bring a child into the world given the limitations of her situation, this paper will affirm that it can be an act of faithfulness before God to take responsibility for intervening in the natural process of pregnancy by terminating it.

There is a tendency to feel that it is more virtuous to continue a pregnancy without considering the possibility of abortion. However, Calvin asserts, we cannot reduce stewardship to a kind of wonder or awe in the face of the natural world. The pregnant woman has a responsibility to take seriously the relative merits of each course of action open to her. A woman who considers abortion and then opts to continue her pregnancy should never be made to feel guilty that she has pondered the question of abortion. It is better to give birth intentionally than to feel that the diagnosis of pregnancy constitutes an absolute obligation to bear a child. In most pregnancies the question of abortion will never arise, but when it does, the choice of abortion can be an expression of responsibility.

We understand readily that it is moral for a husband and wife who wish to engage in sexual relations, but who are not in possession of sufficient resources—emotional, physical, financial, etc.—to care for a child born at that time, to use contraception. The use of contraception in such a case enables the couple to enjoy the gift of intimate physical communion in their relationship while being responsible about the procreative power of their intimacy. The ability to exercise responsibility in this case is the ability to project future possibilities, to assess both the prospective strengths and limitations in a concrete situation, and to decide whether one can follow through if a commitment is made. Our ability to project both human needs and human limitations, and to make reasoned moral choices based on the work of the projective human consciousness, is an important part of the distinctive humanness of which biblical authors spoke when they affirmed that we humans are created “in the image of God.”

The decision to bear a child means committing one’s human resources for the purpose of sustaining and, in many ways, continuing to create this human life over a pe-

riod of 18–25 years. Bearing children is a process of covenant-initiation that calls for courage, love, patience, and strength. In addition to these gifts of the Spirit, these covenants also require the various fruits of our labor in a money economy, the economic as well as spiritual resources appropriate to the nurture of a human life. The magnitude of the commitment to be a human parent cannot be overestimated, and should not be understated. Unfortunately, because the roles and functions of active parenting are not assigned a money value in our economy, the personal and social value of this work, performed primarily by women, is underestimated and even ignored.

Parenting may give us a sense that as human beings we can be God-like participants in creating a covenant. However, the question of abortion arises fundamentally out of the experiences of our finitude. The decision to terminate a pregnancy is a question of one's covenant responsibility to accept the limits of human resources. Much as we would like to have the power to follow through on the consequences of all our actions, we do not. When someone can discern that it would not be good for a child to be born as the result of a particular pregnancy, she has a responsibility to take her human limitations seriously and to act accordingly.

There was a time when being pregnant meant following the process to its natural conclusion, childbirth. When a child was born, there was no choice but to make the best of the situation, which could be extremely difficult for children as well as for their parents. We now have the medical skill to intervene, without threatening the life of a pregnant woman, in the development of a pregnancy. Thus, we are called to consider the ethical significance of each of the options set before us.

This frame of reference for deciding about an abortion is fundamental to our Calvinist tradition of Christian responsibility and freedom. Affirming human responsibility for procreative processes is an affirmation of human freedom. The freedom to do what one judges most appropriate in an abortion decision is qualified by the fact that the purpose of such decisions is the responsible exercise of stewardship. Even when we misuse our freedom, God's forgiving grace is offered.

The responsibilities set before us in God's covenant with us would be overwhelming if it were not for the power of the gospel. The gospel says that we have God's grace in deciding which course of action to take. We have important responsibilities; but we can trust, the gospel assures us, in the grace of God empowering us in the exercise of our free will to discern the appropriate course of action in a morally complex choice. If it were not for the assurance of God's Spirit informing human action in the exercise of conscience, we could not claim that we have the freedom to use modern medical skill to direct human procreation.

The Calvinist affirmation of conscience as one of the primary junctures at which the power of the Holy Spirit breaks through into human experience is grounded in both (a) the Old Testament call to human responsibility, as set forth in the biblical witness to God's covenant with us, and (b) the New Testament assurance of the work of the Holy Spirit as our enabler and guide in the exercise of human freedom before God. Our own Book of Order reminds us that "God alone is Lord of the conscience...." (G-1.0301.) The Calvinist frame of reference speaks to the complexity of the human

experience and of our being responsible for our actions before God. It speaks profoundly to that aspect of our humanness and has done so for centuries.

B. Contraception: A Question of Social Justice

One of the most significant moral questions that the study of elective abortion puts before our church is the question of the relationship of abortion and contraception. How do contraceptive technology and contraceptive practice relate to the incidence of surgical abortion? To date, most reflection on the morality of abortion has been limited to the questions of personal morality that arise after pregnancy and to intervention in the continuation of this natural process. If we regard abortion as a social and ethical issue as well as a personal question, we must examine abortion policy and practice in relation to “contraceptive” policy and practice.

According to Charles Westoff and Jane DeLong, a large percentage of induced abortions in the United States each year are performed for women who have become pregnant because of contraceptive failure.¹ In most of these instances, the women will choose to continue their pregnancies and give birth. However, some women decide to terminate the pregnancy by surgical abortion for the reasons that lead them to use contraceptives. There are several ways by which the abortions resulting from contraceptive failure could be reduced. Above all, it is important for us as a church to “demythologize” the assumption that contraceptives always work and its corollary, that when a contraceptive fails, it is the fault of the user. When we consider that all but 5–10 percent of the surgical abortions performed each year could be prevented by the development and use of more effective contraception, we should examine contraceptive failure and work to make contraceptive practice as effective as humanly possible.

First, we should review the rates of effectiveness of the various means of controlling or diminishing fertility. The table below gives ranges:

Number of Pregnancies Per Year
Among 100 Fertile Women Who Use Method²

Method:	
Abortion	0
Abstinence	0
Hysterectomy	0.0001
Tubal Ligation	0.04
Vasectomy (use by partner)	0.15+
Oral Contraceptive (combined)	4–10
Condom and Spermicidal Agent	5
*I.U.D.	5

* While “The Pill” and the intrauterine devices were introduced to the American market as contraceptives and are commonly thought of as such, it is now known that neither of these methods of diminishing fertility acts exclusively to prevent conception. In both cases, the method’s effectiveness

I.M. Long-Acting Program	5–10
Condom	10
Diaphragm (with Spermicide)	17
Spermicidal Foam	22
Spermicidal Suppository	20–25
Coitus Interruptus	20–25
Various Methods of Fertility Awareness	20–25
Lactation	40
Douche	40
Chance (sexually active)	90

Considered over against unprotected sexual intercourse, the several methods of contraception that medical science has developed within the last century do comprise a significant advance. However, our expectations for contraceptive performance significantly exceed their actual effectiveness.

If we view the moral (or ethical) problem of abortion in social perspective, we discover that the moral question posed by the numbers of surgical abortions performed annually in the United States is more forcefully described as the problem of contraception. As a church we must speak, as forcefully as possible, to the relation of contraceptive technology and practice to the need for surgical abortion. If we refer back to the table above, we learn that the term “birth control” (or “fertility control”) is 100 percent accurately employed only in the cases of surgical abortion and abstinence. It is patently absurd to claim that “abortion is not a method of birth control.” Abortion is chosen in tens of thousands of cases annually in the United States alone because of the unfortunate fact that it is the only 100 percent (i.e., genuinely) effective method of preventing birth that medicine can currently offer. All other methods that we employ to prevent pregnancy or birth are only relatively effective; they merely reduce or diminish fertility.

Ninety percent effectiveness is considered good performance in contraception technique. Yet, if one in ten American cars manufactured this year did not last for at least twelve months, i.e., was broken down and could not be repaired because of defects in manufacture, there would be a national outcry against that industry. The commitment to purchase a car, significant as it may be, is not of the same order of magnitude as the commitment to bear and rear a human child. Of course, in any comprehensive analysis, purchasing a car or a home and choosing to bear a child cannot be compared. The useful comparison here is between our attitudes and standards from one industry to another. An important moral question for our society and our churches is raised by the discovery of the dramatically different standards that are popularly assumed in the respective cases. Recent advances in contraceptive technology have created a public consciousness that regards contraception as virtually perfect, while its “effectiveness” is far from reliable. To assume that the failures of contemporary “family

is attributable in part, if not exclusively, to its action within a few hours or days after conception.³

planning” are attributable to user error, or to assume that present contraceptive technology is satisfactory, is to ignore our social responsibility and to allow a minority of individuals to bear the burden of our unwillingness to address the problem.

This matter is complicated when we realize that contraceptive “effectiveness” is sometimes cited from “theoretical effectiveness” rates as well as “actual use effectiveness” rates. The theoretical and actual rates can vary as widely as 15 to 20 percentage points, particularly when age-specific fertility is factored into the actual rate.⁴ For many of us, it is surprising to learn that combined use of a condom and a spermicidal agent, neither of which requires a prescription, has virtually as few failures as The Pill in actual use. The “effectiveness” rates for the higher risk methods and those which are available only with a prescription are usually quoted from the statistics for “theoretical effectiveness.” Even health professionals often underestimate the value of the nonprescription, low health-risk methods.

As we consider our standards for the contraceptive industry on an individual basis, our evaluations may vary widely. But if we consider the data from a national perspective, the need for changes in contraceptive practice and technology becomes clear. If every female of childbearing age (15–45) used the most effective contraceptive method that is available presently and it functioned at the 1.1 percent rate, which is observed at an age-specific fertility of 35 years+,⁵ there would be at least 450,000 unintentional pregnancies each year. It is irresponsible for the church not to address the question of the relationship of our expectations for medical science in the area of family planning over against the actual performance of contemporary contraceptive technology. In the moral cases of rape or incest, the personal immorality of the aggressor is clear. In the case of women who are pregnant against their wills because of contraceptive failure, the immorality is far less clearly focused because the responsibility is diffused among the various parts of the health care delivery system: the pharmaceutical industry, medical professionals, and the general public as a whole.

There is consensus among our members that methods which prevent fertilization or implantation are preferable to surgical intervention in pregnancy. There are, then, several important moral questions before our church. Is our view of the “effectiveness” of present family planning technology an accurate understanding of contraceptive or abortifacient use in actual practice? This question, to which we have spoken above, brings us to the conclusion that it is morally unacceptable simply to let contraceptive technology remain as is. Significant change is needed.

How can the failure rate of nonsurgical means of contraception be significantly reduced. Here are some important steps we can take: (a) As a church we have a responsibility to call for significant changes in contraceptive policy and practice. We should call upon policymakers in government and industry to form a rational policy for all members of our society in the area of contraception. For example, if it is possible to develop an oral contraceptive that is 85–90 percent effective for the female sexual partner, then it should be possible to develop a similarly effective prescription for the other (male) partner. If these two prescription drugs were understood as one contraceptive method, i.e., to be used by both partners together, the effectiveness would be well above the 99 percent mark. In other words, the annual figure of more than 450,000 unintentional pregnancies, which we mentioned above, could be greatly reduced. Sexual partners and medical professionals would welcome this significant

diminution in the need for abortion services. It is time for the churches to call for the development and marketing of a range of effective male contraceptives. (b) It is incumbent upon us as a church to reeducate our own membership, to create an awareness that family planning cannot be the concern of either sexual partner individually. This project should be an integral part of the teaching ministry of the church. Our churches can be the place where people come to understand that it is technologically impossible for pregnancy to be effectively prevented by either partner alone. (c) Even before the pharmaceutical industry can make an oral contraceptive for males widely available, we can advise our members to use two or three different methods at once if they intend to prevent pregnancy.

C. When Contraception Fails: The Unanticipated Pregnancy

There is no point in the course of pregnancy before which the moral issue of abortion is insignificant. Because a human pregnancy is the development of a form of human life, the pregnant woman has a moral responsibility to choose whether it is responsible to give birth. An unintended pregnancy may become a wanted pregnancy. In many unintended pregnancies, this is the case.

However, a number of unintended pregnancies remain unwanted. This does not arise out of a casual attitude, a callousness, a disregard for children on the part of these pregnant women. Rather, the women whose unintended pregnancies become wanted pregnancies and the women who choose to terminate an unintended pregnancy may have each exercised their human responsibility to consider prospectively the resources needed by a particular human child in a particular situation. The former group may have found that although they had not made preparations in advance of becoming pregnant, they can reasonably expect to be able to provide the various resources that the nurture of a human child requires. The decision may be that of making the child available for adoption. The latter group may have made the best possible projection of resources necessary for the birth and nurture of a human child. Unlike the members of the former group, their consideration may result in the discovery of significant limitations in their resources. Having reached the conclusion that they are not in a position to care for a human child in that context, or to bring the child to birth so it could be placed for adoption, the decision to terminate the pregnancy can be an expression of human responsibility no less than another's decision to give birth.

These two groups are not exhaustive; there is a third possibility: the woman who discovers her unintended pregnancy and does not find the affirmation of her freedom and responsibility from either her religious community or from within herself. In this case, she continues her pregnancy because she feels compelled or coerced to do so, continues to be ambivalent about her course of action, and finds herself cut off from any spiritual or personal means of resolving her ambivalence. This third group is susceptible to the distortions of human intimacy cited in the abortion rights debate—increased occurrence of physical and emotional abuse, psychosis and schizophrenia, suicide. Our church is called at this time to speak clearly about our respect for all women and to assist them to make a conscious, responsible choice regarding unintended pregnancy.

Having outlined choices regarding unintended pregnancy, the question arises concerning their relationship to the developmental character of pregnancy. The church

can offer clear guidelines regarding abortion in each trimester of pregnancy. If possible, an abortion should take place within the first trimester of pregnancy. This guideline does not stem from moral or theological perspectives, as we affirm that there is no point within the first two trimesters (i.e., before viability) at which abortion is a less or more significant moral question than at any other. The grounds for recommending that abortions be performed as early as possible are twofold:

1. The surgical procedures used to perform abortions during the first trimester are statistically safer.

2. On experiential grounds, first trimester abortion is preferable. During the first trimester, the surgical procedure is one of evacuating the uterus, i.e., it is experienced as surgery. During the second trimester, the pregnancy can only be terminated by processes that involve the expulsion of the fetus by uterine contractions, i.e., it is experienced as a process of labor and delivery.

There are two cases in which abortion cannot be performed until the second trimester of pregnancy: (1) Each year there are a small number of women of menopausal age who do not discover that they are pregnant until the second trimester. (2) Diagnosis of a genetic disorder by amniocentesis currently cannot occur until well into the second trimester.¹

The current practice in the United States regarding abortion is almost entirely consonant with these guidelines. With ten years of experience with elective abortion, the percentage of first trimester terminations of pregnancy has leveled off at 94 percent. Of the remaining 6 percent, many are abortions sought by women of menopausal age; one half are chosen because of a diagnosis of serious genetic disorder, and the remainder are performed for women who either did not seek or did not have access to medical care in the first trimester. The latter group is composed primarily of teenagers who are ambivalent about being pregnant and fearful of disclosing their pregnancy to a friend, family member, or a professional who could be of aid. The physicians, clergy, demographers, and attorneys, with whom the justices of the Supreme Court consulted in the early 1970's, before handing down their 1973 decision led the Court to establish a national policy that would generate this pattern of usage.

By allowing the states to restrict the performance of abortion to hospitals only in the second trimester, the Court established a financial incentive for first trimester abortions. (In 1973, only 38 percent of all abortions were performed in the first trimester; by 1978, the number of first trimester abortions had leveled off at above 90 percent.)² At the same time, restricting second trimester abortions to certain facilities, as states have done, continues the protective intent of the law regarding abortion. None of the persons whose circumstances point to a second trimester abortion is burdened with the additional expense of seeking the permission of the judiciary on a case-by-case basis. (The Court's ruling regarding the third trimester will be addressed later.)

As we think about the implications of third trimester abortions we must also take into account the developmental character of pregnancy. To speak only of the absolute dependency of the fetus and of the physical autonomy of the neonate is not to exhaust the full range of possibilities. Later in pregnancy, although the fetus continues to be an integral part of the woman's body, i.e., continues its dependence on her, the fetus

is sufficiently developed to survive as a physically autonomous human being. Although the fetus is still in fact dependent on the woman's body, that dependence is no longer absolute. At this point the moral question shifts from dominion (human responsibility for directing the natural order) toward inviolability. The fetus at this stage has similar moral claim to inviolability as does any human being already born. In other words, the responsibilities set before us in regard to the fetus begin to shift at the point of fetal viability. Prior to viability, human responsibility is stewardship of natural processes under the guidance of the Holy Spirit. Once the fetus is viable, even though in actual fact it does not exist outside the womb, its potential for physically autonomous human life means that Exodus 20:13 can be applied, as it is applied to the whole human community. The only moral exception to the Sixth Commandment in regard to the fetus during the last trimester of pregnancy is the endangerment of the mother's life. In such instances the difficult moral dilemma of self-defense presents itself.

The natural point of viability, after which the weight and organic development of the fetus permit its survival outside the womb, coincides roughly with the end of the second trimester, and thus with the end of the period during which elective abortion is permitted by the 1973 Supreme Court decision. We can affirm this decision, then, for religious reasons as well as medical, as it upholds the inviolability of autonomous human life. The Court's decision was, of course, not based on a particular religious perspective. Finding no clear consensus in this sensitive area, the Supreme Court based its decision on the legal tradition of intent to protect the safety of the pregnant patient.

In the last few years, the ability of the medical profession to aid the very small newborn to sustain life outside the womb has progressed wonderfully. Extrapolating from this progress, we can imagine the theoretical possibility that the point of "viability" could be moved back indefinitely. However, it is unlikely, barring a complete revolution in medical science, that this theoretical possibility will ever be the case. It is unlikely that an environment for fetal development that would be an acceptable substitute for the human uterus will be developed. If we wish to stay within the realm in which physicians can offer predictive judgments, we know that the low birth weight neonate, aided by intense oxygenation, temperature control, and a (relatively) sterile environment (i.e., an "incubator"), who survives a period of days or weeks of hospitalization will probably grow to be a healthy child and adult. When more intense, "heroic," measures are employed, neonatologists are unable to predict whether the neonate will later develop serious neurological problems. It is known that these infants, for whom extraordinary life support systems have been used, develop neurological disorders in a significantly greater number than the whole population.³ Thus, extraordinary means should be used only at the discretion of the physician and the parents. In view of the impossibility of predicting the future possibility of disease resulting from incomplete development of the fetus's nervous system, it would not be helpful to press too rapidly toward an earlier point of viability for its own sake. It would appear that there is a natural point in the development of the fetus's nervous system before which its survival outside of the uterus will not be a practical possibility.

Our understanding of what constitutes moral practice in the use of surgical abortion is not based on a set of categories, such as social and economic resources of the parents, emotional stress, rape and incest, life endangerment, etc. Because the factors

entering into any particular abortion decision are so complex, a single rule regarding Christian practice in the use of abortion is probably not possible. It is statistically likely that virtually 100 percent of all women whose lives are endangered by pregnancy will choose abortion. It is statistically a bit less likely that every woman who is a victim of rape will choose surgical abortion; it is statistically far less likely that a woman or couple who perceive the pregnancy as a cause for financial or emotional stress on the family will actually choose to terminate that pregnancy. Yet the moral claim of each person to choose abortion is no less strong in these situations. The morality (or immorality) of a particular abortion is not contingent on the kind of problem that prompts its consideration, but on the seriousness of that problem in the particular case. We affirm the value of decision-making empowered by the Holy Spirit. Because we understand the morality of abortion to be a question of stewardship of life, the responsible decision to opt for abortion arises from analysis of the projected resources for caregiving in a specific situation and cannot be made without regard to these kinds of human resources.

D. Moral, Legal, and Medical Histories Regarding Abortion

In providing a resource to the church to assist the church's reflection on the use and morality of abortion, it is important to describe the developments that have converged in the late twentieth century. The history of these various developments is woven from a fabric of medical, legal, and theological information. To explore the Christian ethical significance of abortion, we need to be familiar with (1) the legal and medical understanding about abortion as well as (2) the difference between legal or medical thinking about abortion and theological or moral thinking. A brief look at the variety of points of view concerning abortion, as expressed at various times in history and from various professional perspectives, can help us in formulating a contemporary position on the abortion question. Because the medical history of abortion is less complex and is basic to understanding the legal and moral history, we shall deal with medical developments first and then review legal and moral issues.

1. Medical Developments That Generated the Possibility of Safe Elective Abortion

It is important to note the several developments and their timing in medicine relating specifically to abortion. Our examination of the twists and turns of medical progress that we take for granted today and the time lags between one advance and another, enables us to understand the legal history of abortion as such and to avoid making uncritical assumptions that presuppose a long history of moral prohibitions against abortion. (See Appendix A.)

Before developments in medicine in the nineteenth century, all known methods of terminating pregnancy were a serious threat to a woman's life. No chemical or surgical means available could offer any assurance of the woman's health. Any medication or instrument that could be used to cause a miscarriage was forbidden to physicians as early as the Hippocratic Oath. As Hippocrates taught, to use either a drug or a surgical tool with intent to produce an abortion was also seriously to risk the patient's life. Never to risk life is the ethical mandate that guided physicians in ancient Greece. The physician's professional responsibility to his (or her) patient has continued to this day. The intent of the United States Supreme Court's 1973 decision is to respect the professional responsibility of physicians.

There were no significant medical discoveries related to the performance of abortions until the nineteenth century. The first was that infection could be prevented. Any surgery, abortion included, carried with it three chances in eight that the patient would die, and three quarters of these deaths were from postoperative infection. The work of Pasteur and Lister (1857–1867) made physicians aware that bacteria cause infection and that antiseptics could be used to prevent it. These ideas were accepted in this country in the mid-1880's. However, the problem related to surgical abortion remained; there was no way to treat internal infection, even in the later decades of the nineteenth century.

An equally significant development in the history of surgery was the discovery of anesthesia in the 1840's. Until that time many patients died of shock on the operating table. These two developments, the use of antiseptics to control infection and the development of anesthesia to prevent shock, changed surgery considerably! Along with two other subsequent advances, they made surgical abortion a safe medical procedure.

The first of these additional developments was the discovery of a process of suturing the uterus that allowed doctors to halt uterine hemorrhage. This was first used in 1883. This new technique is best known to us as the one that made Caesarean sections possible as elective procedures. Before this time, performing a Caesarean section meant the doctor had chosen to save the life of the baby and sacrifice the life of its mother. (The converse of this choice, craniotomy, meant taking the neonate's life in order to spare the woman. In either case, a terribly difficult choice had to be made and, yet, these were the best options available for many centuries.)

The last step was the advent of the so-called "miracle" antibiotics (penicillin, sulfa, etc.) in the midtwentieth century, which made it possible to treat an internal infection. Before this time, uterine infection was especially dangerous because it could not be treated. Thus, within the last forty years, we have witnessed the first period in history in which surgical abortion is a safe medical procedure. As a result, voluntary abortion is a realistic possibility for the first time.

2. Medical Developments That Changed Our Understanding of the Religious and Moral Issues in Family Planning

The understanding of how reproduction takes place has changed as dramatically as surgery in the last 100 years. It was not until 1875 that the German embryologist, Baer, postulated that human reproduction results from the combination of egg and sperm; his discovery was not accepted within the medical profession until after World War I. Until that time, it was believed that sperm contained complete miniature human beings (called an homunculus) and that the role of the woman's body in the reproductive process was simply to provide a fertile environment in which the human "seed" could grow. The word for "seeds" in Greek, as in the parable of the sower and the seeds or the parable of the seed growing secretly, is *ta sperma*, from which medicine has received its English language word, "sperm."

The debate over Baer's hypothesis was similar to the debate over Darwin's hypothesis. Were we humans "merely animals," reproducing by the methods of mammal-

ian reproduction? The discovery that mammalian reproduction involves the meeting of gametes (the sperm and the egg) had occurred in the nineteenth century. However, many church leaders and church members refused to believe that observations of animal biology could be applicable to human reproduction. Baer's hypothesis, not proven by observation until the late 1960's, remained in disfavor throughout his lifetime and beyond, in favor of the traditional understanding of human reproduction formulated from Aristotle, derived by observing the reproductive capacities of plants using seeds. Botanists now know and school children are now taught that even most plants reproduce by sexual methods of reproduction. However, these scientific paradigms that we take for granted today were generated within the last fifty years! For the better part of the Christian era, faithful Christians made decisions based on information that has now been shown to be inaccurate. When new information is discovered scientifically, or when a whole new paradigm for scientific understanding emerges, these scientific developments may also bring about the need for changes in our theological or ethical interpretation of human actions.

We must note as we look at any religious or legal evaluation of contraception or abortion before the 1930's that the fetus was viewed as the property of the male, which happened to be found within the uterus only for the purpose and time period of gestation. Thus, as the female was understood to have no active or positive contribution in the creation of the new human being, the "ownership" of the fetus and the right to determine what should be done to, with, or for a child were the father's and not the mother's. An example of this previous understanding of the family as property is the fact that wives and children are given their husband's or father's names. Thus, when we look at the laws in the second half of the nineteenth century against women using the (then) new developments in barrier methods of contraception and intrauterine devices, we should remember that the law was grounded on the assumption that decisions made by one person (the woman) regarded the property of another (the man).

In previous historical periods, faithful persons made ethical decisions on the basis of the science of their day. Future generations may look at our wisdom and call it folly because we lack the scientific sophistication of that later day. There is one criterion that remains regardless of the state of the medical or scientific art, and we share this criterion with the whole history of Christianity both past and future. It is important that abortion decisions be informed by the best medical knowledge and that our decisions be made in the context of our faith.

At the time when the prohibition of contraception and abortion was formulated by Catholic and Protestant church leaders, all parties engaged in the question accepted Aristotle's embryology. Thus, when they spoke of "conception," they were not making the distinction that we do today between the two gametes (egg and sperm) and the zygote (fertilized egg). The "act of conception" in those nineteenth-century documents is what we in the twentieth century call sexual intercourse. In the nineteenth century, when Christian churches proscribed any intervention in the natural process of human reproduction "after conception," they were saying that only abstinence (or what would develop later as a program of periodic abstinence) was permissible for Christians as a means of limiting the number of births.

3. Moral Judgments and Social Consensus Regarding Abortion Throughout Judeo-Christian History: Protection and Prohibition

Because historical evidence is limited and sporadic, it is difficult to discern prevailing attitudes toward abortion more than 100 or 200 years back into history. Abortion is mentioned in a restrictive or prohibitive injunction, but there are also large gaps in time for which we have no reliable records.

The case of medieval England may well be the most nearly typical historical situation we have. There was no law regarding abortion specifically, so the legal historian is forced to assume that in view of the serious danger that abortion presented to a woman's life, there was no need to threaten punishment for abortions. At the close of the medieval period, when the common law tradition was being codified, a law regarding abortion was written into that code. British common law regarded the attempt to induce abortion, whether effective or not, as a crime of the abortionist. In the event of the woman's death, the person who performed the abortion was held guilty of homicide, the murder of the patient. In the event that the patient lived, which was probably the rarer case, for medical reasons outlined above, the abortionist was guilty only of a misdemeanor. Much later, when the American republic was being formed, British common law was carried forward in colonial courts uninterrupted and was amended during the course of constitutional development. This law, which regarded abortion per se as a misdemeanor (while holding the death of the pregnant woman or girl to be murder), became United States law when our Constitution was adopted in 1789.

During the long period of British precedence and even after the American adoption of British precedent, surgeons were not physicians. At the time these laws were written, surgeons, for the most part, were barbers. They were the men who owned the finest, sharpest blades. Surgery and the practice of medicine were not unified until the nineteenth century, when advances in anesthesia and antisepsis made possible the modern scientific practice of surgery as an integral part of the medical profession. Thus, the British law and early American law, while not aimed at doctors, may well have been drafted to discourage the barber-surgeon from performing abortions.

It is more likely, however, that those who were brought to trial under an antiabortion law, the group at whom the law was aimed primarily, were the practitioners of what we now call the areas of "gynecology" and "obstetrics." Within Christian history until about two hundred years ago, it was considered immoral for a male physician to attend a female patient in labor or birth or for the purpose of an examination of her reproductive organs, except in a life-threatening emergency. The Empress Maria-Theresa of Austria, a progressive woman of the Enlightenment, was one of the first women known to have asked a male physician to attend her as an obstetrician. She also instituted a program of childbirth in the hospital in Vienna, where women would be attended by male doctors. Until this time, the persons attending women during pregnancy, labor, and childbirth were women. A woman might have been in the care of a member of her extended family, or a neighbor, or a friend who had more experience than she in giving and attending birth. Until the transition from midwifery to obstetrics with male physicians was complete, the antiabortion laws were aimed at these women who served as companions of and consultants to women in their childbearing years. The protective intent of the law was both well-intentioned and useful; it was grounded in the knowledge of the medical realities of the time and protected the pa-

tient from an unwise practitioner, and the practitioner from the demands of a desperate patient.

This long-standing European and American legal tradition prohibiting induced abortion served much the same purpose with regard to the same groups of women and men, patients and providers, be they midwives, surgeons, or physicians, for almost the whole course of the Christian era, until the midnineteenth century. Despite the many changes that have occurred since 1800, the protective intent of antiabortion law, which had been the foundation of the law in this area from the medieval era to the present, remained the sole or most basic ground for laws governing abortion in the United States until 1976. During that same period of nearly two thousand years, there have been a number of shifts in the church's perspective on the theological question of abortion. Let us turn now to the specifically religious history of this issue.

The earliest mention of an artificially induced termination of pregnancy occurs in the Old Testament. There is one mention in the law code (Exodus 21:22–25) of accidentally induced miscarriage. If a pregnant woman is injured and she miscarries, the man who struck her is obligated to pay her husband compensation for the loss of his property. If the woman herself is harmed or dies, the law of an “eye for an eye” applies. Clearly, the implication of this law was that the Hebrews considered inducing a miscarriage not to be a homicide, not even manslaughter. Rather, the law protects the property rights of the husband. It is clear in this law, which occurs in a series of laws regarding damage or loss of various kinds of property, that the induction of a miscarriage, in this case unintentional, was not considered to be the moral equivalent of homicide. The placement of this prescription of a fine for property damages together with similar offenses and penalties was not inadvertent. If this act had been considered murderous, it would be found within a series of interpretations of the Sixth Commandment.

There are two basic reasons why the authors of the Bible were not concerned about abortion as a voluntary procedure. First, abortion was obviously not a realistic medical possibility. There are three Old Testament references that provide a reliable indication that the Hebrews did not practice even the unsophisticated and dangerous methods of voluntary abortion known to their contemporaries. Jeremiah laments the intolerable character of his existence by wishing that he had died in the womb: “So my mother would have been my grave, and her womb for ever great.” (Jer. 20:17.) The third chapter of Job is a similar lament cursing the day of his birth, i.e., cursing his existence. The actual message of the lament is not pertinent here; however, one of the details is significant. One of the most common unsophisticated methods of abortion was beating the stomach of a woman late in her pregnancy until the fetus died. At this time, the woman's body will begin labor and expel the fetus. Today midwives and doctors know of this natural reaction of the woman's uterus to produce abortion, and historical references to this practice indicate that it has long been known to the gynecological “experts” in many cultures. Jeremiah is clearly unaware that labor automatically follows the fetus's death. Neither do any of his redactors nor do Job and his editors correct this misunderstanding. Thus, it is probable that the Hebrews did not practice voluntary abortion.

As the texts in Jeremiah and Job indicate, the Hebrews were unaware of induced abortion. In Ezekiel 16:3–5 the practice of “exposing” newborns as a means of control-

ling fertility is described. Ezekiel obviously disapproves of this practice; it is a Canaanite practice abhorred by the Hebrews. While the texts from Jeremiah and Job demonstrate that the writers of the Hebrew Scriptures did not have knowledge of any method of controlling birth, Ezekiel's reference to exposure informs us that the Hebrew writers were familiar with this practice. They chose, for the obvious reason of faithfulness to the Sixth Commandment, to disapprove absolutely.

A clear indication that abortions were taking place in biblical times would be either a prohibition or invective against it. Even as late as New Testament times, we find no injunction against abortion. The earliest Christian prohibition of abortion is in the "Didache," a set of guidelines for the life of a Christian community near Antioch. The admonition against abortion in this list of prohibitions was probably addressed to those who might perform abortions. Its purpose was for the protection of their would-be patients. (It would be nearly fifteen hundred years after the writing of the "Didache" before a Christian theologian would clearly advocate the extension of the fetus's life in order to make possible its baptism as his reasoning for the prohibition of abortions.)

The Hebrews and the early Christians were not concerned with methods of controlling birth because they were perennially aware of being too few in number. Had any forms of birth control been available to them, they probably would have been uninterested in limiting their natural fertility. Our contemporary situation differs radically from the situation of persons in Old or New Testament times. Underpopulation is no longer a threat to the continued existence of either our religious community and its tradition or our society as a whole. To find guidance in determining what is responsible in planning our families, we cannot go directly to biblical references on childbearing. We need to find our own theological framework for understanding voluntary decisions about abortions, not adopt theirs. We find this framework in the biblical model of freedom and responsibility, not by looking to Scripture for references about abortion per se.

There was a significant shift in thinking about sexuality from the Hebrew, then Jewish (scriptural), perspective, which viewed our sexuality as a part of our humanness and therefore as part of God's gift of creation, to a more ascetic view of sexuality, under the influence of Hellenistic (neo-Platonist) philosophers. For them sexuality and sexual activity were inherently evil, a human characteristic that resulted from our "fallen" condition in this world and, thus, a characteristic that would not be a part of our wholeness in the life to come. Within the New Testament, the Pauline epistles already reflect this view. This devaluation of sexuality by the early Christian writers can be understood in view of their position as a marginalized people who disdained involvements, interests, and engagement with this world and held to hopes for the coming of the Kingdom of God. The integration of Platonistic thinking within Christian theology began by the end of the first century A.D., when Justin Martyr set up his school of Christian philosophy in Rome. It can be said to conclude in the time of Constantine, who established Christianity as the official religion of the Roman Empire, thus ending an era of marginalization for the Christian communities and initiating acceptance within the culture and of standardization of doctrine (orthodoxy).

Augustine's writings in this area are typical of his time, neither the most deeply misogynistic, nor among the least severe in his negative evaluation of human capacity for passion. Humanity is tainted with original sin, according to Augustine, because

human life is conceived “in passion.” As a result of this reasoning, sexuality came to be regarded as sinful because it is pleasurable, but justifiable because it is necessary for procreation. This Augustinian interpretation has probably been one of the most influential ideas in the history of Christianity. The notion that sexual relationships are justifiable only for procreative purposes is profoundly influential even today in thinking about contraception and abortion.

The creation of a single standard of orthodoxy for the Western church under its leaders in Rome generated the next steps in the development of the church’s prohibition of abortion and contraception. In preparation for the great council of the whole church that Constantine gathered at Nicaea, there were several regional gatherings (also called councils or synods) of bishops, which Constantine sponsored as well. Two of those meetings addressed the moral question of women who sought or obtained abortions. At the Councils of Elvira and Ancyra, punishments of excommunication for a specific period of time were established. Note that in neither case was the punishment for homicide recommended. In addition, it is much more illuminating for our history to note that not all abortions were condemned: only those sought by unmarried women and “adulteresses,” who were “seeking to hide their fornication.” Not only does this text indicate that there has not been an absolute condemnation of abortion as a violation of the Sixth Commandment within the church’s history. The illustrations of Elvira and Ancyra inform us that while the prohibition of abortion within the medical or health care community had a protective intent, the church had its own different motivations for limiting or, later, prohibiting abortions, even as early as the third or fourth century.

During the era that followed Constantine’s establishment of a catholic church, i.e., the medieval period, the new Christian orthodoxy was clarified and refined. Again, to find a clear statement of the thinking typical of his time, we look at writings of the eminent, synthetic theologian at the close of the era. In the work of Thomas Aquinas we discover a new teaching about abortion; the question of the morality of abortion became a corollary to the question of salvation. Following Aristotle’s belief that the human soul was infused into the fetus at sometime between the fortieth and ninetieth day, Thomas wrote that abortion was permissible before 40 days for a male fetus or 80 days for a female fetus. After 40 or 80 days, the fetus had an eternal, human soul and required baptism for its salvation.

His convictions about the soul and its genesis were entirely in line with those of the scientists and physicians of his day. Throughout the Middle Ages the physical formation of the fetus was identified with its animation: When the fetal body developed a human shape, physicians assumed that this shape indicated that it was now in possession of a human soul. The Aristotelian teaching on how life begins could be briefly described as follows: Life in every form, be it vegetable, animal, or human, was made to be a living being, rather than an inanimate object, because of that which gave it a particular form, the form of a spaniel, or of a zinnia, or of a man, which formative power or principle Aristotle called its soul (*anima*). Aristotle, and biologists following him, identified three major categories of soul: “vegetable soul” (which caused plants to be); “animal soul” (which caused animals to be); and “rational soul” (which caused humans to be). His term “*Homo sapiens*” for human being states simply that we are *Homo* (“being”) *sapiens* (“knowing” or “reasoning”): the being that is able to reason. For

Aristotle and his intellectual heirs, the characteristically human faculty *par excellence* was our ability to reason: our intelligence.

In the two higher categories, the being was said to be in possession of the higher soul appropriate to its apparent form, as well as one or both of the lower kinds of soul. In other words, plant life had only a “vegetable soul”; animals had both “vegetable” and “animal souls”; and people were understood to have all three souls—“vegetable,” “animal,” and “rational souls.”

When Aquinas integrated the newly rediscovered scientific writings of Aristotle in his theological work, he chose to identify the “rational” or human soul in Aristotle with the traditional Christian concept of an eternal soul. Thus, in an Aristotelian or Thomistic framework, the fetus was understood to be alive at every stage. However, the seed (sperm) had only vegetable soul, as it had only the form of vegetable life. The early stage of fetal life in utero was formed by both vegetable and animal soul, and after a period of gestation, the fetus was said to be infused with a rational or eternal soul.

Aristotle was an empiricist. He taught that the scientist-philosopher could observe the point during pregnancy when the rational soul was infused into the fetus. The observable criterion for human life was the appearance of external genitalia. The “form” of the fetus was unmistakably human at the point in fetal development when there was an empirically verifiable feature that would indicate one of the qualities unique to humans, in this case, the ability to reproduce itself. Greek physicians had fixed the points at which the external genitalia are visible quite accurately by observing stillbirths. The belief in “delayed animation,” based on Aristotle’s theory, which Aquinas espoused, prohibited all abortions after the 40th or 80th day of gestation to insure the salvation of the fetal soul. This belief in delayed animation became the doctrine of the Roman Catholic Church at the Council of Trent (1545–63): “Whereas no human body, when the order of nature is followed, can be informed by the soul of man except after the prescribed interval of time.” This remained the Catholic belief about human ensoulment until 1869, and abortion was permissible or forbidden on the basis of this Thomistic reasoning. While a variety of motivations for opposition to abortion remain, although protection on medical grounds is no longer needed, the most fundamental doctrinal ground for religious opposition to abortion rights in the current debate is the principle of Thomas Aquinas permitting and prohibiting abortion. Of ultimate significance in a Thomistic theological framework is the baptism of the live fetus or neonate being the guarantee of the salvation of its soul. In opposing the baptism of infants and affirming it as a Sacrament of repentance, Calvin takes a different view on God’s providential care for the fetus and neonate. (Institutes, IV, Ch XVI. 20.)

Before 1869, there was only one very brief period during which abortion was prohibited absolutely without any qualification. Pope Sixtus V (1521–1590), in his Bull, *Effraenatum*, forbade abortion at any point during pregnancy and made it an offense punishable by irrevocable excommunication. Sixtus had been elected to the Papacy in a struggle between a “Libertine” party and a “Puritan” party fighting for control of the church. By this fiat, and several others, he successfully excluded a significant number of his opposition from their positions of ecclesiastical power. His purpose was to punish persons he considered sexually indulgent. The identification of sexual self-discipline with Christian piety was a legacy he had received from ancient Christian

philosophers, notably St. Augustine. Sixtus's teachings on sexual morality were rescinded four years later by his successor.

With the sole exception of this fiat, some form of delayed animation theory was the foundation for theological reasoning about the morality of abortion until the late nineteenth century. In some cases Thomas's own rule was applied, which forbade abortion for all practical purposes, as pregnancy could hardly have been definitely diagnosed before 40 days of gestation. Thus, Thomas's rule enjoyed a congruence with the medical need for protective restrictions. After the Reformation there was no single body of church law; various European nations dealt with abortion in their own ecclesiastical and secular legal codes. Movement was another empirically observable criterion for life, which St. Thomas adopted from Aristotle. This criterion was also a basis for a perspective on abortion documented in the English common law. The fetus was considered to have come alive, and therefore to be inviolable, after "quickening," the first time the woman could feel the fetus moving.

In English law, quickening was used as an observable criterion for abortion decisions. Before that time, there was no offense for terminating pregnancy under the King's ecclesiastical law. As in Thomas's model, after the point when the fetus "came alive," i.e., possessed an eternal soul, as evidenced by intrauterine movement, abortion was forbidden in order that baptism could be performed. For example, a pregnant woman prisoner who was convicted of a capital crime could be executed immediately unless the "moment of quickening" had passed. If the fetus had already "quickened," a postponement of her execution was required until after birth, because, as it was the King (or Queen) who ordered the sentence, the death of the unbaptized fetus would be "on the King's (or Queen's) head," i.e., the monarch's responsibility before God. After her child was born, the baby was baptized and its mother was executed, in both cases as swiftly as possible. This particular British law is important to us today as we look back into our own history because it clearly defines the purpose of the religious prohibition on abortions and thus discloses to us the primary theological motivation in restricting the termination of pregnancies.

The nineteenth century saw significant changes in the theological evaluation of the morality of abortion, bringing various elements of this history to the particular configuration of attitudes and theory that is often assumed to be the churches' singular interpretation of the morality of abortion throughout Christian history.

The earliest phase of these nineteenth century changes began in the 1820's and 1830's, in response to the first of the medical advances that were discussed earlier. In the 1820's, Horace Wells discovered the anesthetic property of nitrous oxide. Soon after, a variety of other chemical substances such as chloroform and ether were also identified, which made it possible for the surgeon to work while his patient was in a sleeplike state, free of pain. When anesthesia was discovered, the attitude of the general public about surgery changed rapidly and for the first time, patients began to request surgery. Medical professionals and other highly educated persons recognized, however, that although the dangers of surgery had been diminished considerably they had by no means been removed. A great deal of debate emerged as to what system of accountability would protect the patient in this new age when surgery had become painless and was perceived to be a simple matter, but when, in fact, the risks continued to be considerable. Were laws needed to require of all doctors and hospitals that

they bring their testimony regarding the “relative safety” of each surgical case before the courts and that surgery could be performed only with the court’s permission? Or, as surgeons and other doctors argued, was the best course of action to entrust the decision-making power to the members of the medical profession, who, as professionals, would be accountable to themselves and to their peers? It was from this debate that the statutory limitations on the performance of surgical abortion emerged.

The first of these laws was passed by the New York legislature. In 1828, it considered a bill limiting all surgery to cases where the surgery was necessary to preserve the life of the patient. (The “relative safety text” was a standard procedure in hospitals in New York at the time.) Two years later the legislators passed a bill that singled out abortion, as it was the only surgical procedure that was performed on the basis of extramedical pressure. The New York legislators deemed it wise to regulate the performance of abortion in order to prevent surgeons from performing a surgical procedure without the woman’s considering the risk to her life. When other state legislatures introduced regulations that singled out abortion from other surgical procedures, the protective intent that was clearly expressed in the debate preceding the passage of the New York law became the implied, if not explicitly stated, intent of the laws adopted.

In the second half of the nineteenth century, there was a series of changes in the church’s teaching about human intervention in the reproductive process. The opinion underlying the changes in religious teaching was that the natural function of sexuality was procreation. The 1869 General Assembly of the Presbyterian Church in the United States of America stated that to thwart that end was a “crime against God and against nature.” These changes in theological perspective included laws against both abortion and contraception. Catholic and Protestant moralists have differed in the twentieth century over the ethical significance of contraceptive means of controlling birth, but in the late 1860’s virtually all branches of the Christian church condemned any attempt to control birth as categorically immoral.

Changes in the theological treatment of the moral issues were probably brought about by a combination of the several factors rather than any one of them. First, medical science was developing new methods of contraception. During the nineteenth century, “pessaries” or cervical caps (the forerunner of the twentieth century diaphragm) and intrauterine devices were developed. I.U.D.’s, usually made of iron, were manufactured in the nineteenth century in Germany, and the ability of such devices to prevent pregnancy was established. Although the nineteenth century “contraceptives” were not as effective as today’s, the scientific advance generated a great deal of public interest and a wholly new set of expectations never known before in the history of the world. There are several facets of the churches’ response to these developments. First, and probably foremost, it appeared inherently immoral to both Protestant and Catholic clergy that women might have the power to decide the fate of the homunculus contained within the man’s sperm. Even as late as 1869, Aristotle’s theory that the (nascent) miniature human being was contained within each individual human seed (sperm) was accepted as scientific fact. It is easy to understand indignation at the suggestion of women being given the freedom to thwart the process of reproduction. In view of the legal strictures that had already governed the performance of surgical abortion for nearly forty years, we could probably infer that the ecclesiastical invective in 1869 against any intervention by a woman after “conception” (intercourse) was against the newly developing nonsurgical methods of controlling fertility! Before this time, an-

tiabortion injunctions or legislation were intended to stop the persons who would be performers of abortion. In 1869, for the first time, we find theological invective against women, who would be the users of the new “contraceptive” devices.

In addition, on both sides of the North Atlantic, several related visions of social change began to emerge, under the label of “the women’s movement” or “feminism.” Radical women were proposing that females should have access to higher education, should be franchised to vote and hold elective office, that females would not be harmed by physical activity in sports and would benefit from wearing clothing more conducive to the health of their internal organs, as well as some other ideas that have yet to be accepted in our culture. There was, no doubt, some fear of and probably considerable resistance to the new medical developments that could give women the power to determine their lives in unprecedented measure.

Antiabortion legislation again enjoyed a wave of popularity. As noted earlier, anti-sepsis was not common medical practice until the 1880’s. During the intervening period there was a second wave of vigorous campaigns, especially throughout the Western states to stop practitioners, both licensed and unlicensed, from performing abortions. While abortion had become a painless operation, its danger had not diminished because of the intrauterine infections introduced by nonsterile techniques. By the end of the 1870’s, practically every state in the union had an antiabortion law. In both the first and second waves of antiabortion legislation, the form of the laws indicates that they were motivated by the medical necessity of protecting the patient from the practitioner. In contrast, the religious objections to any form of contraception or abortion inveighed against the women themselves. No doubt, in this second phase of legislative activity, there were coalitions of various people interested in a common end for various reasons. However, even though the antiabortion laws were passed during the nationwide lobbying effort funded by Alfred Comstock that outlawed contraception, other “unnatural” sexual acts, and the sale of prurient literature, these laws continued to take the form of the earlier New York State law. Under these laws, most of which stood until the Supreme Court Decision in the case of *Roe v. Wade* in 1973, the abortionist, not the woman, could be tried and found guilty of the crime of abortion. These antiabortion laws were not intended to punish or inhibit sexual promiscuity, as might be suggested, because there was no exclusion for women who were married or victims of rape or incest. Most significantly, whether or not the woman was pregnant, the abortionist was guilty of abortion, if he or she introduced any chemical substance or instrument into her womb with the intent to produce an abortion. These laws were written to protect the prospective patient in a time when a popular but quite mistaken assumption was that surgical abortion was a relatively safe procedure. That the abortionist might be licensed to practice medicine was not a defense against criminal conviction for abortion; these laws were written to let doctors (and others) know that they must inform their patients how very dangerous an abortion would be.

Long after other surgery had ceased to be life-threatening, the possibility of infection of the uterus, which could not be cleaned and dressed as other surgical wounds, continued to make abortion a dangerous surgical procedure. Thus, perceptions and attitudes about surgery in general had changed, and the memory of the certain threat to life that it once posed had faded many years before we came to the midtwentieth century reconsideration of the legal status of abortion. In the nineteenth century, we find the idea that contraception and abortion could be part of medical service. There

had always been ways of trying to abort or of trying not to conceive, but in the nineteenth century the transition of medicine from a palliative act to a curative act, grounded in a scientific understanding of the human body, generated expectations in the area of family planning long before the technology was sufficiently refined or widely available. The ecclesiastical response in the nineteenth century to the possibility of safe and effective contraception or abortion was the condemnation of birth control as “murder.”

Between then and now there has been an extraordinary change in attitudes toward contraception. Although all church bodies do not affirm the use of contraceptive means of limiting fertility, most Protestant churches do, recognizing that women chose contraception, even when it was still illegal, out of a concern for their health and safety and for their children. The emergence of decriminalized contraception is a fascinating history in itself, which did not end in this country until the 1958 Supreme Court Decision *Griswold v. Connecticut*, which struck down state laws forbidding the prescription, sale, and use of contraceptives to and by married persons. A significant theological change occurred at the same time, namely, sexuality was now understood to be a gift from God in both its procreative and communicative functions. It was appropriate for couples to engage in sexual intimacy, using contraceptives, thereby separating one function from the other.

E. An Analysis of Four Questions and Concepts Assumed to Be Necessary for Understanding the Morality of Abortion

Our reflection seeks to establish a framework within which faithful Christians can understand when abortion can be considered a responsible ethical option and when it is an irresponsible choice. The following section presents four concepts often employed in discussion of the morality of abortion. All have nineteenth century roots and need to be tested in the light of twentieth century knowledge about reproduction. The purposes of these analyses are to clarify concepts that are sources of confusion among participants in the current debate and to function as a resource for dialogue and reflection. The areas for investigation are headed by the following four propositions:

1. The question of the morality of abortion is not dependent on an analysis based on a theory of a conflict of rights.
2. The question of the morality of abortion is not dependent on the question of the inviolability of autonomous human life.
3. The question of the morality of abortion is not dependent on the question of when human life begins.
4. The question of the morality of abortion is not dependent on the question of the morality of sexual activity.

1. The question of the morality of abortion is not dependent on an analysis based on a theory of a conflict of rights.

The attempt to develop a universal formula that will enable us to analyze the significance or value of the fetus over against the significance or value of the pregnant woman is logically a conundrum and a theologically unhelpful abstraction. Because

the 1973 Supreme Court Decision *Roe v. Wade* remained agnostic on this question, recognizing a plurality of views on the status of fetal life, a great deal of discussion has emerged from those who place an absolute value on the fetus over against the pregnant woman. Opponents of the Court's decision hold that in place of the explicit agnosticism of the judiciary, the Court should have been guided by an absolute conviction of the value of fetal life and therefore should have established an unqualified guarantee of its right to protection under the law. The transcript of the Court's decision exhibits a genuine sensitivity to the profound importance of theological convictions with regard to this question and, at the same time, an unwavering respect for the variety of sincerely held beliefs among United States citizens and the variety of perspectives found in the several strands of our theological and philosophical heritage. The text of their decision states:

Texas urges that, apart from the Fourteenth Amendment, life begins at conception and is present throughout pregnancy, and that, therefore, the State has a compelling interest in protecting that life from and after conception. We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.

The Court's refusal to affirm any one of these traditions or any one of the variety of present convictions grows out of its traditional posture of respect for religious liberty. In other words, the Court has invoked the constitutional right to privacy on this level: United States citizens who are members of the Jewish faith, members of a Protestant communion, baptized in the Roman Catholic or Orthodox churches, followers of Islam, members of other religious groups, and those who have chosen not to affiliate with a religion have the freedom before the law to choose their course of action according to the teachings of their own faith and according to their own conscience. In order to guarantee religious liberty, the Court chose to recognize no more (and no fewer) rights of a fetus than had been already established by earlier precedents in the law. Because the Court explicitly omitted affirming an absolute right-to-life of each fetus, individuals and groups that hold this particular conviction have objected strenuously to the decision. For our purposes, it does not suffice to say that our theological understanding of the morality of abortion differs.

There are several inadequacies in a theory that views the morality of abortion as an issue involving a conflict of rights or a conflict of interests. From a psychological perspective, the work of Carol Gilligan at Harvard demonstrates that the highly abstract quality of this theory is a typically masculine pattern of logic superimposed on a decision-making process that falls primarily to women. This theory itself and even its theological cousin, the doctrine of immediate ensoulment, do not have a long history within our Judeo-Christian tradition. The doctrine of immediate ensoulment, which holds that an eternal soul is infused in the fetus "from the moment of conception" and thus implies that from that point the fetus has need of baptism if its soul is to enjoy salvation, was established in 1869. The prior history of ensoulment and the various reflections on delayed animation served as guides to the church (or churches) by identifying a stage in the fetus's development after which its protection should be guaranteed in order that it might be baptized. The theological point was a moot one, however, in view of the life-threatening danger of abortifacient techniques or postabortion complications. Before the development of these speculative. theologies of animation, early

Christian teachings simply restated the long-standing notion of viewing the fetus, although located within the woman's body, as the property of its father.

In this century a liberalization of this absolutist teaching on animation has emerged. As late as the 1930's, Catholic clergy were counseling women carrying an ectopic pregnancy not to avail themselves of the lifesaving medical techniques available to them, on the theological grounds outlined above regarding animation and baptism. By the midtwentieth century, however, many Catholic theologians (and probably most Catholic priests) had come to affirm the morality of terminating an ectopic pregnancy (or any other life-threatening pregnancy) based on the "just war" theory of Thomas Aquinas. Thomas taught that war is never justified in itself; but when an unjust aggressor initiated an attack upon a Christian country, the Christian monarch was morally justified in responding to the aggression by engaging in the war for the purpose of his own or his country's defense. The midtwentieth century liberalization of the absolute prohibition on human intervention in the reproductive process reasoned that in a similar fashion, the woman whose life is threatened by an "unjust aggressor," i.e., the fetus, would be morally justified in choosing to terminate her pregnancy.¹ This moral reasoning fit hand-in-glove with the legal exception to the prohibition of abortion, based on a relative safety test.

Particularly within the last twenty-five years, we have witnessed the convergence of these elements in the interpretation of the moral significance of abortion. The myth has emerged that Christian moral analysis of abortion has always hinged on assessing the relative merits of the interests of two opposing parties. In the case of a pregnancy that endangers a woman's life or health, certainly the consideration of the question of abortion can take this logical form. Both the doctor and the patient must consider the tension between the two values in conflict: the intrinsic worth and potential of the fetus and the value of the woman's life. This tension could be described as a conflict of interests, but that sort of reductionist analysis does not do justice to the complexity of the concerns that enter into the decision that the woman, her physician, and her family must make. To develop a moral analysis that treats the question of every abortion primarily as a conflict of rights is to assume that the woman who chooses an abortion is unequivocally selfish, that she has no concern for the fetal life within her body, that her only concern is for herself. In an era when a relative safety test was medically necessary, moral reasoning that reduced the question of abortion to an analogy of war or interpersonal conflict could suffice. Subsequent to the development of medical skill, which makes elective abortion possible, a theory that limits our analysis of the morality of abortion to a conflict-of-rights model expresses a fundamental contempt for women, who do indeed care for children as well as themselves. In a time when elective abortion is possible, such a moral theory is no longer adequate because the constraints of its logic do not allow us to consider the possibility that there may be other, morally legitimate reasons for choosing to terminate a pregnancy.

The right-to-life theory does justice neither to the social realities that should be considered nor to the personal realities that are present in the process of moral deliberation in the actual case. Responsible women and their families who are actually considering the possibility of abortion do not experience their dilemma as a conflict of rights or interests. On the contrary, women who are in the process of weighing a concrete choice to terminate or to continue a pregnancy experience themselves as located within, perhaps even the center of, a nexus of responsibilities. Let us consider, for ex-

ample, a woman and her husband who have two children and have learned of their present pregnancy that a genetic disorder such as Down's syndrome has been diagnosed. As she (or they) reflect on the choice that the physician's report has set before them, she will undoubtedly take into consideration not only a projection of what the extraordinary needs of a Down's syndrome child might be but also the needs of the two children she already has. She may choose, based on her projection of what this particular situation calls for and of the various strengths and resources that she has to offer (taking into account the limits of her strength as well), to terminate the pregnancy. If she already has three or four children, she may be more likely to feel certain that she cannot take on the additional responsibility of bearing and rearing a Down's syndrome child. If this is her first pregnancy, she may feel more readily able to conclude that she could give the appropriate care that such a child needs. Another factor that enters into her decision would be family income level. If they are an affluent family and can afford professional child care in their home, her projection of the boundaries of the resources that she can offer her child(ren) will be quite different than that of the woman who will be able to supplement her own physical and emotional strengths with only occasional help or none at all.

A conflict-of-rights theory falls short of its goal of enabling us to understand the moral significance of the choice for or against abortion, because it cannot account for the personal, social, and economic realities of this existence. It excludes even the "spiritual" realities that we enjoy in this life, such as integrity, concern, and a sense of responsibility. These theories, propounded by both secular and religious people, which attempt to decide the moral problem of abortion by setting "fetal rights" over against "maternal rights," cannot go beyond their own symmetry. We are left with the abstract equivalency of the woman's humanity and the fetal humanity. Neither can be denied.

If the humanity of the fetus is absolutized, then the woman is reduced to a vessel in its service. In response to this theory, a counterargument arises that, in a similarly absolutist fashion, denies any significant value to fetal human life and refuses to allow that abortion is a moral question. We need to understand the problem in all of its facets in order to receive guidance.

The exposition of this particular theory often includes one or two derivative arguments: one from organogenesis and one from fetal innocence.

The argument from organogenesis, which identifies the appearance of various organs or biological systems at certain points in pregnancy, is intended to persuade us of the humanity of the fetus by an appeal to sentiment. Our identification of these fetal developments with what we know to be parts of our physical selves has a persuasive immediacy but, on consideration, we realize that it too reduces our humanity to the point where it no longer has meaning. If I see pictures of a developing fetus, identifying its heart with mine, its eyes with mine, etc., and later realize that it was of another species—perhaps the arms were not quite right, they turn out to be wings, and I suddenly recognize that it is a fetal bat, for example—the deceptive capacity of this argument from organogenesis becomes clear. While the fetus may be human, we cannot reduce the complexity of what it means to be human—a complexity that we can only express in its fullness by the language of faith, e.g., to be "made in God's image"—to the single dimension of a biological reality. Even the kicking of the fetus during the latter part of the pregnancy, which gives parents such joy as they eagerly anticipate a

birth, we now know to be caused by the fact that the nervous system, one of the later fetal developments, is not yet sufficiently formed to control the voluntary muscle system. These kicks may cause us to imagine a child at play, or one who is communicating with us, when in fact the fetus is not yet sufficiently developed to hold its arms or legs still. For prospective parents to enjoy this phenomenon is entirely appropriate. However, it is not legitimate for us to judge ourselves and one another on the basis of this kind of one-dimensional reasoning.

The argument that the fetus is morally innocent is similarly intended to persuade us that the fetus should be absolutized over against its “competitor.” Christians who reason ethically within a Thomistic tradition use the analogy of the fetus as an “aggressor” when abortion is being considered because the woman’s life is endangered by her pregnancy. Conversely, in all cases when abortion is being considered for a reason other than life-endangerment (if one is using an analogy to Aquinas’s just war theory to explain the moral significance of abortion), the fetus is not an “aggressor,” therefore, it is “innocent.” If we reason about abortion by analogy to war, fetal innocence is implicit in this theory. However, there are two additional points about the “innocence” of the fetus, which call into question the value of this concept as an answer to the theological or philosophical question as to the morality of using one of the chemical, mechanical, or surgical techniques of abortion now available to us.

(a) The phrase “innocent fetus” can be used in dialogue or debate in the popular sense of these terms, i.e., without clarifying the fact that the theological claim regarding innocence in this case is limited to its converse relationship to Thomistic moral theory. When this language is employed, without reference to the larger theological framework of which it is a part, the listener might well assume—and probably often does—that the fetus’s innocence is being contrasted with the woman’s sinfulness. We all know that pregnancy results from sexual activity. Thus, references to an “innocent fetus,” when that technical term is lifted out of the sophisticated and subtle theological argument of which it is rightfully a part, imply a moral judgment of the pregnant woman. The connotative power of this term makes it useful in a prejudicial way and gives it a theological meaning entirely different from the original meaning. This theory, which implies guilt, does not do justice, for example, in a case of rape or incest.

(b) The Christian doctrine of original sin, as formulated by Augustine, defines human sinfulness in a manner that is entirely incompatible with the connotative use of a concept of fetal innocence. Augustine’s teachings regarding original sin speak of our human condition and hold that humanity is tainted with sin, not as a result of our actions, but by virtue of our very humanness. In Augustinian language, we are subject to original sin because we are descended from Adam and Eve and conceived in passion. In other words, regardless of whether the fetus has ever committed a human act, i.e, made a conscious moral choice and acted on it, the category of innocence does not apply. In the Classical Christian understanding of innocence and sin, neither the woman nor the fetus is less or more sinful than the other. Unless we take the severely ascetic view that pregnancy is a punishment for sexual activity, or the view that sin consists only in immoral acts, then it is heretical to posit on the innocence of the fetus over against the woman in any fundamental theological sense.

In summary, a moral theory of abortion that takes as its model a conflict of rights or interests between two persons is inadequate to describe the process of moral reflec-

tion by which thoughtful persons weigh a variety of responsibilities as stewards of the world that God created. This theory does not allow us to differentiate between a responsible and an irresponsible choice. The theory precludes the possibility of a choice, except in the case of self-defense. This type of theory cannot help but exclude every other factor in the concrete situation. If there are factors other than life endangerment that warrant abortion, a conflict model does not provide an adequate frame of reference.

2. The question of the morality of abortion is not dependent on the question of the inviolability of autonomous human life.

It is sometimes assumed that the question of the morality of abortion is exhausted by reference to Exodus 21:13. (“Thou Shall Not Kill.”) The Roman Catholic Church’s response (c. 1869) to the demand for abortion, generated by the discovery of anesthesia, used the term “murder.” This recent religious history has often become a filter through which we have viewed (and unknowingly interpreted) the long history of moral, legal, and medical perspectives on abortion. Abortion, prohibited as “murder” to physicians for the sake of the women who were their patients, when filtered through this recent stratum of religious history, appears to have been a proscription against intervention in the pregnancy in order to protect fetal life. By the midtwentieth century, a general awareness of the original protective intent of the traditions of medical ethics, legal limitations, and religious proscriptions had been lost.

If we examine the whole of Exodus, Chapters 20–21, we discover that the Decalogue, which expresses the generic case of God’s intention for human relationships, is followed immediately by a series of “ordinances” that detail specific behaviors in specific contexts. Among these concrete applications of the broad rubrics of divine intention, we find the sole mention of artificially induced miscarriage in the Hebrew Scriptures. Chapter 21 relativizes the general proscription of Chapter 20, so far as pregnancy is concerned. The word “ratsack” (to murder) appears only four times in the Old Testament in addition to its use in the Decalogue. (Num. 35:27; Deut. 4:42 and 5:17; 1 Kings 21:19; and Hosea 4:2.) Old Testament word study does not solve the problem of the morality of abortion, but it does point us toward the fact that direct application of the moral rubric “murder” is a modern judgment, rather than an ancient one.

The fact that various parties in the current abortion debate cannot agree to a single language regarding “personhood” in describing this moral choice demonstrates the uniqueness of the moral question of elective abortion. When we begin to describe the moral choice set before a pregnant woman, some insist on speaking of two “persons,” while others speak of only one “person.” Unless one believes in a theology of immediate ensoulment and the use of the term “person” is a secular code word for that specific doctrine, speaking of the blastocyst, or the embryo, or even the fetus, reduces the meaning of the word “person” to a point of absurdity. On the other hand, to insist on speaking of only one “person” whose “personhood” is admissible within our conceptual understanding of the moral question of abortion denies what we know by common sense to be the case: that there is something happening within the female’s body at that time that can never take place within the male body, and that the word “person” is used interchangeably, i.e., with the same meaning, for both genders. Clearly the use of the term “person,” if it is descriptive of the male, cannot suffice to explain the entire

significance of the female who is in the process of gestation, if that description is to allow for a projective as well as a present analysis.

The word “person,” unlike the terms “body” or “soul,” has a meaning that includes both a physical aspect and a spiritual (or at least mental) aspect. If we choose a definition such as Emerson’s—“an intelligence served by organs”—it is clear that during the period of gestation, only the woman can be demonstrated beyond any doubt to possess intelligence as well as physical being. But we can conceptually place an anticipatory value on the primitive form (the fetus) of that which is yet to be realized. When we speak of the relationship of the pregnant woman and the fetus that is developing within her body, we are speaking of a unique category of human existence, a relationship that is not strictly analogous to any other. Thus, the moral question of whether and when it is appropriate to intervene in the developmental process of pregnancy is a question that may be compared to other moral questions but cannot be reduced to any one of them.

In the course of its hearings, the Task Force on Science, Medicine, and Human Values received a very special gift in the testimony of a mother whose adult daughter had been murdered a few years earlier. Ms. * testimony before the task force is included in Appendix II. It is unique in several respects. Hers is the only testimony of a woman who made a conscious moral choice to terminate a pregnancy. In this particular case, the physical limitations of her body were such that she was forced to choose between performing the physical tasks required of any mother of two young children and being able to rest in bed without moving in order to prevent a miscarriage. One feature of her statement, in particular, is a paradigm for the abortion decision as exercised by responsible Christian persons. Ms. * wrote in her statement of her two then-living children at her bedside as she was deciding whether she would terminate her pregnancy. She drew an explicit connection between her responsibilities as mother and primary active parent of the two children and her decision to end her pregnancy. In other words, it was in the interest of her two children to end her pregnancy, to get up out of bed and perform her duties to them as a parent. This sense of responsibility she understood fully and took entirely seriously. In making her decision to induce a miscarriage by performing the physical activities of parenting, she weighed her parental duties against her responsibilities for the fetal life in her uterus. This feature of her particular testimony is paradigmatic for all abortion decision-making. We cannot understand the human significance—the meaning—of a choice regarding abortion, and thus we cannot evaluate such a choice ethically, until we have perceived the integral relationship between the sense of responsibility for human children (which is fundamental to the parenting process and, thus, also to the human relationships within the Christian institution of the family) and the conviction, with regard to a particular pregnancy, that it is ethically preferable that this pregnancy should be terminated.

Two points of medical sociology are worth noting here also: Ms. * did not have adequate medical care. She should have been hospitalized for this process and aided by surgical intervention. Had this been the case her young children would not have witnessed the physical pain that she suffered, nor would she have had to lock them out of the room where she miscarried, in order to spare them from witnessing the event. Physicians and hospitals are now free to offer medical care in this kind of emergency.

* The name is omitted to protect the privacy of the individual.

This story gives the layperson a clue to the difficulties that demographers encounter in estimating the rate of induced abortion in the United States before 1973. A case such as this, in which both the woman and her physician knew that a conscious choice had been made but were prevented legally from reporting the event, illustrates the kind of fundamental problems that inhere in data recorded more than ten years ago.

Her story is unique, too, in a third, very powerful way. By an exceptionally cruel fact of her own personal history, she was able to compare for us the experience of her child being murdered and the experience of an induced abortion. In so doing, she offered a theological tool that enables us to distinguish between abortion and murder, not by saying that one happens during pregnancy and the other later on—but by examining both motive and purpose as well as act, and judging the morality of the choice on the basis of all three. Murder is, by her testimony, an act of hostility, of aggression, an attack. The murderer seeks to dominate and chooses to murder in order to gain the sense of having absolute power over the other person. The responsibly chosen abortion bears no similarity of motive or purpose to the act of murder. Elective abortion, when responsibly used, is intervention in the process of pregnancy precisely because one takes seriously the needs of a human child.

We are speaking of two separate and distinct moral categories when we speak of murder and of elective abortion. Murder can never be a responsible moral choice. The case of intentionally choosing to take the life of another human being for morally acceptable reasons, such as in war or for self-defense, is a justifiable homicide, a “lesser” homicide than the act of murder. Elective abortion can be a responsible choice or it can be chosen irresponsibly. The fundamental difference between the moral categories of abortion and murder is expressed in the theological distinction between dominion and domination. Our dominion over nature means that we are responsible before God not only for ourselves as individual persons but for the whole of nature insofar as we are empowered to direct its design.

Our church’s affirmation of elective abortion as a responsible ethical choice may engender a fear that respect for the inviolability of all human life will be lost. This fear is probably the reason why our moral thinking about abortion can jump so swiftly to the moral category of “murder” without taking into account actual experience, i.e., examining motive and purpose in relation to act. When we say that our church affirms elective abortion by virtue of the humanness of the fetus and its physical dependence on the body of the pregnant woman, we are speaking about a different moral category of acts than does the Sixth Commandment.

3. *The question of the morality of abortion is not a question of when human life begins.*

The morality of abortion cannot be based on the question of when human life begins. The modern scientific answer to the question of when life begins is that human life and its reproduction are a continuum. In fact, there are forms of human life in the human ova and sperm, in the human zygote (which the joining of the two gametes creates), in the human fetus which develops in the womb, in the human infant.

It is ultimately senseless to ask when in this continuum from one generation to the next a recognizably human form of life can be found. Human life is never absent. Thus the question “When does life begin?” with regard to a particular pregnancy cannot be

answered. A more appropriate question might be, “At what point in the reproductive process should intervention be prohibited?” At ovulation, intercourse, fertilization, diagnosis of pregnancy, quickening, or during the first or second trimesters? At what point is abortion no longer a morally defensible option?

Reasoning that seeks to establish a point at which human life “begins,” logically excludes the value of the woman’s life except as the instrument for creation of new human life. This kind of thinking excludes the consideration of any other concerns, such as the family environment or the prospects for the life of a child. To take the question “when?” as a starting point, thus, is to preclude responsible decision-making in particular cases. The question of abortion warrants a theological framework that informs decision and actions. In short, the question of the morality of abortion is not simply a question of when human life begins; rather it is primarily a question of whether in this particular case one is prepared to give birth to and care for a child.

To reject the notion that the starting point of a decision for abortion is the question of the beginning of human life is not to diminish the importance of the developmental character of human reproduction. If the theological and ethical analysis of abortion is based on the question of when human life “begins,” it is logical to conclude either (1) that there is no point in the continuum in which there is a moral right to intervene or (2) that there is an early period in the development of a human pregnancy that is of less or no moral significance. A moral theory of gradualism, suggested by the physically developmental character of pregnancy, leads to the questionable moral conclusion that abortion in the early weeks of pregnancy is a less significant moral question than abortion that is performed later in the gestational process. We assert that there is no point in the development of new human life before which the moral issues are insignificant.**

In the course of midtwentieth century research—in which new plastic intrauterine devices and prescriptions to be taken orally or intramuscularly have been developed—a great deal is being learned about fertility and pregnancy. On the one hand, in the effort to develop a “Pill” that would generate fewer deleterious, even fatal, side effects, the principle of the synergism of combining two hormones was discovered. The second generation of “low-dosage” pills are far less dangerous than their predecessors. Researchers studying the how and why of this synergistic effect discovered that these newer pills do not prevent ovulation in as many as 50 percent of the cases. However, their effectiveness is as good or better than the first generation of oral contraceptives.²

By examining the phenomena related to this particular contraceptive (or abortifacient?) technique, embryologists have learned that without any human contraceptive or abortifacient intervention, the vast majority of all fertilized eggs do not reach full term, i.e., result in a live birth.

In addition, contemporary embryological research discloses that intrauterine devices significantly reduce the number of diagnosed pregnancies but do not prevent sperm and egg from meeting. Thus there is fertility control that is contraceptive and

** Please refer to Chapter 3, “The Covenant of Life and the Caring Community” (the preceding paper) for a discussion of the relationship between DNA and human life.

that is abortifacient. The scientific concept of the “moment of conception,” the fertilization of egg by sperm, when used to discern the inherent morality (or immorality) of the various methods does not provide clear guidance. One is left either with the unquestioned morality of the traditional “barrier” devices and therefore the use of those alone or with the conviction that as the reproductive process is a continuum, so too the variety of means of intervening in that process lies along a spectrum.

4. *The question of the morality of abortion is not dependent on the question of the morality of sexual activity.*

This statement may seem at first to be the most surprising of the four propositions in this section. Indeed it is difficult to trust the judgment of a woman (or man) who has engaged in sexual activity of which we, as individual Christians or as a church, do not approve, when she (or they) are considering abortion. Thus, it is often easy to confuse our attitudes about sexual activity outside marriage with our judgments concerning the morality of abortion. Let us juxtapose two different thoughts at this point.

First, it is helpful to keep in mind the fact that over 20 percent of the persons who choose to terminate their pregnancies are married couples,³ who do so for virtually the same reasons that motivate unmarried pregnant women. Abortion can be considered a responsible choice within a Christian ethical framework, when the resources are not available to care for a child appropriately. In other words, the morality of abortion is not defined by judgments on the morality of the relationship that brought about the pregnancy. Decisions concerning abortion involve projective consideration: Can I (or we or others) care adequately for a child? When the church speaks prescriptively, as a moral authority about sexuality in relation to marriage, it speaks of the ideal case. There still exist a great number of persons whose experience falls outside the church’s model for marriage and family. What we have said regarding the ideal case, the model understanding of sexual morality, would indicate that sexual partners should be prepared on a variety of levels—emotional, economic, legal, etc.—for the birth of a child before the onset of sexual activity.

Nonetheless, we do consider it appropriate for young couples to marry, even though they are “not ready to have children,” with the understanding that they will “be responsible,” i.e., they will use birth control. This sexual activity is entirely within the bounds of marital intimacy which our church affirms. If their contraceptive technique fails, do we understand it to be morally appropriate for this couple to consider and perhaps choose to terminate their pregnancy? Do we consider it appropriate for a family that has experienced, through contraceptive failure, eight pregnancies in nine years (or six in six? or three in three?) to consider abortion in the case of an additional, unintended pregnancy? The young, unmarried woman in her teenage years, considering the problem set before her by a pregnancy, considers the same questions as she weighs her responsibilities: Can I provide the necessities of food, clothing, shelter adequate for a human child? Am I emotionally mature enough to be an adequate parent (or single parent)? Can I provide a social context (in my family, marriage, or community) in which a child can be raised with the loving care that will ground him or her emotionally for the adult years? A menopausal woman, who discovers to her surprise that she is pregnant, has similar questions: Do I (still) have the physical and emotional resources to begin a 20–25 year commitment to raise a child? Is it responsible for me to bear a child, when I have doubts that my strength or health may not outlast the pe-

riod of a new child's dependence on me? The several situations above seem very different to us at first glance, but on closer, or more thorough, inspection, the reasons for considering, and perhaps choosing, abortion are virtually the same.

As we consider the morality of abortion, it is helpful to draw a distinction between sexual ethics, our understanding of the morality of sexual activity, and an area we might call family ethics, the moral responsibilities involved as we make decisions about the contours and chronologies of our families. There has been a significant shift in our understanding of the relationship between marriage and family since the advent of modern expectations regarding contraceptive techniques. We understand sexual intimacy and procreation to be distinct in a manner that was not possible before the birth control movement in this century. Concomitantly, Christians have come to affirm God's gift of sexuality for its intrinsic worth as a profound form of human communication, a special case among the variety of experiences of human intimacy. At the same time, the church has emphasized the importance of confining sexual intimacy to a context in which there is a clear, mutual commitment to the relationship.

Another way to view the proposal that abortion be understood as a question of "family ethics" but not a corollary of sexual morality is to look at attitudes toward abortion in situations when pregnancy has resulted from rape or incest. In cases where the woman or girl has become pregnant as a victim of sexual violence, most persons agree that she should have the option of abortion. There tends to be a great deal more sympathy or sensitivity toward these women because they did not choose to engage in the sexual relationship or, rather, they were powerless to resist sexual assault. While it is desirable that the greatest number of people be sensitive to the trauma that these women have suffered and that their legal right to choose abortion be maintained, we cannot speak of their having a categorical moral right to abort based solely on the fact that they were victims of assault. When considering the morality of abortion, we should not separate women into two categories according to our view of their sexual morality. A married woman does not "earn" the moral right to abortion by virtue of a universal consensus that she is sexually moral; neither does the woman or girl who is a victim of incest or rape have the right to choose abortion by virtue of her sexual moral status. For the victim of sexual violence, the questions are the same. The intensity of the question whether one is able emotionally to care for a child as a result of this particular pregnancy will be exceptionally poignant.

The morality of abortion is a separate question from the morality of sexual activity, but an additional question is unavoidable. As a church and particularly as clergy counseling on abortion, how are we to respond to the woman or girl who fits the stereotype? Who has become pregnant in a sexual relationship of which we (or I) do not approve?

Our theological understanding of the work of the Holy Spirit mediating the grace of God is pertinent here. It has been the teaching of the Christian churches, since Augustine, that God gives us freedom of the will and that we are also guided by the Holy Spirit in the exercise of that free will. When faced with significant moral choices, men and women who prayerfully consider the options set before them can be assured that they are empowered by the gracious work of God's Spirit to make an appropriate moral choice. Our assertion that abortion need not be an absolute prohibition is grounded in the conviction that God's gifts to us include both the power and the free-

dom to make moral choices concerning even the most serious questions. Our capacity for moral agency is not limited by our own human frailties nor finitude. Thus, it is less than faithful for us to presume that someone—female or male—whose moral choices in the area of sexual activity we cannot affirm, is unable to make a good choice regarding the subsequent moral questions raised by a problem pregnancy. The power of God’s Spirit is equally available to all who face this decision.

F. *The Church’s Ministry*

The Christian community, whether the horizons of that community are perceived as the boundaries of the local parish, a denomination, or the church universal, is a covenant community. Not only are individual Christians in a covenant relationship with God, but God is also in relationship with humanity through the communal structures of the church. In an ideal situation, the church is a loving community in which Christians share their concerns about all matters of significance. The New Testament itself celebrates these values as they were expressed in the new church after Christ’s resurrection. (Acts 2:42–47.)

Ideally, the support, wisdom, compassion, and respect with which Christians honor one another in other matters would also be available to persons who face decisions about abortion. However, given the heritage of the church’s concern for protecting the soul of the unborn infant and its historical theological denigration of the value of sexuality apart from reproductive purposes, it is not surprising that the church is often unable to be a supportive community. It is a tragic sign of the church’s sinfulness that our propensity to judge rather than console too often means that persons in need are given the additional burden of isolation. It would be far better if the person concerned could experience the strength that comes from shared sensitivity and caring.

At the same time, it is important to observe that at some point in the decision-making process, the pregnant woman who chooses abortion suddenly reaches a stage without ambivalence: “I can’t do anything else. This must be.” She may reach this point before or after the formal counseling process has begun. The ambivalence that the individual (or family) experiences arise from her awareness of responsibilities that she will have to assume. She may have struggled and come to a decision that differs from the conviction of her husband. She may even have recognized that this decision will have profound implications for the future of her marriage. Even in these difficult, ambiguous circumstances, the lack of ambivalence comes when she gives weight to each of the pertinent factors, at which time the courage to act appears. We can trust that such a sense of conviction arising in a context of carefully weighed concerns represents sound judgment; our theological task is to elucidate how this judgment can be made.

The abortion decision need not be a tragedy or an agony. Choosing abortion may make us sad, but it need not generate feelings of regret, guilt, or shame. Clergy who counsel with women who are considering abortion have learned that they are not angry or filled with hate, as an aggressor would be; the most elemental feelings are anxiety and fear. They may, in some cases, seem close to panic or terror. “I don’t know what I can do.” It is precisely because of the humanity of the life developing *in utero*

that a projective analysis is needed, and that a decision cannot be avoided. Their sense of human responsibility as stewards of human life calls them to contemplate the possibilities, however few they may be.

Members of the clergy who have witnessed the seriousness, the care, and the concern that women have evidenced in making this decision should begin to speak on behalf of others who must remain silent. Clergy who have the privilege of access to these most private thoughts and most intimate reflections are in a unique position; they can speak aloud the general case without disclosing any confidences. Opportunities for preaching and teaching should be fully used. Of all professional groups, clergy who have been involved for a number of years in abortion counseling have the greatest opportunity to set fact in place of fear. Thus, clergy can witness clearly to the courage in women of all ages making choices regarding pregnancy. When outside the sanctuary of her doctor's or her pastor's office, this woman may hear the voice of moral disapproval. The voice of moral affirmation should also be heard.

It is particularly difficult for parents who have conceived intentionally to learn that examination of the fetus's chromosomes indicates the certainty or probability of a serious genetic disorder. The method of abortion that is available to these couples is experientially similar to childbirth. Often, by the time the diagnosis can be made, the fetus has begun to move in the uterus and the enlargement of the woman's uterus is such that her pregnancy cannot be kept confidential. Thus, this case is a most difficult, even a tragic, situation. As the church, we are called to be compassionate and understanding, to make clear our support of these families. We should be discussing this subject in adult forums, informing ourselves about this "treatment" for genetic disease, so that members of a church know that they can trust others in their Christian community to understand the ethical legitimacy of this relatively new area of medical practice. This subject should be addressed from the pulpit, letting the whole community know that as Presbyterians, we can choose to interpret this decision as a part of our covenant responsibility before God.

Ultimately, it is the responsibility of the pregnant woman and her husband (or partner) to make the choices. In the first instance, they have the choice of whether to do the amniocentesis. After having been informed of the factors of the risk of disease on one hand and risk to the fetus on the other, the couple may choose not to have the test. They may also opt against amniocentesis because they would not choose to terminate the pregnancy in any case. If this is their choice, it should be respected by the church, i.e., both clergy and other church members. If a serious genetic disorder is diagnosed, there remains a second decision to be made: whether to terminate the pregnancy. Some couples may choose amniocentesis, knowing that they would not consider abortion, for the purpose of learning that they can continue the pregnancy with the assurance that none of the problems that could be diagnosed during pregnancy are present. Our church affirms the right of conscience of prospective parents at both points in the decision-making process. The decision to continue or to terminate a pregnancy is ours by virtue of God's gift of responsibility. These decisions must be made by the person or persons who would be most intimately involved in the bearing and rearing of an afflicted child.

Thus, there is no obligatory or even recommended category for considering abortion. Abortion in the case of genetic disorder is not legitimated because we can set a

minimum standard for “humanness,” a criterion of human normalcy.¹ It is legitimated for the same reason that any abortion is morally legitimate, because the person (or persons) who would be most intimately involved in bearing and rearing a child have discerned that they do not have the resources to care for the special needs of a human child in this particular situation.

G. The Special Problem of Teenage Pregnancy

The increasing number of teenage pregnancies each year is sobering.¹ While the number of pregnancies among teenagers is increasing, the number of teenagers who choose abortion is not increasing as rapidly.² Nor is the number of teenagers who choose to put their babies up for adoption.³ In other words, there is an increasingly large number of teenagers who are choosing single parenthood. There are approximately 1.2 million out-of-wedlock teenage pregnancies each year: 38 percent choose abortion; 13 percent miscarry; the rest carry the pregnancy to term. Only 4 percent give their babies up for adoption or for care by friends or relatives.⁴ Public health officials describe these increases as an “epidemic.” It is time for the church to clarify its understanding of when and by whom contraception should be employed. The dialogue about this issue is a painful one: one we may wish to avoid. However we have a responsibility to engage in such reflection. Whether or not we approve of a teenager’s sexual activity, we can agree that contraception is always preferable to abortion as a means of controlling birth. We may judge the pregnant teenager as unwise or less than virtuous, but we cannot allow our moral analysis to stop there. This “epidemic” is a disastrous phenomenon. Many young women in this generation will become parents without finishing high school. It is difficult enough for an educated single parent to provide for her family but much more difficult for a young woman without education, skills, or a job. The church, as an institution that values the quality of family life, should call for rational social policy that includes sex education and gynecological care for the teenagers and day care, especially infant care, for the children of teen-age mothers.

Until recently there were only two options that the churches recommended to pregnant teenagers: marriage or offering the child for adoption (usually following a secret confinement). A third option used by teenagers, far less frequent, was suicide. Today the range of options has been broadened by (1) the decriminalization of abortion and (2) changes in attitude and policy in the schools and public funding. However, no outcome of the teenager’s pregnancy is entirely satisfactory. The church teaches that ideally a child should be born in wedlock. However, the prognosis for marriages that occur when the bride or the groom are under 20 is very poor. Do we honor the estate of matrimony or diminish it by commending it to people for whom the projected divorce rate is above 50 percent? Nevertheless, marriage may be a wise choice for some couples.

Given this, we respect the right of a teenage female to decide about her pregnancy as she feels is right. If a pregnant teenager concludes she can neither undergo abortion nor offer her baby for adoption, it is our moral and social responsibility to provide the variety of resources, social, personal, and economic, which her new family requires. Programs such as parenting education, food and nutrition supplements, provision for special health care needs, and the general provision for basic economic needs

are the responsibility of the whole society for each of its members. For young women who choose single parenthood as their option and for their children, the humane society provides that which is needed for a life with dignity.

As we noted, there has been a significant shift within the last twenty years toward single parenting, a shift away from offering the child for adoption. The data regarding this development raises several moral questions, because formerly it was assumed that adoption was the single satisfactory option for the unmarried, pregnant teenager. While the decriminalization of abortion has made that option less dangerous and frightening, a large number of pregnant teenagers still give birth.⁵ The fact that today only a handful choose adoption indicates that in the previous era teenagers probably accepted secret pregnancy followed by adoption because of economic and social pressures.

Now, moral questions about the self-evident desirability of adoption as a choice for the teenager are beginning to emerge. Before we can affirm adoption without qualification, we need to examine questions relating to adoption. What are the risks to the health of the mother and child caused by poor or substandard prenatal nutrition and care when carrying to term? What are the psychological consequences of adoption as compared to early abortion and birth? Do we have the right as a state through our laws, as a religious institution in our teachings, or as individuals to coerce another in decisions on bearing children, rearing them, or giving them up for adoption? This is disrespectful of the other's personhood. Much more thorough attention must be given to the options teenagers face so the church can make wise and loving recommendations. The question of adoption should be researched and reflected upon as thoroughly and carefully as is the question of elective abortion.

Neither surgical abortion, nor marriage, nor a generation of yet-to-be-educated and therefore marginalized (single) parents, nor adoption may be an entirely humane solution to teenage pregnancy. However, the church must speak to the change in family structure that teenage pregnancy is generating. Mary Calderone has said that using fear of pregnancy to diminish sexual activity among teenagers is "a cruel and unusual punishment." In the face of the very real possibility of pregnancy resulting from sexual intercourse during the fertile teenage years, our church teaches that it is best to postpone intercourse until the partners marry. However, in the event that a teenage couple engage in sex despite the traditional teachings of the church, they have unequivocal moral responsibility to use effective contraception because new human life should not be created casually.

New information should allay our fears that information will generate activity or that sharing information communicates permission. Social scientists studying sex education programs discover that presentation of realistic data about contraception, in light of its relative ineffectiveness, serves both to delay the onset of sexual activity and to reduce its frequency. Churches should be scrupulously honest with young people about these realities. In addition to setting forth theological and moral reasons for postponing sexual activity until marriage, we must teach about contraception, its possibilities as well as its failings. This would postpone or diminish sexual activity before young people are prepared to start a family, inform them that no method of preventing pregnancy used alone is foolproof. We do not wish to encourage teenagers to engage in sexual activity, but we fail in our ministry with and to them if we do not offer some-

thing better than the illusions and misinformation that are still common in our time. We should not fear that speaking about contraceptive information will encourage its use when already we witness the results of not speaking. Our ministry to and with the younger generation requires us to review our responsibilities as a church and address their needs in the best possible way.

(For pastors and church members who would like to study this question further, *Teenage Pregnancy: The Problem That Hasn't Gone Away*, published by the Alan Guttmacher Institute, is recommended.)

H. Public Policy in Relation to Our Theological Perspective

A Christian understanding of abortion should enable a woman to integrate the decision that she makes concerning abortion with her overall image of herself as a responsible person. In the area of public policy the church's stand should reflect respect for other religious traditions and allow full exercise of religious liberty. For example, Jewish teaching does not protect the life of the child until both the head and shoulders have emerged from the vaginal canal. Catholic teaching prohibits almost all abortions. The Presbyterian Church exists within a very pluralistic environment. Its own members hold a variety of views. Public policy that demonstrates respect for a variety of viewpoints protects religious liberty and freedom of conscience.

The legislation, introduced during the 1950's and 1960's, allowed for abortion only after counsel with, and the agreement of, various professionals—a gynecologist, a psychiatrist, a jurist, etc. The woman was encouraged, sometimes even forced, to demonstrate her desperation. On the other hand, the professional was concerned about whether she should be permitted an abortion. In the context of prohibition or modified prohibition, decision-making about abortion falls into a "desperation-permission" syndrome.

In these circumstances, a woman may obtain an abortion performed by a licensed physician by proving to physicians, attorneys, psychiatrists, or several professionals that her situation is sufficiently desperate to warrant an abortion. At the same time, the woman seeking abortion may not sense that she has thought through the values involved in this case and come to an ethical decision herself. Nor do the professionals think they have made the ethical decision in this case. No one has the freedom to make such a choice, and this is the loss. No one has responsibility for the decision. Thus, the "desperation-permission" syndrome under laws that fall short of clearcut decriminalization is a system that tends to suppress conscience.

Elective abortion removes the "desperation-permission" syndrome and puts abortion squarely in the realm of decision-making. Women should not be coerced into bearing an excessive burden of shame or guilt about an abortion. A woman whose decision is respected will often spontaneously feel a sense of sadness for that which could not be. Her feelings of sadness are her affirmation of human life, childbearing, and childrearing.

We affirm Christian freedom and responsibility (Christian conscience) in the process of deciding whether to abort and we have a responsibility to work to maintain a public policy of elective abortion, regulated by the health code, not the criminal code.

Our own Presbyterian tradition, which is also part of our nation's heritage, holds that "God alone is Lord of the conscience." We seek national policy that embodies that conviction, carefully guarding the separation of church and state with respect for the freedom of the individual's conscience.

This study does not hold that the moral significance of abortion is established by saying abortion is a "woman's right." However, for the genuine exercise of conscience to take place, women must have the right to make the decision. The freedom to exercise her conscience in this matter is precisely the freedom of which this familiar slogan speaks. The legal right to have an abortion is a necessary prerequisite to the exercise of conscience in abortion decisions, and the practical option to choose an abortion is also necessary. Access to and funds for abortion are essential for decision-making. The efforts reflected in the Hyde Amendment and other funding restrictions are an unacceptable attempt to limit moral choice. This right precedes any right that states may claim for themselves to establish funding methods based on protecting the fetus. Legally speaking, abortion should be a woman's right because, theologically speaking, making a decision about abortion is her responsibility.

There are two levels of freedom and responsibility involved in the dialogue concerning abortion: (1) The freedom and responsibility of a woman before the law and (2) Her freedom and responsibility before God. First, as citizens, we have a responsibility to guarantee every woman the freedom of reproductive choice: Even though many of us will never be faced with a problem pregnancy, the abortion question touches every citizen at this level. Although some might refrain from any use of contraceptives or abortifacients for reasons of conscience, they are morally obligated to respect the freedom of other persons to act on their own religious convictions.

It may be difficult for us to understand one another's passionately held beliefs regarding the morality of contraceptives and abortion. Our commitment is to the right of the person to make his or her own decisions in this very personal area. This commitment implies another: that of tolerance of diversity in convictions. Statutory law often reflects one viewpoint attempting to constrain others. Such legislation may even reflect a dangerous and far-reaching attack on the role of an independent judiciary in our system of government.

Many individuals who state that they would not choose elective abortion nonetheless believe that other citizens should have the right to do so. This posture is a result of having differentiated the two senses in which we speak about "freedom" in this debate, legal and theological. These persons are saying that they would not choose to exercise the theological freedom set before us, but they do recognize and respect the importance of establishing the legal freedom of others to do so.

The Supreme Court's decision to decriminalize abortion moved the regulation of abortion from the criminal code to the health code in each state. The decriminalization of abortion has made safe abortion services available. Decriminalization of abortion forces no one to terminate a pregnancy against the dictates of her conscience. We should preserve this legal climate in which the exercise of conscience is respected and in no way abridged.

The Supreme Court's 1973 decisions in the cases of *Roe v. Wade* and *Doe v. Bolton* recognize a pluralistic religious view. The Court's decision to decriminalize abortion does not coerce anyone to violate a religious principle. Continuing the tradition in American abortion law of the protection of the woman patient, the Court repealed the prohibition against abortion for only the first and second trimesters of pregnancy when abortion is statistically safer than childbirth, allowing the states to limit abortions in the third trimester when abortion presents a greater risk than the natural process of labor.

The passage of the proposed Human Life Amendment or similar statute would reverse the intent of American law regarding abortion: protecting the pregnant woman.

Before the liberalization of antiabortion laws in the midnineteenth century, the physician had to establish the medical necessity of an abortion to preserve the patient's life. As it is difficult to predict early the dangers in the latter stages of pregnancy, the medical community in general has welcomed the decriminalization of abortion because it permits them to speak candidly of the range of potential dangers without fear of criminal prosecution. As a result, physicians may counsel the patient early in pregnancy about a potential danger. Then, if the patient chooses abortion, it can be performed during the first trimester when the surgery is significantly less dangerous than later in pregnancy or at birth. Since 1973, maternal morbidity and mortality have dropped throughout the United States, as evidenced by the fact that there were 359 deaths annually during 1958–62, 160 during 1968–69, and 19 during 1974–78.¹ Average maternal mortality in the United States per year since the *Roe v. Wade* decision is eight deaths; before 1973 the national average was in the hundreds annually. (However, for women whose health care is provided by federal funds and who are required by law to demonstrate the necessity of abortion for medical indications in order to receive medicaid funds, the mortality and morbidity rates remain significantly above average. Their situations *de facto* are the same as for the general population before 1973.) Our church affirms the increased safety that the present policy of elective abortion provides for women of child-bearing age in the United States.

The present public policy, as established by *Roe v. Wade*, serves to protect the legal rights of women. The right to privacy, under which the Court established the religious freedom of health professionals as well as patients to perform (or refrain from performing) abortions, is the right of individual choice in matters of faith and morals. However, it is not accurate to characterize the right to choose abortion, as exercised presently in the United States, as an entirely private choice. The structure of accountability that is built into the Court's decision and that functions currently is that the decision to terminate a pregnancy must be made by the patient in consultation with her physician. The patient alone cannot, under current law, demand an abortion. There is no guarantee that she will receive an abortion based only on her judgment and without a physician concurring. The Court's decision is based on its respect for the medical profession. The accountability of physicians has been deemed sufficient to insure their appropriate behavior in this area and in any other area of practice. For example, no statutes exist that outlaw the performance of abortion for purposes of gender selection. However, the law does establish the right of a physician (or a nurse?) to refuse to perform abortions for such a reason, which is in fact the common posture of medical professionals today.

Abortion is distinct from the decision to have an abortion. Abortion is a medical intervention that is no different in principle from any other surgical or obstetrical intervention. It should be as available, similarly funded and its quality controlled, as other interventions. Not every physician is professionally allowed to do every procedure, nor is every physician morally obligated to perform every procedure. Even within certain seemingly identical groups of physicians, opinions differ. For instance, there is a great deal of controversy about coronary bypass and, therefore, in a given case, certain cardiac surgeons will not perform them but others will. These differences should be medical, not political, questions in cardiac surgery and in abortion. Medicine itself should never be used as a political tool to deny medical help to the most people possible.

The current public policy, which allows the doctor to intervene in order to preserve the health of the woman, reestablishes the traditional principle of protection of the patient for the later portion of pregnancy. And, as before, the principle that protects the patient is also protection for the physician. In the United States today, there is no elective abortion in the third trimester. However, if a medical emergency arises and medical intervention—either the induction of labor or Caesarean section—is needed, the physician has the legal right to act. If a woman develops a significant health risk related to pregnancy, such as toxemia or gestational diabetes, her physician has the legal right to deliver her baby prematurely. In such cases, every effort is made to save both patients, mother and child. But, if the doctor or doctors are unable to save the baby as well as its mother, the Supreme Court decision protects the physician from either civil or criminal prosecution. Current medical practice in the third trimester and its status before the law remains virtually the same as in the period before 1973. The change in language from life endangerment to preservation of health means that the physician is not required in every instance of third trimester intervention to go to court and receive specific permission in advance. However, under the provision for preservation of the woman's health, a physician may be required by a court, after the fact, to document the need for the intervention provided by this feature of the 1973 decision. The obstetrician's hands would be tied by legal liabilities at precisely the moments when swift intervention with modern techniques can mean the possibility of not only preserving the mother's life but delivering a healthy baby.

There is one exception in medical practice to the moral principle that elective abortion is permissible before viability, i.e., in the first and second trimester but not after that point. After viability the fetus has a moral right to inviolability, as does any other physically autonomous human being. In extremely rare cases, a genetic disorder may be diagnosed late in pregnancy, which would make physical life impossible outside the womb, such as anencephaly, the lack of development of a brain or brain stem. In this event, our laws and our moral teachings would be cruel and inhuman if they were to force a woman who is carrying a fetus so diseased to continue her pregnancy to its natural completion. In the event of such a diagnosis, it is humane to change the schedule of birthing, i.e., to induce delivery at the patient's discretion, to conclude this pregnancy. Access to medical intervention when the fetus is diagnosed as unable to exist autonomously *ex utero* is a form of compassion through which God, together with pastor, family, and friends, can begin to free the couple from the pain of these memories and give them hope they can have a healthy baby. It is humane for physicians to offer to induce delivery in these rare cases. Thus, the law should safeguard this option.

Appendix I is presented in three sections.

Table I documents early developments up to the nineteenth century.

Table II documents nineteenth and twentieth century developments up to 1968.

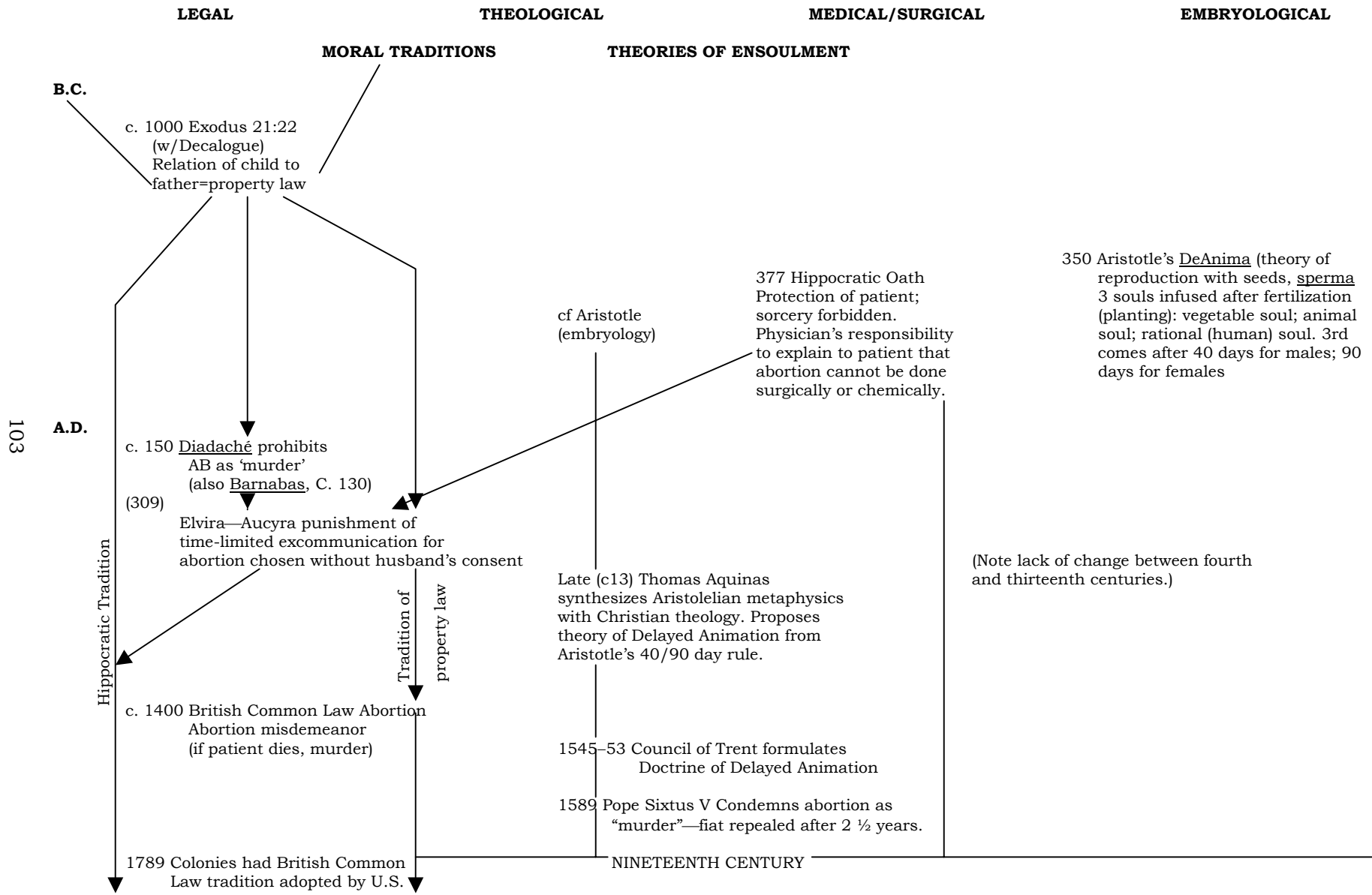
Table III documents developments since 1968.

In providing these tables, it is hoped that the reader will find it easier to correlate changing legal, theological, medical, and embryological understandings.

Appendix I

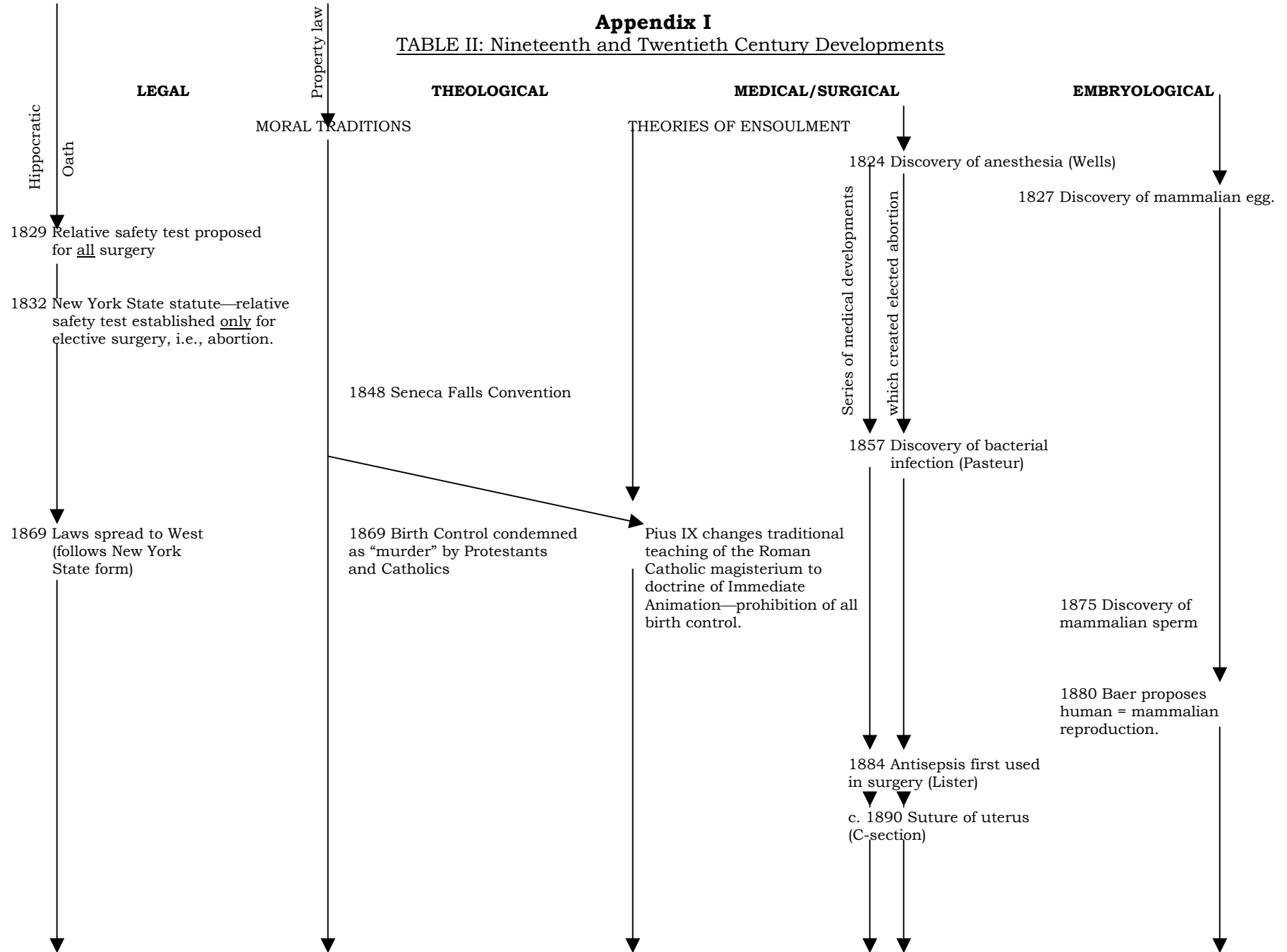
CHRONOLOGY OF DEVELOPMENT OF UNDERSTANDING AND PRACTICE REGARDING ABORTION

TABLE I: Early Developments



Appendix I

TABLE II: Nineteenth and Twentieth Century Developments



Hippocratic

LEGAL

1958 *Griswold v. CT.*
Decriminalization of contraception.

1960's A.L.I. "reform" legislation begins
state by state.

1967 C.C.S. formed by
Howard Moody (ABC)

Appendix I
TABLE II: Nineteenth and Twentieth Century Developments (Continued)

THEOLOGICAL

No change (Protestant or Catholic) ... this line ends.

1965 Vatican II commissions
study of contraception.

MEDICAL/SURGICAL

1945 penicillin/sulfa drugs discovered
Era of elective abortion begins.

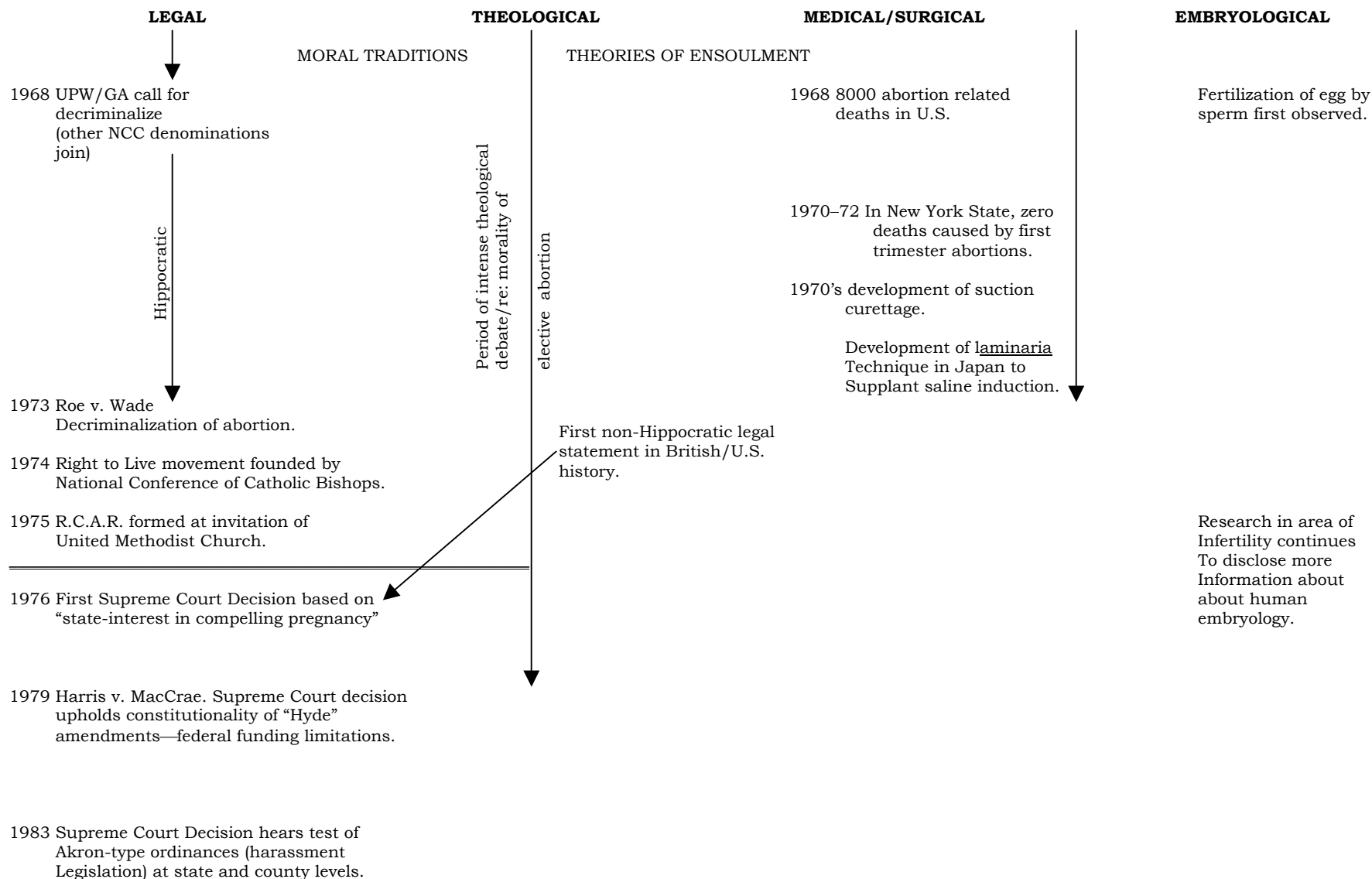
1950's Development of oral "contraceptives"

1965 Amniocentesis technique developed. U.S. rabbinate
become first genetic counselors (Tav Sachs).

EMBRYOLOGICAL

1930's With conclusion of
Darwinian controversy,
Acceptance of Baer's
Hypothesis.

Appendix I
TABLE III: 1968—Present



Appendix II

I come to you today as a woman called to gospel ministry in midlife, who feels that the “matter of abortion” is a highly personal matter since the woman must come to terms with the decision and the consequences of that decision. I am the mother of three children, two living and one dead; I am married to a Presbyterian minister. The rest will develop in the following narrative.

Several years ago, as a nurse working in an outpatient clinic, I was asked by a doctor, an old friend who was the son of my former obstetrician, to assist him in an abortion. It was my first experience and I did it because I trusted his skills and wanted to help him. I met the young, beautiful woman who came from one of the affluent families in town and who seemed very alone to me. As I stood there and held her hand tightly, I watched her face. I felt very uneasy and could not figure out why.

All went well and there were no complications. Both doctor and patient came through fine. There was only one hitch: I had fainted and when I woke up I was lying beside the table staring at the doctor. “I saw her face. The total look of horror was too much so I passed out.” I was babbling and aware of it. Within half an hour it was all over that hospital: A nurse had fainted at an abortion. How embarrassing!

My “very unprofessional” behavior was the result of a memory—long buried—which had been triggered by the woman’s loneliness and agony. Back in 1962, I had spent an agonizing 10 days in bed, alone most of the time, trying to prevent a second so-called “spontaneous abortion,” a miscarriage, from occurring. Four months previously, I had passed an intact, well-shaped 6-week fetus. Two trips to the family physician who was a greatly respected member of the medical profession had revealed “no evidence of pregnancy, but keep tabs on the spotting.” _____ my obstetrician, gave me a drug that seemed to level off in early evening each day, leaving me in second stage labor contractions for several hours. He did not change the dosage.

Finally after the 10th day of pain, I deliberately quit taking the drug. I knew instinctively that this was not meant to be. By that time, I was speaking only to God and to my belly and feeling very alone. I had two small children sucking their thumbs and looking worried and annoyed as this thing dragged on and a husband who tried to comfort me during the evening bouts with pain, who went to work each day. The seeds of future discontent and our eventual divorce were sown during that time. He tended to look the other way and laid an amorphous blame on me for not pulling this thing off well. Money was tight and he was tired of diapers and long days and interrupted nights.

Passing the fetus was awful. I was terrified waiting and pushing alone in that bathroom after everybody was asleep. The bloody nondescript pieces were scary. It was not a fetus or a baby at all. It was nothing identifiable at all but I kept the evidence to show the doctor.

Afterwards, in the hospital where I was taken for a D & C, I was placed in the maternity wing, where I could hear babies crying all night and being brought to their mothers for nursing. I begged to be placed on a surgical floor, and this was finally done. For a year after, I cried a lot ... my small daughter called my favorite spot “the crying chair.” I felt guilt and I could not tell anybody at all. I had a terrible ache where both little fetuses had been. But I had, I felt, made a choice all alone, praying for guidance... listening to my insides and to the silence of those around me who could not articulate their feelings easily. I felt an obligation not to mess up things for them. Clearly, another child so soon would not do, even though we were not poor, starving, homeless, persecuted, or diseased.

While this was not a surgically induced abortion, nonetheless, my experience contains many of the same elements. Nature and I cooperated and, as it turned out, I was right. I could not know that for sure until it was over. I became very aware of what the act of choosing to abort for any reason really means to a woman.

So I do not come to a decision that we call “pro-choice” easily. First I had to experience the pain of loss myself in order to understand the experience of other women.

I conclude that because the process of gestation and birth is so very personal and such a lonely event, the decision to terminate pregnancy must be allowed to the woman herself. I am fully aware that the loving husband and father-to-be has a say. But even at the last stage of birth, the wife will push that husband away and focus inward on her baby and herself. I love dearly to see the couple sharing the birth moment in the delivery room ... each helping the process along with training for the big event ... the safe delivery of a wanted child who will know a happy, safe, nurturing environment. The tears of joy are shared and all are touched by this. It becomes even more meaningful that the choice made by the woman depends upon the possibility of this outcome: a happy one.

I do not believe that anyone who cannot give birth can possibly understand what it means to take on active responsibility for co-creation with the Creator. I do not believe that a Supreme Court of men or a male President should be given that kind of power, ignorant of the experience itself.

Finally, I want to say something about abortion as murder. I told you that I am the mother of three children . . . two living and one dead. What I did not say is that the dead child was a murdered child. She was shot by a boy who was denied entrance in the U. S. Air Force Nuclear Weapons Program and who had to prove, in another rite of passage, his manhood. He (believed that he) needed to demonstrate his power over another human being by taking her life. I do not believe any woman feels that way when she decides to end a problem pregnancy. Rather she feels she is making a choice from options that seem to leave her no other choice. She is on anything but a power trip, except, and I qualify this, when the conditions around her have violated her so much that her act is an act of counterviolence. Only she can really know that moment. She is, indeed, claiming her selfhood and attempting to survive. Often for the sake of those dependent upon her.

Usually, the woman who ends her pregnancy weeps and she does it alone more often than not. And the ache inside her stays for a very long time; I speak from experience.

COVENANT AND CREATION: THEOLOGICAL REFLECTIONS ON CONTRACEPTION AND ABORTION

Policy Statement

Biblical faith depicts persons as stewards of life, heirs who are responsible for the care of God's world. This responsibility leads persons of faith not only to an exploration of all of creation but also to efforts that maintain order, secure justice, and improve the quality of human life. Because human life, in the biblical sense, is much more than the perpetuation of physical existence, people of faith should commit themselves to improving its quality spiritually, educationally, and culturally as well as medically. This commitment will often necessitate difficult moral choices in the midst of conflicting values.

The church itself should pattern for society a way of life wherein sexuality, conception, birth, and raising children are issues of profound responsibility, fidelity, and care. That way of life inevitably stands in judgment on our present cultural ethos, which extols casual and promiscuous sexuality.

Some of the most difficult moral choices persons face in their care of creation are related to contraception, pregnancy, and abortion. Christians will make these decisions knowing that the value and dignity of human life are bestowed by God the Creator who calls us into a covenant relationship with our God and with each other. Faith in God surely leads to profound respect for human life.

For the most part, Protestants have affirmed the role of contraception as a responsible exercise of stewardship with regard to procreation. Limiting the size of a particular family or limiting population growth in a whole society is generally understood to be a kind of caring for one's family and for the next generation. Contraception is clearly the most morally appropriate way to control fertility and to plan families.

Current contraception technology is far from reliable. The church is called to exercise social responsibility by advocating more effective contraceptives for males as well as females and to educate our own membership that family planning must be the concern and responsibility of both sexual partners. A greater emphasis in church and society on contraception would significantly reduce the possibility of unintended pregnancies.

When, however, an unintended pregnancy occurs or a genetic problem with the fetus is diagnosed, the question of abortion often arises even though it is not the only solution. An understanding of various kinds of circumstances surrounding unintended pregnancies is especially important.

Tragically, many women become pregnant as a result of rape or incest. All too frequently contraceptives fail, even though conscientious efforts to prevent pregnancy have been taken. In addition, the increasing number of teenage pregnancies each year is sobering and presents especially agonizing situations.

There is no point in the course of pregnancy when the moral issue of abortion is insignificant. The serious moral decision is to be made on the basis of the covenantal character of parental responsibility. Bearing children is a process of covenant-initiation that calls for courage, love, patience, and strength. In addition to these gifts of the Spirit, parent-child covenants also require the economic as well as the spiritual resources appropriate to the nurture of a human life. The magnitude of the commitment to be a human parent cannot be overestimated and should not be understated.

The decision to terminate a pregnancy may be an affirmation of one's covenant responsibility to accept the limits of human resources. Because we understand the morality of abortion to be a question of stewardship of life, the responsible decision to choose abortion may arise from analysis of the projected resources for caregiving in a specific situation.

Abortion can therefore be considered a responsible choice within a Christian ethical framework when serious genetic problems arise or when the resources are not adequate to care for a child appropriately. Elective abortion, when responsibly used, is intervention in the process of pregnancy precisely because of the seriousness with which one regards the covenantal responsibility of parenting.

Biblical faith emphasizes the need for personal moral choice and holds that persons stand ultimately accountable to God for their moral choices. The freedom to do what one judges most appropriate in an abortion decision is qualified by the fact that the purpose of such decision is the responsible exercise of stewardship. Even in the face of the most difficult decisions, of which abortion is surely one, the gospel assures us that we can trust in God's Spirit to guide us in our decision. Furthermore, given the fact that such hard choices involve some unpleasant consequences whatever the decision, the gospel reminds us again and again of God's grace, which is sufficient for us in spite of our limitations, and assures us that even if we err in misusing our freedom, God's forgiveness restores us in covenant love. Only in the knowledge of such grace and guidance could we dare to claim the responsibility and freedom to use modern medical skill to intervene in the process of human procreation.

The Calvinist affirmation of conscience as one of the primary junctures at which the power of the Holy Spirit breaks through into human experience is grounded in both (a) the Old Testament call to human responsibility, as set forth in the biblical witness to God's covenant with us, and (b) the New Testament assurance of the work of the Holy Spirit as our enabler and guide in the exercise of human freedom before God. When faced with significant moral choices, women and men who prayerfully consider the options set before them can be assured that they are empowered by the gracious work of God's Spirit to make an appropriate moral choice.

Any decision for an abortion should be made as early as possible, generally within the first trimester of pregnancy, for reasons of the woman's health and safety. Abortions later in pregnancy are an option, particularly in the case of women of menopausal age who do not discover they are pregnant until the second trimester, or women who discover through fetal diagnosis that they are carrying a fetus with a grave genetic disorder, or women who did not seek or have access to medical care during the first trimester. At the point of fetal viability, the responsibilities set before us in regard to the fetus begin to shift. Prior to viability, human responsibility is stewardship of life-

in-development under the guidance of the Holy Spirit. Once the fetus is viable, its potential for physically autonomous human life means that the principle of inviolability can be applied.

The church is called to model the just and compassionate community in its ministries to members and its witness to society. The church has responsibility to help make acceptable alternatives available to persons struggling with an unwanted pregnancy if they are to exercise their freedom responsibly. Moreover, the church must seek to support persons as they exercise their moral freedom, which it can fulfill through such means as proclaiming the biblical faith, clarifying alternatives and their probable consequences, and offering support in love to persons struggling with difficult choices. Christians should make their personal decisions in the context of the community of faith.

It is a tragic sign of the church's sinfulness that our propensity to judge rather than stand with persons making such decisions too often means that persons in need must bear the additional burden of isolation. It would be far better if the person concerned could experience the strength that comes from shared sensitivity and caring. The church is called to be the loving and supportive community within whose life persons can best make decisions in conformity with God's purposes revealed in Jesus Christ.

The church should energetically support efforts of family, planning, education in contraception and human sexuality, adoption of unwanted children, care for unwed mothers, and, in general, advocate wholesome and responsible stewardship of the human body and its procreative process. As the church is able to give expression to these values and commitments, the need for abortion will be reduced. Whatever a woman's decision may be, the caring support of the church should always be hers.

In the area of public policy the church should call upon policymakers in government and industry to form a rational policy for all members of our society in the area of contraception. This would need to include research and development in contraception knowledge and technique and the provision for unhampered access to contraceptive information and services for males and for females of childbearing age.

The church's position on public policy concerning abortion should reflect respect for other religious traditions and advocacy for full exercise of religious liberty. The Presbyterian Church exists within a very pluralistic environment. Its own members hold a variety of views. It is exactly this plurality of beliefs that leads us to the conviction that the decision regarding abortion must remain with the individual, to be made on the basis of conscience and personal religious principles, free from governmental interference.

Consequently, we have a responsibility to work to maintain a public policy of elective abortion, regulated by the health code, not the criminal code. The legal right to have an abortion is a necessary prerequisite to the exercise of conscience in abortion decisions. Legally speaking, abortion should be a woman's right because, theologically speaking, making a decision about abortion is, above all, her responsibility.

As Presbyterians and U.S. citizens we have a responsibility to guarantee every woman the freedom of reproductive choice. We affirm the intent of existing law in the United States regarding abortion: protecting the pregnant woman. Medical intervention should be made available to all who desire and qualify for it, not just to those who can afford preferential treatment.

In the United States today, the right to choose abortion is a constitutional right, clarified by the United States Supreme Court *Roe v. Wade* decision (1973). We firmly oppose efforts to amend the Constitution in order to prohibit abortion. Under terms of the 1973 decision, elective abortions are confined generally to the first two trimesters of pregnancy. This conforms to the moral principle we affirm that elective abortion should be available before fetal viability but only in the rarest instances after that point, for instance, in rare cases involving medical judgment and late diagnosis of grievous genetic disorders.

The Presbyterian Church believes that society must offer good health care, both pre- and post-natal; day care facilities and homemaker services where needed; maternity and paternity leaves and family service centers; and expert counseling services. In addition, we must work toward a society in which life long respect and dignity for all people is manifest in the opportunities to obtain adequate resources for maintenance of life and health. In these ways the church seeks to strengthen the various alternatives available to women in making decisions about pregnancies.

Obviously the most desirable moral situation is that every pregnancy be intended and trouble-free, but our life experience is very different from this ideal. Abortion is not the only solution for unintended or problematic pregnancies, although it may at times be the most responsible decision.

Thus, the 195th General Assembly (1983):

1. Urges Presbyterian congregations and their individual members to:

a. Provide a supportive community in which such decisions can be made in a setting of care and concern.

b. Respect the difficulty of making such decisions:

c. Affirm women's ability to make responsible decisions, whether the choice be to abort or to carry the pregnancy to term.

d. Protect the privacy of individuals involved in contraception and abortion decisions.

2. Affirms the church's commitment to minimize the incidence of abortion and encourages sexuality education and the use of contraception to avoid unintentional pregnancies, while recognizing that contraceptives are not absolutely effective; and

a. Commits this denomination and urges its members to encourage research in and development of contraceptive knowledge and techniques to make

this awareness and facility easily available to all and to support legislation and public funding activities that strengthen family life;

b. Urges Presbyterians to support sexuality education programs in families, churches, schools, and private and public agencies;

c. Encourages mutual responsibility by men and women for contraception;

d. Affirms the need for research in and development of a range of contraceptives that can be used by men;

e. Encourages couples to use more than one method of contraception in order to minimize the possibility of unintended pregnancy due to contraceptive failure;

f. Affirms the use of voluntary sterilization by couples who have completed their families.

3. Recognizes that negative social attitudes toward women cast doubt on women's ability to make moral decisions and urges ministers and congregations to work to counter these underlying social attitudes and affirm the dignity of women.

4. Recognizes that children may be born who are either unwanted or seriously handicapped; and affirms the church's ongoing responsibility to provide supportive services to families in these situations and to help find appropriate institutional care and adoptive services where needed.

5. Affirms the 1973 *Roe v. Wade* decision of the Supreme Court, which decriminalized abortion during the first two trimesters of pregnancy.

6. Celebrates the courage of clergy and others who were willing to risk participation in the Clergy Consultation Service before 1973.

7. Opposes attempts to limit access to abortion by:

a. Denial of funding for abortions to women who receive federal funding for their medical care.

b. Restriction of coverage by insurance companies for abortion procedures.

c. Passage of federal, state, and local legislation that has the effect of harassing women contemplating abortion.

d. Restriction of federal funding to medical centers and teaching institutions where abortions are performed.

e. Passage of a constitutional amendment or other legislation that would return control over abortion to individual states or prohibit it as a national policy.

f. Restriction of the jurisdiction of the Supreme Court and the federal courts in the area of abortion.

8. Urges the Presbyterian Church through its members, congregations, governing bodies, boards, and agencies, including the Presbyterian Health, Education and Welfare Association, to model the just and compassionate community by:

a. Opposing adoption of all measures that would serve to restrict full and equal access to contraception and abortion services to all women, regardless of race, age, and economic standing.

b. Working actively to restore public funding by federal, state, and local governments for the availability of a full range of reproductive health services for the medically indigent.

c. Supporting funds, such as the Abortion Fund, for use by women who face abortion decisions but who no longer have access to public funding, so they may freely choose an appropriate course of action without coercion or restriction.

d. Challenging Presbyterian doctors and institutions to provide contraception and abortion services at cost or free-of-charge to those who no longer have access to public funding.

e. Providing openness and hospitality to women who need new structures of support while making an abortion decision or awaiting the delivery of a child.

f. Providing continuing support for women who, having made an abortion decision, may have doubts as to the wisdom of their choice or, having delivered a child, are not able to cope with the separation of adoption or the responsibilities of child care.

g. Opposing efforts to use zoning regulations to preclude the establishment of abortion clinics.

9. Recognizes that the issue of teenage pregnancy and premarital sexual activity is sometimes confused with the abortion issue itself. While time, task, and space have not allowed for extensive presentation in this paper, we express our concern by requesting that the General Assembly Council, through the appropriate agency, pursue a study of teenage sexuality and responsibilities in light of the covenant of creation.

FOOTNOTES

Chapter B

1. Westoff, Charles F., and DeLung, Jane S., "Abortions Preventable by Contraceptive Practice," *Family Planning Perspectives*, Sept.–Oct. 1981, p. 218.
2. Hatcher, Robert A., *Contraceptive Technology 1980–1981*. New York: Irvington Publishers, Inc., 1981, p. 4.
3. *Ibid.* p. 35.
4. *Ibid.* See pp. 101–116 for a general discussion of this subject.
5. This number is reached by comparing the number of pregnancies each year with the effectiveness rate of contraception.

Chapter C

1. Tietze, Christopher, *Induced Abortion: A World Review, 1981*. New York: The Population Council, 1981, p. 86.
2. *Ibid.* p. 86.
3. *Ibid.* p. 70.

Chapter E

1. Gilligan, Carol, *In a Different Voice: A Psychological Theory and Women's Development*. Cambridge, MA: Harvard University Press, 1982.
2. Hatcher, Robert A. *Op. cit.*, p. 60.
3. Calderone, Mary Steichen, *Manual of Family Planning and Contraceptive Practices*. Baltimore, MD: Williams and Wilkins Co., 1970, p. 338.

Chapter F

1. Tietze, Christopher, *Op. cit.*, p. 60.

Chapter G

1. *Teenage Pregnancy: The Problem That Hasn't Gone Away*. New York: The Alan Guttmacher Institute, 1981, p. 4.
2. *Ibid.*, p. 52.
3. *Ibid.*, p. 27.
4. *Ibid.*, p. 17.

5. *Ibid.*, p. 37.

Chapter H

1. *Ibid.*, p. 101.

Bibliography

Aquinas, Thomas, *Summa Theologica*. Westminster, MD: Christian Classics, 1982.

Aristotle, *De Animo, In the Version of William of Moerbeke*. New Haven: Yale University Press (1965).

Augustine, Bishop of Hippo, *The Confession of St. Augustine*, Books I–X. Translated by F. J. Sheed, Kansas City, Kansas: Sheed, Andrews, McMeel, c 1942.

Calderone, Mary Steichen, *Manual of Family Planning and Contraceptive Practices*. Baltimore, MD: Williams and Wilkins Co., 1970.

Garvey, John and Morriss, Frank, *Catholic Perspectives: Abortion*. Chicago: The Thomas More Press, 1979.

Gilligan, Carol, *In a Different Voice: A Psychological Theory and Women's Development*. Cambridge, MA: Harvard University Press, 1982.

Hatcher, Robert A., *Contraceptive Technology 1980–1981*. New York: Irvington Publishers, Inc., 1980.

The New Dutch Catechism (1969).

Teenage Pregnancy: The Problem That Hasn't Gone Away. New York: The Alan Guttmacher Institute, 1981.

Tietze, Christopher, *Induced Abortion: A World Review 1981*. New York: The Population Council, 1981.

Van Eys, Jan, "Genetic Medicine and the Concepts of Health and Disease," *Church and Society*. The United Presbyterian Church, USA, Sept.–Oct. 1982.

Westoff, Charles F., and DeLung, Jane S., "Abortions Preventable by Contraceptive Practice," *Family Planning Perspectives*, Sept.–Oct. 1981.