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Vision: A Journal for Church and Theology

Beginning of life

Editorial

Dan Epp-Tiessen

Does God care how we make babies? Does God care that we make babies? What are the implications of our conviction that life is a gift of God? How can pastors and congregations respond sensitively to the pain of infertility and miscarriage? How should Christians think about artificial reproductive technology, prenatal diagnostic testing, abortion, and other beginning-of-life technology? This issue of *Vision* addresses these questions and more.

This issue was birthed in an unusual way. Five of the articles originated as presentations at a conference on Pastoring at the Beginning of Life, held at Goshen College in April 2002. We are grateful to Keith Graber Miller, one of the organisers, for asking whether *Vision* would be interested in publishing some of the presentations. We thank the conference speakers who reworked their addresses into publishable form. Our thanks, too, to other writers who contributed their reflections to round out this issue.

New life is a gift of God. Several articles assert that this conviction is the appropriate starting point for Christian thinking about beginning-of-life issues. If we start with this conviction, our primary concern will not be how to manage or control the process of procreation, but how to receive the new life God grants. Some of our writers remind us that all human life, even life that is limited by disabilities, is a gift of God. Sherry Wenger's experience with her daughter Elise, who has Down syndrome, illustrates this point. George Stoltzfus wonders what kind of a community we will become when our technology makes it possible to prevent the birth of children with "abnormalities." Gary Harder's funeral sermon testifies to the power of Adam's life, a life that lasted but a few days. God's purposes can be worked out in mysterious and wonderful ways through broken lives.

Some readers may wonder why we have not included an article devoted specifically to abortion. One reason is the sheer volume

of material that has already been published on this topic. A second reason is that, as Chris Huebner observes, Christian ethics is far more than a matter of asking what decisions we should make when confronted by specific issues and situations. Christian ethics is about asking what basic convictions, practices, and stories will shape us into the people God is calling us to be. By examining some of these convictions and practices, many of the articles do speak to the issue of abortion.

Some writers in this issue reflect on their own beginning-of-life experiences, most related to infertility. Keith Graber Miller, Brenda Srof, an anonymous couple, Melissa Miller, and Sherry Wenger remind us that the church dare not speak only in theoretical ways about the beginning of life. People face real-life questions, issues, and decisions, and they need concrete assistance from the church in the form of understanding, support, guidance, wisdom, and even admonition. Stories of real people test the appropriateness of our theology and our pastoral practices. I find these stories encouraging, as they testify to how family members, friends, pastors, and congregations have often been sources of comfort, strength, and support. I find these stories challenging, as they indicate that the church is not always a safe place to share painful experiences and process difficult issues. May these stories sensitise us to the anguish that sometimes surrounds beginning-of-life experiences, and may they encourage us to develop appropriate pastoral and congregational responses.

Some writers in this issue reflect on their own beginning-of-life experiences. May these stories sensitise us to the anguish that sometimes surrounds these experiences, and may they encourage us to develop appropriate pastoral and congregational responses.

One discussion at the Goshen College conference highlighted the need for biblical reflections and worship materials dealing with infertility. We hope that you find such resources in the articles by Keith Graber Miller and Dan Epp-Tiessen, in the sensitive retelling of Hannah's story by Rachel Miller Jacobs, and in Melissa Miller's ritual to mark a miscarriage.

New technology with the potential to benefit humanity usually has a dark side, because it also poses risks and dangers. This is especially true of artificial reproductive technology, prenatal

diagnostic testing, and embryonic stem cell research, which seem to be racing ahead faster than our ethical reasoning can keep pace. Sherry Wenger suggests that it may not always be appropriate for Christians to use the technology available to us, and that in some cases our reasons for using a particular technology ought to be different than those of the medical establishment. George Stoltzfus agonizes over the dilemma posed by the enormous potential of stem cell therapy: it promises to cure many serious ailments, yet the tissues needed for research are harvested from aborted fetuses and embryos left over from fertility treatments.

Chris Huebner challenges the prevailing paradigm, which assumes that medical technology is morally neutral and bioethics is a matter of discerning how to use this neutral technology in positive rather than negative ways. Chris points out that technology itself presupposes certain moral convictions, that it shapes us into a certain kind of people—people who value mastery, autonomy, and control over our lives. Technology's vision of the good life stands in some tension with the Christian vision that we receive life as a gift, and that faithfulness involves giving control of our lives over to Jesus Christ.

Chris's article and Gary Harder's sermon both remind us that beginning of life and end of life should not be separated in Christian thinking. Our lives come from God, and ultimately they return to God. Gary's sermon, occasioned by the death of an infant, provides a fitting conclusion to our articles. As good funeral sermons do, it points us to yet another death, a death that was followed by a resurrection—a beginning of life that is the source of our Christian hope. Thanks be to God for the gift of life!

Does God care that we make babies?

Dan Epp-Tiessen

"Does God care how we make babies?" Willard Krabill asked at the conference on Pastoring at the Beginning of Life, held at Goshen College. The response of the conference planners and the editors of *Vision* is an unambiguous affirmation: "Of course God cares how we make babies!" If we did not believe this we would not be offering the material in this issue for your consideration.

Both Old and New Testaments contain passages emphasising biological procreation and texts stressing missional growth; the church can benefit from the truth of both perspectives.

I want to change one small word in Willard's question and thereby ask an even more basic one, "Does God care *that* we make babies?" This question requires a more complex answer, and I want to offer reflections on a variety of biblical texts that suggest two different responses. On one hand, of course God cares that we make babies, but on the other hand, it is not essential that we make babies. I want to explore these contrasting perspectives and reflect on how the church can benefit by allowing both of them to inform our theology and pastoral practices.

Before proceeding, some words about language are in order. My colleague Harry Huebner has pointed out a danger inherent in using the language of making babies: it suggests that human agency is the central factor in procreation. One of the key points of this article is that human life is first and foremost a gift of God. Therefore, as Harry observes, it is more appropriate for Christians to focus on how we will receive God's gift of life than it is to speak of "making babies."

The language we use shapes how we think about issues such as artificial reproductive technology, prenatal diagnostic testing, abortion, and stem cell research using fetal tissue. The secular and technological approach begins with the assumption that we

humans are the ones who make babies, and therefore we are free to decide how "our" babies will be made, and when it is appropriate to terminate the process that would otherwise lead to a new baby. As Christians we are called to begin at a different point, with the conviction that divine rather than human agency is central to procreation. If we take this beginning point seriously, then our major concern is not how we can exercise human control over the process of fertility. Instead, our primary focus is on how we as human beings can cooperate and act in keeping with God's creative process, in a way that cherishes the gift of new life which God grants.

Bearing children is important not only for the welfare of the larger human community, it is also critical for the formation of God's people.

Willard Krabill's lighthearted question, "Does God care how we make babies?" can remind us that God does care, and that God wants us to remember the primacy of divine over human agency. Although I use the language of "making babies" in this article, I want to avoid the suggestion that we need only consider human activity when we discuss beginning-of-life issues. I use this risky language because of its potential to encourage reflection on how we will exercise our human agency in a way that is in keeping with God's agency in procreation and with God's purposes for the world.

Making babies is essential

According to the Bible, the first words God speaks to humankind are "Be fruitful and multiply, and fill the earth" (Gen. 1:28). These words are a command, but in Genesis they are referred to as words of blessing, implying that God gives both the command and the power to fulfill it. Having children is not just an obligation laid on humans; the ability to procreate is a gift bestowed on humanity by a God who desires that a thriving human community inhabit the newly-created world. After the flood, when Noah and his family emerge from the ark, God extends the same blessing and exhortation to be fruitful and multiply (Gen. 9:1), again indicating concern that the human race flourish and prosper. When the disciples of Jesus wanted to keep the children at a distance, he welcomed the little ones and

blessed them, declaring that God's kingdom belonged to such as these (Mark 10:13–16). Surely Jesus' action is another illustration that children are a precious gift, and that indeed God cares that we make babies.

Bearing children is important not only for the welfare of the larger human community, it is also critical for the formation of God's people. This is most evident in the book of Genesis, which devotes much attention to how the promised son can be born to the aged Abraham and Sarah. Then we read of Jacob, another son of the promise, whose twelve sons become and represent the twelve tribes of Israel. In Genesis, children are essential as God begins the great task of creating a special people through whom "all the families of the earth shall be blessed" (12:3).

Making babies is not essential

The Old Testament contains many stories of non-Israelites joining the covenant community, and Jews of the later Hellenistic period were open to accepting converts from other religions. Still, the dominant paradigm for the people of God was of a community created by biological growth. According to this model, the community of faith was ethnically homogeneous and all Jews were related by virtue of being descendants of Abraham, Isaac, and Jacob. In this paradigm (not unlike the one that has sometimes been at work in the Mennonite church), making babies is essential, because the community of faith perpetuates itself primarily by means of procreation.

According to Paul's vision, making babies is not essential. The church lives by proclaiming the good news, not by procreation.

Jesus promotes a different paradigm. When he receives word that his mother and brothers wish to see him, he asks, "Who are my mother and my brothers?" Then he declares, "Whoever does the will of God is my brother and sister and mother" (Mark 3:34–35; see also Matt. 12:48–50; Luke 8:19–21). Jesus downplays biological connections and thereby redefines the nature of family. His family is not defined by blood relationships, but by the relatedness that comes from a shared commitment to doing the will of God. Many implications follow from this assertion, not least of which is that making babies is not essential for the people

of God. The community grows primarily by inviting people to faith, by evangelism.

On another occasion a woman says to Jesus, "Blessed is the womb that bore you and the breasts that nursed you" (Luke 11:27–28). Jesus responds, "Blessed rather are those who hear the word of God and obey it!" The woman's statement assumes that Jesus is a great man, and that his mother is blessed by virtue of producing such a remarkable son. So why does Jesus reject this compliment to both himself and his mother? The woman's statement reflects the values of a patriarchal society, which taught that a woman's greatest contribution was to produce good sons (see 1 Tim. 2:15), and that a woman should live out her aspirations through these sons. For women, bearing children was deemed essential to a meaningful life. Jesus challenges these patriarchal assumptions by stressing that faithfulness to God is far more important, even for women, than making babies.

Paul adopts the principles expressed by Jesus and spells out some further implications. He develops lengthy arguments to demonstrate that the "true Israel" is not composed only of physical descendants of Abraham but of people who are committed to Jesus Christ (Rom. 9:6–33; Gal. 3:23–29, 4:21–31). Gentile Christians are "children of the promise, like Isaac" (Gal. 4:28), and they have been destined "for adoption as [God's] children through Jesus Christ" (Eph. 1:5). For the writer of Ephesians, salvation involves Jesus Christ reconciling both Gentiles and Jews to God by destroying the dividing walls between them, thereby creating one new humanity (2:13–22). According to Paul's vision, making babies is not essential. The church lives by proclaiming the good news, not by procreation.

The value of diverse perspectives

When confronted with two different biblical perspectives we may be tempted to use our western either/or system of logic and opt for one or the other. In this case, because the Old Testament places more weight on one perspective and the New Testament on the other, Mennonites might be tempted to play off the New Testament against the Old as we are sometimes prone to do.[1] Two reasons not to adopt this approach are: both testaments contain passages emphasising biological procreation and texts stressing

missional growth, and the church can benefit from the truth of both perspectives.

In the New Testament Jesus highlights the importance of children by blessing them, despite the objections of his disciples. Second Timothy 1:5 refers to third-generation Christian faith; "I am reminded of your sincere faith, a faith that lived first in your grandmother Lois and your mother Eunice and now, I am sure, lives in you." This text witnesses to what must have been a concern even in the early church already: biological growth and nurturing children of believers into the faith.

The Old Testament contains exceptions to its dominant vision of God's people as an ethnically homogeneous community that perpetuates itself through procreation. These exceptions are particularly prominent in the book of Isaiah. In 2:2–4 we see a glorious vision of the nations streaming to Mount Zion so that they may learn how to live according to the words and way of the God of Israel. The so-called suffering servant is to be a channel of God's salvation to the nations (42:4, 49:6). Eunuchs who are faithful to God's covenant (but incapable of fathering children) are promised "a monument and name better than sons and daughters" (56:5). In this same passage God asserts that foreigners are invited to become part of the covenant community and to worship, because God's desire is that "my house shall be called a house of prayer for all peoples" (56:7; compare Mark 11:17).

Diversity of perspectives in the Bible is often seen as a problem to overcome or resolve, sometimes by ignoring or denying its existence, and sometimes by determining which is the theologically and ethically "correct" perspective. Sometimes Christians should opt for one biblical perspective over another, as in the case of texts that legitimate slavery versus those that undermine slavery. In other cases we do well to avoid either/or choices. If the Bible contained only the prophetic critique of Israel's sacrifice and worship (see 1 Sam. 15:22; Isa. 1:10–15; Amos 5:21–23; Mic. 6:6–8), what biblical basis would we have for stressing the centrality of worship in the life of God's people? If the Bible contained only the priestly emphasis on the details and sacramental effect of worship and ritual (see Exodus 25–31, 35–40; Leviticus 1–10), what biblical basis would we have for asserting that worship may be perfect in all its details but still not

please God if it does not inspire just and righteous living? Sometimes biblical diversity is not a problem to overcome but a resource to use.[2]

Many of our deepest theological convictions may be true, but by themselves they remain only a partial expression of the gospel, and therefore it is important to supplement them with the truth of other perspectives. What then can the church gain by considering the two contrasting biblical truths about making babies?

Some theological and pastoral implications

God's first words to humankind, "Be fruitful and multiply," are a vivid testimony to how central procreation is to our nature and calling as human beings under God. In secular terms we sometimes speak of the biological urge to have children. As Christians we have a theological basis for acknowledging this powerful biological drive, and we can affirm it as nothing less than a gift from God. Recognising how central being fruitful and multiplying is to our human nature can provide a pastoral basis for acknowledging the deep pain and emptiness many couples and also single people feel because they are not able to bear children. Our churches have tended to downplay or be oblivious to the pain and loss arising from infertility. As a result, many people suffer in silence, deprived of the support and rituals that a caring Christian community could offer.

Recognising how central being fruitful is to our human nature can provide a pastoral basis for acknowledging the deep pain and emptiness many couples and also single people feel because they are not able to bear children.

The truth that making babies is central to who we are as human beings needs to be supplemented immediately by another truth: it is by no means essential that we make babies. As Jesus indicated, obedience to God is far more important than procreation. Pastorally, this fact becomes the basis for declaring that the inability to bear children, or the decision not to, in no way diminishes our faithfulness or our worth before God and the community of faith.

Keeping the two theological truths mentioned above in creative tension can also guide us in assessing artificial reproductive technologies. Because bearing children is a calling

from God, Christians can be open to at least some forms of artificial reproductive technologies. But because having children is not essential, we are also free to set limits on how far we are prepared to go. We are also free to ask hard questions about the ethics and cost of such technology, and about what priority to give such technology in relation to other medical needs in our society and larger world.

God's blessing of humankind with the exhortation to be fruitful and Jesus' blessing of the children indicate how the church ought to view children—they are precious gifts of God. This means that our churches and homes ought to be child-friendly places. Practices such as making pastoral visits to new parents, placing a flower at the front of the church to acknowledge the arrival of new life, and publicly introducing babies the first time their parents bring them to church are important ways the church expresses its conviction that children are a blessing from God and are welcome in the faith community. Such practices also acknowledge the significance of a new child for parents and other relatives.

The ritual of child dedication affirms that children are a gift from God, and also affords parents the opportunity to publicly commit themselves to raising their child in the context of a faith community and a loving Christian home. One of the most important parts of the dedication ritual is the church's pledge to support both child and parents by participating in the raising of the child. I once asked a friend, who had grown up in a somewhat dysfunctional family, how she had managed to turn out so well as a person. Her immediate response was "I got much of what I needed from the church."

In a society that overvalues work and certain kinds of productivity, the church's conviction that children are a blessing from God encourages us to affirm that raising and nurturing children is both a privilege and an important form of Christian ministry. The church should support mothers, fathers, and others who decide to forgo paid employment in order to devote more time and energy to raising children. (The church should also be aware that staying home to raise children may be a luxury that only certain classes of people can afford.) The church should support parents who temporarily reduce their committee and

other church involvements because they recognise that raising the next generation of Christians is one of the most important contributions they can make to the mission of the church.

Last summer, just before reading the papers that form the core of this issue of *Vision*, I read two books by Jean Vanier, founder of the l'Arche movement, which provides homes for adults with physical and mental disabilities. I was struck by some profound contrasts. Sherry Wenger notes how prenatal diagnostic testing is sometimes encouraged so that prospective parents can abort "abnormal" fetuses and thereby avoid having a child with disabilities. Vanier is certainly correct in observing that our society often regards such individuals "as nature's mistakes, as sub-human."[3] In contrast, Vanier believes that every human life is to be welcomed into this world because it is a precious gift from God, no matter how broken the body or mind may be. "There is meaning to every life, even if we cannot see it. I believe that each person, in her unique beauty and worth, lives out a sacred story."[4] These convictions about life as a gift provide a more helpful Christian starting point for discussing issues such as abortion and prenatal testing than does the debate about the exact moment when human life begins.

While the church should affirm that children are a special blessing from God, it should do so sensitively, because this affirmation can intensify the pain of people unable to have children, and may even leave the impression that childless people are less than whole. Pastors should exercise care in planning and leading child dedications and Mother's Day services. When celebrating and praying for our children and families, we should also acknowledge painful experiences related to children. There will most likely be people present who have been unable to conceive, or who have miscarried. Someone's child may have a disability, or may have died. Someone's adult child may have made unhealthy life choices, and someone may be unable to see their child because of separation or divorce. By naming these realities in the context of worship, we validate people's painful experiences, and we bring those experiences into the healing presence of God.

The Bible's contrasting responses to the question "Does God care *that* we make babies?" intersect in a fascinating way in one

particular use of the exhortation to be fruitful and multiply. The command is first given to humanity at the time of creation (Gen. 1:28), and then to Noah and his sons who emerge as a new humanity after the flood (Gen. 9:1). Then Jacob receives the command, but the timing is most peculiar (Gen. 35:11). Jacob has already fathered the sons who represent the twelve tribes of Israel, and his days of being fruitful are over. Here the exhortation to be fruitful and multiply functions not as a literal command that Jacob is to produce more children. Rather, it signals that what God is doing through Jacob by creating the people of God is on par with the creation of humanity in Genesis 1 and the re-creation of humanity after the flood. The emergence of God's people in some sense represents the creation of a new humanity. Procreation is important in this text, but it is subsumed under the broader concern for the creation of God's people.

Commitment to the family of faith is more basic than our commitment to biological family. These two commitments need not be at odds, provided we remember that how we live in our biological families should be determined by our even more fundamental commitment to the family of Jesus.

This text and Jesus' words about family remind us that commitment to the family of faith is more basic than our commitment to biological family. These two commitments need not be at odds with each other, provided we remember that how we live in our biological families should be determined by our even more fundamental commitment to the family of Jesus Christ. Stressing the priority of our faith community can bring comfort and encouragement to childless people by affirming that infertility does not prevent them from living out their true calling in life. Giving priority to the faith community can also help reorient the priorities of people whose over-preoccupation with their biological family and its needs hinders them from living out their calling to follow Jesus.

According to the New Testament, God's new humanity is created by proclaiming the gospel. Many of our Mennonite congregations still operate explicitly or implicitly with the model that the church perpetuates itself by means of biological growth. The biblical texts explored in this article remind us that making

babies and biological growth are extremely important, but that we are also called to adopt the paradigm of a missional church, which lives by witness, service, and spreading the good news of Jesus Christ. Making babies is both essential and not essential.

Notes

[1] For a discussion of this Mennonite tendency and why it is inappropriate, see Waldemar Janzen, "A Canonical Rethinking of the Anabaptist-Mennonite New Testament Orientation," in *The Church As Theological Community: Essays in Honour of David Schroeder*, ed. Harry Huebner (Winnipeg: CMBC Pubns., 1990), 90–100.
[2] For a discussion of how the church can deal in a helpful way with biblical diversity, see Janzen, "A Canonical Rethinking," 107–10.
[3] Jean Vanier, *Our Journey Home: Rediscovering a Common Humanity beyond Our Differences* (Ottawa: Novalis, 1997), 3.
[4] Ibid., 147.

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Bringing infertility out of the shadows

Keith Graber Miller

Periodically the media treat us to a new case in the annals of reproductive technology. Remember the Buzzancas? In 1998 they resorted to surrogacy after many years of failed infertility treatments. Conception occurred in a petri dish, using the sperm and the egg of anonymous donors. The zygote was then placed into a woman with no genetic ties to any of the parties. In a sense the child had five parents—John and Luanne Buzzanca, the anonymous donors of the sperm and the egg, and the surrogate mother. The story took an even more bizarre twist when John filed for divorce a month before the baby was born. Luanne sought child-support payments, but John said he wasn't the baby's father "in any legal sense," although he had signed a contract. The judge agreed. The judge also ruled that Luanne was not the legal mother: the baby had no legal parents.[1]

In our silence we fail to provide the pastoral care that couples need amid the losses of infertility, and we leave them bereft of guidance as they confront a bewildering array of possible technological interventions.

As this case illustrates, the human desire to have children is strong. Also evident is the power of our reproductive technology, means we may turn to when our desire to procreate is painfully thwarted. And the story of the Buzzancas graphically displays the mess that sometimes results from indiscriminate use of that technology; the case serves as a textbook example of how advances in reproductive science race ahead of the law, leaving complex ethical and legal questions unanswered and leaving children in the lurch.

Such extreme high-profile cases claim our attention, while silence surrounds the common reproductive problems experienced by growing numbers of people in our congregations. Despite the Mennonite practice of congregational sharing about health concerns, many gut- and womb-wrenching experiences and

decisions related to the beginning of life remain in the shadows in our churches, sometimes unspoken even in small groups and with intimate friends. In our silence we fail to provide the pastoral care that couples need amid the losses of infertility, and we leave them alone and bereft of guidance as they confront a bewildering array of possible technological interventions.

In our congregations we urgently need to find ways of giving each other permission to speak about beginning-of-life issues and experiences. We need to explore together how biblical stories can best shape us and inform our choices around these matters. We need to enhance our ability to deliberate together about the ethical issues, so that we can be accountable with one another and support one another in the courses we pursue. We need to find ways to walk alongside each other through losses and moral dilemmas at the beginning of life.

Sermons that encourage openness

How do we open up conversation in our congregations about health care issues surrounding the beginning of life? Preaching that is sensitive, careful, and challenging is a critical step in bringing infertility out of the shadows in our churches. The Bible is replete with passages that provide fodder for stimulating sermons on procreation, infertility, and the beginning of life.

According to the Bible, the impulse to procreate is basic to human nature as created by God. The first chapter of our Scriptures includes a divine mandate, addressed to the newly created humans, to be fruitful and multiply (Gen. 1:28). This command is repeated to Noah and his family as they set foot on dry land again (Gen. 9:1). To have offspring, in the biblical view, is to carry on and support the work of creation. To procreate is, as the word's Latin roots indicate, to act in behalf of creation. According to the Old Testament, God is the ultimate source of all life, and all human procreation is therefore both gift and mandate from the life-giving God.[2] Preaching on these biblical materials can help us honor the strength of our desire for children, and see the basis for that powerful impulse in our biology and our theology.

But for many couples, the biblical directive to be fruitful is difficult, if not impossible, to follow. Approximately 15 percent of

married couples in North America experience infertility, which is defined as the inability to conceive a pregnancy after a year of trying, or repeated failure to carry a pregnancy to term. Secondary infertility, the inability to bear another child after a successful pregnancy, affects perhaps half of infertile couples. The incidence of infertility has nearly tripled in the last thirty years, because of a variety of environmental, medical, and sociological factors. These include later marriages, postponed attempts to conceive, sexually transmitted infections, and some forms of birth control. Ninety percent of the time a physical problem can be identified. Of that 90 percent, roughly a third of the time the difficulty can be attributed to the man, and a third of the time to the woman. In the remaining cases, it is a problem for both members of the couple—and in some sense, that is always so.[3]

Bible stories reveal the pain that accompanies an inability to conceive and bear children. Rachel's plea to Jacob offers an engaging title for a sermon on this subject: "Give me children, or I shall die!" she demands in desperation. Jacob angrily responds, "Am I in the place of God, who has withheld from you the fruit of the womb?" (Gen. 30:1–2). When biblical women are barren, and many are, God is identified as the cause; God is the one with power to close and open the womb. Sarah observes to Abraham, "You see that the LORD has prevented me from bearing children" (Gen. 16:2). The author of 1 Timothy writes, in what I hope was a weak moment, that women will be saved through bearing children (2:15). This passage seems to leave childless women doubly doomed, both here and hereafter.[4] To the natural pain of infertility and the accompanying sense of failure (the questioning of our virility, the loss of our dreams) such texts seem to add a theological condemnation. Pastoral preaching on infertility should sensitively address the various aspects of pain these texts engage.

Barrenness often functions as the driving motif in a biblical narrative or a sequence of narratives: for Sarah (Gen. 11:30; 16:1), for the women of the house of Abimelech (Gen. 20:18), for Rebekah (Gen. 25:21), for Rachel (Gen. 29:31; 30:1), for the wife of Manoah (Judg. 13:2), for Hannah (1 Sam. 1:2, 5–6), and for Elizabeth (Luke 1:7). In all these stories, barrenness is not the final word; it is a foil for the life-giving power of God. In each case, through divine intervention the curse of barrenness gives

way to the blessing of conception and childbearing.[5] But in some of these stories, before God gets around to satisfying their desire for children, people take initiative to find a way. Despite its distance from our world in time and technology, the Bible also includes stories of people who, facing a life that isn't turning out as they expected, use their ingenuity to overcome their barrenness. Like us, the ancients wrestled with the perennial human problem of what to do when life fails to live up to our hopes and expectations, when it dashes our dreams. This dilemma is the stuff of good sermons.

The Bible includes stories of people who use ingenuity to overcome their barrenness. Like us, the ancients wrestled with the perennial human problem of what to do when life dashes our dreams.

When Abraham and Sarah are not able to conceive their promised child, they use Hagar as a surrogate (Gen. 16:1–15). As in the Buzzanca story, this surrogacy arrangement has its complications. In the end, both Sarah and Abraham act with contempt toward Hagar and Ishmael, and shamefully drive them away (Gen. 21:9–14). Only because God steps in do Hagar and Ishmael survive and flourish. When Rachel, Jacob's beloved wife, finds herself barren, she says to Jacob, "Here is my maid Bilhah; go in to her, that she may bear upon my knees, and that I too may have children through her" (Gen. 30:3–7). Jacob's other wife, Leah, experiences some secondary infertility after birthing four children, so she gives Jacob her maid Zilpah, and births two more children through her before conceiving more on her own (Gen. 30:9–13). Deuteronomy 25:5–6 prescribes the practice of levirate marriage, a kind of surrogacy: "When brothers reside together, and one of them dies and has no son, the wife of the deceased shall not be married outside the family to a stranger. Her husband's brother should go in to her, taking her in marriage," and the first son whom she bears "will succeed to the name of his brother who is dead." These texts illustrate the possibilities for human intervention to overcome childlessness, as well as the complications that sometimes attend such arrangements.

This brief survey suggests an abundance of biblical stories which pastors can draw on to preach about God's care for human procreation and about the human pain and dilemmas surrounding

infertility. Other appropriate biblical materials for beginning-of-life sermons are birth predictions, announcements of pregnancies, birth stories, and texts expressing God's concern for life in the womb. Such sermons should introduce members to pastoral needs at the beginning of life, and to the complex ethical and health care issues surrounding infertility. Good pastoral preaching will create space for people to come forward with their own hurts, needs, and decisions, and will allow for ambiguity and the expression of unresolved anguish.

Resources that aid discernment

Twenty-five years ago, when a couple found they were infertile, they just didn't birth children. And they found ways to come to grips with their infertility, either remaining childless or adopting. Today the options have expanded dramatically, with the introduction of procedures such as in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and intracytoplasmic sperm injection (ICSI).[6]

When couples enter the arena of assisted reproduction, they inevitably face complex ethical problems. In addition to matters of justice and stewardship related to the high cost of treatment,[7] key issues include:[8] Do humans have a right to have children? If so, how far does that right extend? Why is it limited to the wealthy and the well-insured? May conception be separated from sexual intercourse? If God in love created all that is, and if our procreating is an expression of that love, should lovemaking always be a part of the process of conceiving a child? May infertile couples use donors' sperm or eggs, in nonmarital or extramarital reproduction? What is the status of surplus fertilized embryos? What are their rights? In a consumer society, how do we avoid treating childbearing and children as commodities to be bought and sold?

Developments in reproductive technology have outpaced our ethical and theological reflection on these beginning-of-life issues, and we now have trouble distinguishing the extraordinary from the ordinary. Sociologist Donald Kraybill observes that

> *We are caught in . . . an ethical gap as technology races far ahead of our ethical forumulas of bygone years.*

> *Ironically, as the technological precision increases, the moral precision wanes. The old answers that prescribed the boundaries between right and wrong, good and evil, are suddenly blurred by the provocative questions stirred by the spiraling genetic technology. After four decades of playing theological catch-up with the nuclear age, we finally have realized that the old "just war" formula is archaic for fighting nuclear wars. Now we face a new game of ethical catch-up as we try to maintain stride with the technological leaps in [assisted reproduction and] genetic engineering.*[9]

We are facing more complex ultimate decisions at the same moment that we—at least in the west—are being stripped of communal support because of our individualism and our desire for privacy. Many people are struggling with their health care issues alone, or with health care professionals who have their own biases and vested interests. Contrary to what our culture may tell us, conception, birth, and death are not just private and personal experiences; these events occur in communities. In these events our lives are interconnected with others'. Pastors, health care committees, and others need to support and nurture people in our congregations, and raise tough questions with them.

We are facing more complex ultimate decisions at the same moment that we—at least in the west—are being stripped of communal support because of our individualism and our desire for privacy.

A 1990s case that caught the media's attention was that of Mandy Allwood, a British woman who took fertility drugs to get pregnant with her lover. When Allwood did become pregnant, she learned that she was carrying eight fetuses. Some 20 to 30 percent of the pregnancies achieved through drugs or in vitro fertilization yield more than one fetus. Because no one had ever birthed eight live babies, doctors recommended surgically reducing the crowd in Allwood's womb so that at least some of the fetuses would be viable. This technique—now performed more than 3,000 times a year in the U.S.—involves inserting a thin needle into the most accessible fetuses and injecting a small amount of the poison potassium chloride.

Physicians refer to this as selective reduction, a euphemism for abortion. Allwood refused to undergo the procedure, and eventually miscarried the entire octet.[10] This case may seem far-fetched, distant from the experiences of people in our congregations. It isn't. Mennonite couples have had to make decisions about selective reduction, about using donor sperm and eggs, and about other technological assistance in conceiving children.

In our own family, Ann and I struggled with both primary and secondary infertility. It was nineteen months before we became pregnant with our first son, Niles, and we had completely given up on birthing more children when we became pregnant with Simon, more than seven years after our first pregnancy. We only took the first steps down the road of infertility treatment, stopping after a semen analysis, hysterosalpingogram, and laparoscopy. Between the births of our two energetic and delightful boys, we adopted Mia Bei, our remarkable daughter from China, a process that traded one set of issues for another—issues related to out-of-country adoptions and our willingness to consider a child with physical "imperfections." Adoptive parents, too, need the support and wisdom of their pastoral caregivers and congregations.

The pastor's role is not to rubber-stamp whatever choices people make. Pastors need to ask difficult questions in order to help people discern appropriate steps and respond in faithful ways to the health care issues before them. Ministers can provide information about reproductive technologies, or discuss the possibility of adopting or remaining childless. They can address theological understandings of procreation and barrenness. They can reflect on waiting, on hoping, on giving up, on other avenues for expressing the human drive to create and nurture new life.

Some church leaders are advocating for and developing health care committees or task forces in their churches. These committees can advise, convey information, and offer support. They should include a health care professional, a person who has studied ethics, someone who networks well with the congregation and community, and a member who can work with local hospitals or health care institutions. When people face health care decisions, the committee can assist with counsel, support, companionship, and making connections.

A health care committee could produce congregational resources about ethical and pastoral considerations in health care matters. The caring commission of College Mennonite Church (Goshen, Ind.) has developed a booklet, *Dealing with Death: A Guide to Resources*, which includes theological reflections, a living will declaration, a health care power of attorney, and a bibliography. A task force could assemble resources for dealing with critical issues at the beginning of life.

Ethicist Maura Ryan argues that infertility has become, in part, a "socially constructed impairment." She writes that "the availability of technology increases the burden many patients feel to pursue all methods of conceiving a genetically related child." Now, she says, "not even menopause releases the infertile woman from the 'obligation' to continue trying." Says Ryan, "When reproductive medicine denies finitude, when it denies 'the law of the body,' it fails patients in the area where they most need assistance: in discerning what is an appropriate pursuit of fertility."[11] Congregations need to find sensitive ways of assisting couples in such discernment.

Pastoral care that makes room for distress and grief

Pastors and other caregivers need to be sensitive to the emotional distress, anxiety, pain, and sadness experienced by both men and women as a result of infertility. I remember well the years of grieving every twenty-eight days over the loss of a potential life. During our decade of primary and secondary infertility, we didn't live by the year but by the month. "A couple exploring their infertility will experience physical, emotional, spiritual, and, perhaps, financial stress. The medical investigation may be protracted, intrusive, and at times like trying to finish a jigsaw puzzle without all of the pieces. Each month means a rollercoaster of hope and disappointment. Anger, fear, sadness, failure, helplessness, guilt, embarrassment, loneliness, and envy form a constellation of intense feelings."[12]

As a couple's infertility becomes apparent, they may feel isolation during social discussions of pregnancy, childbirth, and child-rearing. Well-meaning people often say insensitive things to struggling couples about God's will, about just needing to relax, or about being grateful for having at least one child.

Studies indicate that infertile couples often experience some sexual dissatisfaction or dysfunction.[13] The medical procedures used in infertility diagnosis and treatment often disrupt a couple's sexual spontaneity and privacy: "have sex repeatedly during this 48-hour period," "masturbate into this cup." When all attention is focused on sexual activity for the purpose of reproducing, intercourse outside the fertile period can seem futile or meaningless. Sex can become mechanical. Taking basal body temperature daily and timing intercourse can create performance anxiety that interferes with arousal and emotional closeness. Caregivers need to be sensitive to the tensions that may develop in the infertile couple's relationship.

Coming to terms with infertility is a process of mourning. For infertile couples, the anguish is compounded by having nothing tangible to mourn, and having no rituals to facilitate their grieving.[14] We have watched many friends experience the pain of miscarriage, a form of infertility with additional grieving. It has always been striking to me that in the church, where many people speak critically about elective abortion as "taking a life," we so readily shrug off a miscarriage as a bundle of expelled cells. Most churches provide no ritual to mark the loss, and the couple is expected to move on with life. The grief for those who experience miscarriage, and for those who never experience pregnancy at all, is profound, because infertility means "the loss of an image, of a dream, of a family—the joys and trials of parenthood and of genetic continuity—a link with the past and future."[15]

Pastors can contribute to healing by helping couples talk together about their feelings and the meaning of infertility for them, helping them understand their different perceptions and experiences, helping them renegotiate the meaning of their relationship. Often pastors will need to take initiative in these conversations because couples may keep their problems hidden.[16]

Rituals that mark transitions and resolutions

Our churches have many rituals and practices that celebrate the goodness of life—baptisms, communion, baby showers, weddings, flowers near the pulpit for a newborn child, public announcements of pregnancies and births. We do well to celebrate life. We also need to recognize how painful many of

these celebrations are for those who have experienced miscarriage, infertility, the death of a child, or other trauma related to the beginning of life. Most infertile couples I have spoken with say they can barely attend church on Mother's Day or Father's Day. The church has become more sensitive at marking these days than we once were, but I have been in services where all the mothers were asked to come forward to sing, or were all given a flower. Non-mothers remained seated, silent, flowerless.

As an adoptive parent, I am also conscious of how the adoption process is honored differently than a pregnancy. When we adopted Mia in 1998, about half of Goshen College's faculty families were pregnant—or so it seemed. In actuality, seven other couples were expecting. The college newspaper ran a story on the expectant parents. Whom did they leave out? Ann and me, who had been in the process of becoming parents for two years, and were within months of receiving our daughter.

Just as we need rituals to celebrate the children we birth, we also need rituals for anticipating adoptive life, for mourning the loss of early life and potential life, and for acknowledging the pain we feel and the adjustment we make when life is different than we hoped. We need to develop rituals for mourning the loss of dreams, and for marking the resolution of infertility through a decision to remain childless. These intangible losses are difficult to grasp for those who haven't experienced them. Some couples may choose to perform these rituals in an intimate setting, with a small group or a few faithful friends and family members. At other times the ritual may belong in the context of public worship, so that those grieving may experience the support of the larger congregation. Pastors have their ritual work cut out for them.

Does God care how we make babies? Yes, indeed. Does God want us to embrace the gift of life? Yes, clearly. Does God want us to walk alongside those who experience infertility, miscarriage and birth trauma, problematic multiple births and unintended pregnancies, seriously disabled children and the anticipation of disabilities? Absolutely. May God give us strength, wisdom, and grace to open the doors of conversation around beginning-of-life issues, so that we all may find space for hope and healing.

Notes

[1] Donna Foote, "And Baby Makes One," *Newsweek* (2 February 1998), 68.

[2] Dorothy Jean Weaver, "Biblical Perspectives," in *Bioethics and the Beginning of Life: An Anabaptist Perspective,* ed. Roman J. Miller and Beryl H. Brubaker (Scottdale: Herald Pr., 1990), 16.
[3] R. O. Evans, "Infertility," in *Dictionary of Pastoral Care and Counseling,* ed. Rodney J. Hunter, et al. (Nashville: Abingdon Pr., 1990), 579.
[4] Historically, Catholic tradition (and Protestant, to an extent) regarded procreation as the primary purpose of marriage and a major justification for sexual intercourse, which many church fathers deemed morally ambiguous. Most traditions, Catholic and Protestant, now recognize both procreative and unitive purposes in sexual intercourse.
[5] Weaver, "Biblical Perspectives," 17–19.
[6] In vitro fertilization involves combining a man's sperm with a woman's ova in a laboratory. After the eggs have been fertilized and the embryos reach the correct stage of development, the appropriate number of embryos are transferred into the woman's uterus. Gamete intrafallopian transfer involves removing eggs from the woman's ovary, combining them with sperm, and using a laparoscope to place the unfertilized eggs and sperm into the woman's fallopian tube through small incisions in her abdomen. Fertilization occurs in the fallopian tubes as it does in natural reproduction. Zygote intrafallopian transfer is a procedure in which the woman's eggs are fertilized in the lab using the man's sperm (similar to IVF). The fertilized eggs, called zygotes, are then placed in the fallopian tubes and travel by natural process to the uterus. Intracytoplasmic sperm injection is a procedure used when the male does not have enough active sperm to fertilize an egg in the normal way. A single sperm is injected into a mature egg and the fertilized egg is then transferred into the woman's uterus.
[7] Each attempt at in vitro fertilization, for example, costs $6,000–$10,000, and most couples make several attempts. See Robert Crooks and Karla Baur, *Our Sexuality,* 8th ed. (Pacific Grove, Calif.: Wadsworth Pub., 2002), 335. They document that most methods of assisted reproduction have a success rate of between 20 and 28 percent. Success rates drop dramatically for women over forty. When donor eggs are used with IVF, GIFT, or ZIFT, $3,000–$7,500 is added to the cost of each attempt.
[8] See L. S. Cahill, "Infertility Therapies, Moral Issues in," in *Dictionary of Pastoral Care and Counseling,* ed. Hunter, 579–80.
[9] Donald B. Kraybill, "Communal Responsibilities," in *Bioethics and the Beginning of Life,* ed. Miller and Brubaker, 194.
[10] Geoffrey Cowley and Karen Springen, "More Is Not Merrier: When Fertility Drugs Work Too Well," *Newsweek* (26 August 1998), 49.
[11] Maura Ryan, "The New Reproductive Technologies," in *Moral Issues and Christian Response,* 6th ed., ed. Paul T. Jersild, et al. (Fort Worth: Harcourt Brace College Pubs., 1998), 382.
[12] Evans, "Infertility," 579.
[13] Crooks and Baur, *Our Sexuality,* 332.
[14] Evans, "Infertility," 579.
[15] Ibid.
[16] Ibid., 580.

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Family by adoption

Brenda Srof

My story is particular, the story of one person, but it contains universals about the experience of infertility. I offer it in hope that such stories will help create congregations of believers who can talk with one another about infertility and know more fully what it means to be human, what it means to be vulnerable, and what it means to live abundantly in Christ.

My story starts with childhood, the place where our yearnings begin. My play as a child usually included acting out the role of mother. My favorite toy was my dad's discarded chess set. The king was the father, the queen was the mother, the knight was the butler, the bishops were the big sisters, and the family had eight pawn children. I built multi-level mansions out of record album covers and stacked wooden blocks, remnants of the construction my parents had done to make room for their fifth and sixth children.

I did not adopt a child for altruistic reasons, because a child needed me, but because I wanted to be a mother. I believe this attitude toward adoption is healthy. We adopt because we have love that waits to be shared.

Later, as a college student, I met Jody and we were married after our junior year. Perhaps because of our mutual love for children, we decided to start a family quite soon. As a result, we learned relatively early that we had an infertility problem. It was 1985, only a few years after the first test-tube baby was conceived, in 1978. Artificial reproductive technology (ART) still seemed an oddity, and people were not yet rushing to reproductive technology clinics.

I did the standard things, the daily basal thermometer readings and recordings, enough to paper a bedroom wall. I took hormones, went to the clinic for monthly blood draws, and had a hysterosalpingogram, a test to determine whether the fallopian tubes are blocked. I waited and waited. One Friday in desperation I called a friend who worked as a lab technician and asked her to

give me a lab result over the phone, so I wouldn't have to wait until my Monday appointment. I wanted intensely to be a mother and to nurture children. In the midst of my yearning, I felt dread: I hoped for the child that could be, feared that the child could never be.

Jody did the standard semen analysis. In the early going my doctor told me at every visit not to underestimate the male ego. I had a hard time understanding, because the infertility problem was largely mine. I both admired and resented Jody. He was a model of care and support. He tells me now that the worst part was feeling helpless, watching all of the procedures being done to me. But I resented him for the ease with which he accepted the infertility. For me, it was devastating. For him, biological procreation has never been as important.

In the midst of all the effort, I felt loss. Loss of the fairy tale life I had hoped for, loss of the expectation that we would bear children as an expression of our love for each other, loss of control, and loss of my sense of myself as a young woman, alive and fertile.

Jody and I were part of a Mennonite house fellowship that we had formed with five other families. The fellowship knew of our infertility, but we shared more intimately with our pastors, dear friends. They listened and offered encouragement, and we ate many meals together. The best medicine was the fellowship we had together. We felt support all around us, but when it came to making decisions, mostly Jody and I made them by ourselves.

We are both nurses, and in the midst of the infertility work we decided to go to Kenya to teach in a school of nursing. Just two weeks before we left, I had a diagnostic laparoscopy, a procedure in which a fiber-optic scope is inserted in the abdomen so the physician can see the reproductive organs. Several months after our arrival in a small Kenyan village, we received word: "I'm sorry, but barring a miracle, there is no medical hope for a pregnancy." We mourned, and we sighed in relief. We had come to a definite stopping point in our infertility work.

The next step was obvious: adoption. Recognizing that adoption can often be a waiting game, we decided to start as soon as possible. After several investigations into Kenyan adoptions proved fruitless, we returned to the States. On the day after we

moved to Indianapolis, even before the phone in our apartment had been connected, I started my search. Flipping through the yellow pages, I stumbled on the name of an attorney. I called him and blurted out, "I would like to adopt a baby, and I need some help. I just moved into the city, and I'm calling from a phone booth." He laughed at my desperation and my forthrightness.

The social worker told us, "You know, you will come to the place where you will realize that adoption is the best choice for you." I retorted, "No, adoption would never have been my first choice."

The next week we found ourselves seated in leather chairs in front of the lawyer's oversized mahogany desk. As we wrote out our check for the down payment on legal fees, he said, "I will not be finding a baby for you." He must have noticed my disconcerted gaze and went on to explain that he would provide ideas and support for locating an adoptable child. Then began the process of advertising and telling everyone we knew that we were interested in adopting a newborn. Private and modest about intimate matters, we had to overcome our reticence and summon the courage to shout from the rooftops, "Hey! We are here and we want a baby!"

Two months after our first meeting with the attorney, my parents visited us. My mother brought a handmade baby quilt. "You never know," she said. One of the social worker's home visits happened during their stay. Adoptive parents are the only parents who must prove their worthiness and suitability. As the social worker asked the standard questions, my dad chimed in, "Can you do something to find them a baby as soon as possible?" I was touched by my parents' support, and I hoped the social worker sensed it too.

The social worker told us, "You know, you will come to the place where you will realize that adoption is the best choice for you." I retorted, "No, adoption would never have been my first choice. It will always be the second choice."

Just a month later the phone rang. "I have found a baby for you," the lawyer told us. "The social worker is recommending that you be the parents." Four days after Anna was born we were holding her in our arms. She was divine: 4 pounds, 10 ounces—as lovely a child as there ever was or could be. The attorney was

wonderful. He wore pink socks the day we brought Anna home. In addition to being a professional par excellence, he has been an advocate for adoptive families in the Indiana state legislature.

The first to know were good friends from our small group at church. Two days after we brought Anna home, we took her, unannounced, to our regular meeting. Most of the people thought we were babysitting, but our friends had planned a surprise party. I will never forget their kindness. They had walked with us and now they were celebrating with us. Throughout the first week people brought food and gifts. Our pastors came to visit. As one of them held Anna, she tearfully exclaimed, "This is a miracle." And then she added, "This is more of a miracle than biological birth." I knew at that moment what the social worker meant. Adoption was the best "choice" for me. At a shower we received more gifts and cards. Tucked into one of the greetings was this note:

> *We've been moved by the way you've taken Anna into your family and made her your own; by the depth of your concern for her well-being—physical, emotional, spiritual; by the profundity of your love and prayers and care for her. Your adopting Anna in the way you have is an important testimony in the midst of a society obsessed with the biological meaning of family, a society that goes to bizarre and incredible lengths to give people the biological experience of being parents. Your becoming Anna's parents and receiving her as your own child reminds us that, as our faith teaches us, biology is the least part of being parents, a dispensable part, that in fact being family together is a moral and emotional and spiritual relationship and task.*
>
> *Anna's name means "grace." We know that she has graced your lives with her presence, and we think she is also a graced little girl to have you as her parents. Her blessedness makes us remember the Apostle Paul's description of us Gentile Christians as graced by God's adoption of us as his children. Paul tells us that we are included in God's family by adoption, grafted onto the old stock, through Jesus' life and death. In addition to*

bringing back into focus for us the moral and spiritual meaning of having children, your family models for us this grace of what it means to be God's adopted children.

Nineteen months after Anna's birth, our lives were graced by the arrival of Leah, again a beautiful four-day-old who joined our family as miraculously as Anna had. Again the outpouring of support from family and congregational members was immense.

What are the lessons of our experience with adoption? In the midst of infertility treatment, couples experience crisis. The rational gets blurred, and the broader view of the community and the world is threatened. The infertile couple's perspective becomes shortened and self-centered. The church has an important role in standing in the gap for them. Almost unawares, Jody and I experienced the church as an ever-present support.

Adoption is not an easy option. The process of adopting is filled with a broad spectrum of emotions. The adoptive couple must fill out many forms and try various strategies to find a child to adopt. The way is fraught with risks and disappointments. Many hoped-for adoptions are not completed.

Adoption is not an easy option. The process is filled with a broad spectrum of emotions. The way is fraught with risks and disappointments.

The story I have told is incomplete because it does not reflect the experience of my husband and, more importantly, of my children. As Anna and Leah become adolescents, we need to hear their stories surrounding the issues of identity and belonging. My children are fortunate to have many friends and relatives who have been adopted, to whom they can go for support and conversation. I hope that my adolescent children, as well as all adopted children, will find a voice within a society that sometimes does not understand.

Although our society has a fairly positive view of adoption, there is room for growth. A pervasive discrimination against adopted children exists. When an adopted child makes poor choices, people say, "Wasn't he adopted? No wonder." Often media portrayals of adoption focus on the child's return to her biological parents. I would urge a fuller acceptance of adopted

children and adoptive families. My hope is that the church will lead the way. I propose that congregations connect a person of prayer with every adopted child in the church, and every other child, to uplift them.

The world of artificial reproductive technology continues to be male dominated and paternalistic. Women often become objects in a system that de-mystifies conception and de-sanctifies the intimacy of childbearing. The medically dominated infertility industry can give women a sense of non-being within a system of needles and tubes. The church can respond by creating space for conversation and support for couples experiencing infertility.

Many people base their reproductive choices on their belief in a right to reproduce. This position raises questions: What are the rights of the children already here, whose birth was not desired? In the U.S., how do we justify the expense of ART in a system that does not provide basic health care services for the poor? Does the right to adoption and ART extend only to the affluent?

My story reflects the desire for a healthy newborn. I did not adopt a child for altruistic reasons, because a child needed me, but because I wanted to be a mother. I wanted to experience a kind of love and relatedness that is common in families. I believe this attitude toward adoption is healthy. We adopt because we have love within and around us that waits to be shared.

Miracles are abundant in life. As a community of believers we have a broad definition of abundant life that moves beyond our time and ourselves. Living with a sense of abundance, the true abundance found in Christ, will help us counter the fairy tale images our culture perpetuates. My fairy tale world was represented in my earliest play. Now I recognize that happiness is not found in living out one's childhood dreams. Rather, true contentment comes by living with faith in God and with gratitude for God's provision throughout life.

We often do not know what is best in each situation, but if we surround ourselves with people of integrity, we can, through prayer and support, walk a path, albeit a meandering path, that leads to a new day of hope and promise.

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Our infertility journey

Joan and Phil

Joan: As a child, I assumed my life would unfold in certain ways. I would go to college and prepare for a career; then I would get married, and I would have children. I succeeded with the first two, but it wasn't enough. I wanted it all. I wanted the fairy tale.

I assumed I would go to college and prepare for a career; then I would get married, and I would have children. I succeeded with the first two, but it wasn't enough. I wanted it all. I wanted the fairy tale.

Phil: When we were dating and thinking about getting married, we talked about how many children we would have. Joan wanted twelve, as in the book Cheaper by the dozen. *I* ***said*** *I didn't want any. I didn't think she really wanted twelve, although sometimes I wonder. I could have been happy without children, yet I knew they would be an important part of my life when we were ready. We joked about whether a compromise between no children and twelve was six or two.*

We got married and agreed that we weren't in a hurry to start a family, so we focused on school and careers for about five years. Then we decided we were ready. Many of our friends had children or were pregnant. It would be easy. The years of spending money on contraception were over.

We were excited to take the first step toward being parents. It was no great surprise when Joan didn't get pregnant during the first several months. As a child I had surgery to repair an undescended testicle, and her menstrual cycle had never been regular. After six months we began to get concerned, but we knew many women don't get pregnant after trying for half a year.

We had become close to another couple from church. None of us had family nearby, so we became family for each other. We spent

every Sunday evening with them, went on camping trips together, played games, and tried to solve the world's problems. They had a beautiful baby girl. As the months of trying to get pregnant crawled by, the man, a medical professional, made a clay model of a sperm and jokingly brought it to us as a good luck charm. We stuck it on our bedpost.

And then came the month my period was late! We bought a home pregnancy test and carefully read and followed the directions. We waited for it to turn blue. We read the directions two more times and sat on the bathroom floor, staring at it. We viewed it against the comparison stick again and decided it was slowly turning bluer, that we needed to wait just a few minutes longer. We watched that stupid test for twenty minutes before we admitted that I wasn't pregnant.

Joan made an appointment with her gynecologist. We were now officially infertile, a diagnosis that is not made unless people have been unable to conceive after trying for at least a year. The physician explained that forty percent of infertility is male-related, forty percent is female, and twenty percent is a combination. He said the least invasive place to start was to check for male infertility through a sperm sample. I remember my discomfort with taking the carefully collected sample to the lab at the hospital; I muttered what it was before making a hasty retreat. Two weeks later, when I got home one day Joan gently met me with the news that my sample showed no sperm. The doctor wanted to test another sample. Sure enough, no sperm. We didn't even tell our closest friends.

A consultation with a urologist resulted in outpatient surgery for a testicular biopsy and a vasogram. When Phil was in the recovery room, our dear friend was passing through, saw Phil, and became aware of his situation. He talked briefly to Phil, then came and found me in the waiting room. He was reaching out to us, and I was embarrassed not only about our problem but also about not confiding in our friends—and I pushed his caring away.

During the procedure the urologist thought he discovered a blockage in my vas deferens. He was confident he had cleared it. He asked me to wait two weeks and then submit another sperm sample. I optimistically

collected the third sample and with only minimal embarrassment turned it in at the lab. The results came back a week later: no viable sperm. We got rid of the sperm model on our bedpost.

The next consultation with the urologist was sober. Phil's only viable option was medication, an expensive drug that would give him at most a ten percent chance of sperm production. Did we want to spend a lot of money on an outside chance that this approach would result in pregnancy? If it wasn't successful, we'd have lost more valuable time. Was it morally appropriate to spend money on this medication when many people have more pressing needs?

Were we not supposed to have children? Were we unfit to be parents? The minister at our wedding had asked God to bless our marriage. If we couldn't have our own biological child, was God withholding a blessing?

Where was God in all this? We were angry. Depressed. Trying to live our lives and do our jobs. What were our options? We still wanted children, didn't we? Were we not supposed to have children? Were we unfit to be parents? Could we go on with our lives without the children we had dreamed about? The minister at our wedding had asked God to bless our marriage. If we couldn't have our own biological child, was God withholding a blessing?

We decided against the medication and were referred to an infertility clinic. We lived in a metropolitan area and were fortunate to have two clinics a short drive away. At our first consultation, the infertility specialist said we had two options: adoption or donor insemination.

Donor insemination. Now we had new questions to answer. How comfortable were we with using another man's sperm to make Joan pregnant? The clinic would try to match the donor's eye and hair color, height, and weight to mine, but we would know nothing else about the donor besides what his sperm count was at the time of donation. Donor insemination was the only way Joan could experience pregnancy, the only way she could be a biological parent. What would other people think? Would they disapprove? Did we care whether they approved? Would people take their disapproval out on our child?

Again, we didn't readily share this dilemma with others. Were we afraid of being judged, afraid people would look at me as inferior or defective? Did we feel inferior to people who could have children? Did we want to save them from feeling bad that they could? Maybe we were angry that she got pregnant every time he looked at her, or because people make jokes about sperm donations, or because sometimes people aren't comfortable with the idea of donor insemination.

I knew all the answers in my head, knew that infertility had nothing to do with my masculinity, was not related to my abilities as a lover, and was not a punishment from God. Yet emotionally I struggled.

We decided to go with insemination. We filled out the paperwork, I endured the full-body physical and more blood work, and we answered a written psychological assessment. We also had to provide evidence of our financial means and medical insurance.

I wrestled with questions related to my infertility, the fact that I would never biologically parent a child. I knew all the answers in my head, knew that infertility had nothing to do with my masculinity, was not related to my abilities as a lover, and was not a punishment from God. Yet emotionally I struggled. Was I less of a lover because I would never get my wife pregnant? Would Joan still want to be with me sexually if I was incapable of fathering a child? I had believed that carrying my family's genes to the next generation was part of what I would contribute to the world. What good was I if I didn't make a lasting contribution by fathering children? Intellectually I knew this question was ridiculous, but on a gut level I wasn't so sure.

For me, infertility became pervasive and consuming. It affected my body and my self-esteem. It interfered with my job. I started a daily regimen of oral medications to regulate various hormones. Again we made assumptions: now that we were working with an infertility specialist, I would be pregnant in a few months. Wrong. Medication, blood draws, ultrasounds, two days of hormone injections, and two days of inseminations. I learned through an insurance form that I had polycystic ovarian syndrome. After six months I still wasn't pregnant.

Medications changed. I had a hysterosalpingogram. Phil needed to give me daily injections. I spent summer months

wearing long sleeves to hide the bruises on my arms from the many blood draws. And there were bruises on my hips from the injections.

Every month was a roller coaster ride. Surely this month it would work. Each insemination was followed by two weeks of waiting, then the blood test, and then the call from the doctor's office to tell me I wasn't pregnant. Frustration and anger set in. Everyone was pregnant but me. Seeing teenage mothers and people mistreating their children made me furious. I stopped going to baby showers and we didn't go to church on Mother's Day or Father's Day. We would make great parents. We had the financial means and the love to care for children. It wasn't fair.

Life went on, and still nothing. Again, my medication was changed. Finally, with a drug of last resort, I administered shots in my stomach each morning for two weeks before starting the other medications; the injections continued until the inseminations. Our infertility specialist recommended that if this didn't work, it was probably time to think of quitting. We knew he was right. We had invested a lot of emotional energy, time, and money. But we were coming to the end. I was devastated.

The emotions I faced during this time were new and more intense than I was used to feeling. I remember walking from the parking lot to the grocery store one day, seeing a young couple walking toward me holding their baby. I was immediately hit not just with sadness but with anger. These two couldn't have been more than eighteen or nineteen, and they had a baby. Joan and I loved each other and had so much to offer, and we had spent so much time, emotion, and money for nothing. It wasn't fair. I was almost even with the couple when I realized they were carrying a sack of potatoes!

Another insemination, another two weeks of feeble hope, another pregnancy blood test. And the inevitable phone call with the results. The nurse, whom I knew well by this time, said the doctor wanted to talk to me. He got on the phone and said he would recommend we quit trying to get pregnant. With tears in my eyes, I was in the process of concurring when he interrupted and said, "Because you are pregnant! And, in fact, the blood work looks like it's more than one! What do you think of having twins?"

Pregnant. It was unreal. Unbelievable! We'd begun the process of looking at other options, had just become licensed foster parents, and were considering adoption options, and now we needed to do a major adjustment. Pregnant, and with two! Then an ultrasound three months into the pregnancy showed one of the babies had died. "A common occurrence," the doctor told us, "but most people don't know it because they don't have ultrasounds this early." But we did know, and we were deeply saddened by the loss. After that we were afraid to enjoy the pregnancy fully, to get our hopes too high. We tried to remain somewhat unattached. What if something happened to this baby too?

My father died when I was a teenager. Unconsciously, I put up an emotional wall to protect myself. I was not going to let myself ever truly love again. But when I held our newborn son for the first time and looked him over, I was filled with immense wonder and joy. The next day, as I was with him, he choked and couldn't get air, and the nurse tried urgently to suction out his mouth and throat. When he began turning blue, she dumped him in the bassinet and ran with him out of my room and down the hall. I thought we had lost him. I was alone for twenty minutes, unable to get out of bed, and frantic. Phil's parents happened to call and stayed on the phone with me until the nurse brought our baby back. They had used a stronger suction device on him and then given him oxygen, and he was fine. And as he grew and I took care of him, that solid wall I built so long ago slowly crumbled. I now love fully again. Yes, I'm still afraid of loss, but I live in the moment.

We went back to the infertility specialist several years later, hoping to have a second child. Knowing what had worked before, we thought this time would be easier. But after almost a year and a half of unsuccessful treatment, we set a time limit on trying. One month short of our deadline, we decided it was not to be. We had spent a lot more emotional energy and money on trying to get pregnant and were content with our family as it was. It was nice to have a sense of closure, to no longer dread the inevitable call from the doctor's office that reported "not this month." We agreed. But Joan wanted to try just one more cycle: if we didn't try the last one, she'd always wonder "What if…"

That was eight years ago. Our oldest son is now twelve and the twins are seven. We have told the children, in age-appropriate ways, about their biological beginnings. They will know and will need to know this information in various ways throughout their lives. When their physicians ask them for their family history, they will have to say they don't know about their biological father's side of the family. When they study genetics in biology class, they won't be able to document one side of their heritage.

At this point, it doesn't appear to be an issue for any of the children. If it becomes an issue, something they struggle with, we'll be there to help them if they want us to. And if they don't want to discuss it with us, if they just need to be angry with us, that is their right as well, and we'll support them, although it will hurt like crazy.

I don't think about infertility every day as I did for years. It no longer consumes me. In fact, it's not much of an issue. Occasionally a television show or a song will remind me. Sometimes I am reminded when I look at the children. The sadness has become old and familiar, something I'm aware of, only now I can smile about my insecurities rather than obsessing about them. I feel blessed to have three wonderful children, and I focus on how to be the best parent and husband I can be. Now I struggle with how difficult parenting can be, aware of my shortcomings as a father, striving to be more patient and less negative. I love being married to Joan, I love being the kids' dad, and I am truly a lucky man who has so many opportunities to pass on the joy of life to these three wonderful children.

I wish we could have been more open with other people, telling them of the choices we were given, and relying on their care and friendship. Our struggle with infertility was a big burden to carry alone; we could have used the help of the church and of our friends. Our families and the friends we have told have been supportive, and their support has been helpful. The members of our church still don't know, but their not knowing doesn't weigh on us as it once did. I wish it had felt safe to discuss these issues, to sense openness to talk about our infertility difficulties. We were hungry to do so.

About the authors

Joan and Phil (not their real names) thank you for reading their story. They have lingering doubts about how safe it would be, especially for their children, to offer their story publicly using their own names. They wonder if you think it is wrong to use donor insemination. Do you question their judgment in spending thousands of dollars to have children when many children need adoptive homes? Joan and Phil wish pastors wisdom and sensitivity in dealing with congregation members who are struggling with beginning-of-life issues.

When miscarriage steals pregnancy's promise

Melissa Miller

When I lost a pregnancy I had long wished for, I learned firsthand that while "pregnancy means holding something absolutely full with tomorrow, full of joy and promise, . . . miscarriage steals all that . . . suddenly, cruelly, inexplicably."[1] I had known the pregnancy was tenuous, but I so desperately wanted to carry it to term that I gave little heed to the possibility that it could end prematurely. When it did I was plunged into a pit of grief.

Essentially, miscarriage is loss, and grief is the emotional consequence of loss. This particular experience of loss is common—nearly a quarter of pregnancies end in miscarriage, usually in the first trimester—but pastors do well to remember that each person affected by miscarriage codes it differently. Appropriate pastoral care will be informed by an awareness of the uniqueness of each pregnancy and will be responsive to the particular circumstances of the loss: What did this pregnancy mean to this woman, to this father, to this sibling, to this grandparent?

Miscarriage is loss, and grief is the emotional consequence of loss. This particular experience of loss is common, but pastors do well to remember that each person affected by miscarriage codes it differently.

Pastors can respond most helpfully if they gauge the significance of the loss. Factors that contribute to the nature and intensity of grief experienced in the premature end of a pregnancy include these: Was the pregnancy planned and desired? How long had the couple been trying to conceive? Is it a first pregnancy? Has the woman had other miscarriages? How long was she pregnant? What medical factors are part of the picture? Did the child live outside the womb? If so, how long—moments, days, weeks? What kind of contact did the parents have with the child? Did they name their baby? What is the mother's physical and emotional condition? If it was a multiple pregnancy, did any child

survive, or is the couple dealing with the death of more than one baby? What medical care has the woman received? Did her doctor give a reason for the miscarriage? What other losses has the family experienced? What resources for dealing with their loss does the couple have? How resilient are they? What is their capacity for responding to their loss? What connections do they have that nourish their interest in caring for young life (other children in the family, nieces or nephews, volunteer activities in church or community)?

Assessing these factors can be delicate. Although some people in our society speak publicly about the intimate details of their lives, many people find it hard to talk about their difficulties surrounding conception and pregnancy. The subject touches on one's body image, identity, and sexuality—all core issues.

Those whose grief is intense after miscarriage may experience deep sadness, lethargy, depression, guilt, loss of appetite, heightened emotional sensitivity (mood swings, frequent weeping), anger. A woman's body undergoes physical changes as hormone levels adjust to the abrupt shift from the demands of pregnancy to a non-pregnant state. She and her husband need care—self-care, and the care of their church community.

Pastoral care after miscarriage

When a couple in your congregation experiences the losses arising from miscarriage, encourage your community to reach out with tangible signs of love and support, with meals, cards, flowers, visits, touch, prayers.

Allow those who are grieving to rest from their church duties. Avoid pressing people to get over their grief and get on with normal life; such expectations may short-circuit their mourning. When the time is right, when they are ready to resume their responsibilities and re-engage with life, make room for them to return to their usual activities.

Remember that while grieving people may find coming to worship comforting, they are also likely to find it exhausting. Many Sundays I gazed out the tall church windows and watched the play of light on leaves, oblivious to the words of the service.

Keep in mind that miscarriage often affects each of the prospective parents differently. Sometimes a shared loss unites and

strengthens a couple, but sometimes grief drives a wedge between people, and their isolation compounds their pain.

Generally, women react to the loss of miscarriage more intensely than men do. Attend to the intensity of the mother's experience. A pregnant woman carries life within her, which gives her a direct connection with a transcendent life force. Pregnancy is an intimate, holy time. The mirror side is that the death occurs in her body, and the bleeding or medical attention she experiences is a vivid reminder that a life is leaving her, and that her body is participating in a death.

Allow those who are grieving to rest from their church duties. Avoid pressing people to get over their grief and get on with normal life. Remember that while grieving people may find coming to worship comforting, they are also likely to find it exhausting.

Support the child's father in naming the losses of miscarriage for him. His response may be more muted than his wife's, and it may emerge later. Encourage him to find ways to mark his sense of loss, and invite his participation in a mourning ritual.

Remember other family members by inquiring about the significance of the pregnancy for them and about how they are handling the loss. Offer a kind word to grandparents. Take time to greet young children in the family, eyeball to eyeball, and express your sorrow. Acknowledging the loss by saying "I'm sorry your mom's baby died" allows the child to receive sympathy. Respectful, tender touch, such as a shoulder squeeze, can be a comfort.

The gifts of a supportive community

My second pregnancy occurred after six years of secondary infertility, when my spirits were depleted by a wearying cycle of unfertilized eggs, monthly bleeding and grieving, and invasive fertility technology. During those years, the fruit of my first pregnancy, our lovely, healthy son, bounced in and out of my sad space with his mellow, affectionate sunniness. I experienced two subsequent miscarriages, and no additional children in our home filled my need to parent. The lost pregnancies haunt me years later, as I often imagine the children who would have been, how old they would be now, the relationship we might have had.

I had a wonderfully supportive community and excellent, sensitive medical care. After my first miscarriage, my parents drove seven hours to hug me and cry with me, bringing a tiny rose plant. Friends sent flowers and food. My pastors visited and prayed. Other friends penned cards expressing sympathy and care. One family offered the use of their cottage as a retreat.

As the weeks passed, friends continued to inquire about my well-being and to offer their love. One, a pastor, visited me regularly and sat beside me in silence. Whole chunks of time passed as we sat; sometimes she held my hand. The depth of wordlessness was new to me. I was in so much pain I had nothing to say to my visitor, but I knew that it was better with her beside me than if I had been alone. While I mostly remember overwhelming, numbing pain, I also recall her presence as a slight breeze, ever so gently caressing and comforting my spirit.

Another gift my pastoral friend offered was her avoidance of questions. Responding to constant "How are you?" inquiries required more effort than I could muster, even as I knew people were asking out of genuine concern for me. My friend would simply say, "I am concerned about you," or "I am praying for you," statements that registered her care without requiring any response from me.

The other side of silence

Silence has another side, which does not contribute to healing. Sometimes we remain silent in the face of grief because we are uncomfortable with another's pain, perhaps because we fear our words will make it worse, perhaps because we have not come to terms with our own experiences of loss. Only those who have resolved this discomfort will be able to acknowledge the other's struggle and be present in it.

In the weeks after my first miscarriage, many older women confided to me their experiences of lost pregnancies. I had known many of these women for years, and I was surprised at how many had experienced miscarriage, and stunned by how much silence surrounded those losses. Older generations maintain more privacy around intimacies such as pregnancy and miscarriage, but I suspect the silence sometimes inhibits people's ability to mourn and come to terms with their losses.

Marking the loss in the congregation

The key to pastoral care in miscarriage is acknowledging the loss a couple is experiencing, and then helping them decide how the church can assist in marking that loss. Some people are comfortable sharing their loss openly with the congregation, while others prefer private expressions of grief. Helpful actions may include placing a flower in front of the church in memoriam, announcing the miscarriage and praying for the family during Sunday worship, planning a service of mourning and burial, planting a tree in the child's memory, inviting memorial contributions to a charity of the parents' choice, offering counseling, providing reading materials and other resources, and arranging visits from an elder or a woman who has experienced pregnancy loss.

The journey through grief is a solitary one in many ways, because pain is intensely personal. However, church members can help by communicating "I care that you are sad," "I will remember your loss," "I will accompany you on your journey," "God loves you." As time passes, anniversaries may remind the woman of her lost pregnancy. She remembers the date she miscarried and the expected date of the baby's birth. For years, these dates may bring feelings of intense sadness. The church community can comfort the woman by remembering these dates with her for the first year or two, by means of a card, a phone call, or a kind word.

An old adage says that sorrows shared are sorrows halved. Incorporating acknowledgements of loss in church life is a way of carrying the burden of sorrow with those who grieve.

Some church events may trigger intense feelings. Mother's Day celebrations are overshadowed by pain. A sensitive congregation could honor that pain by recognizing shadows in Mother's Day services. Soft-colored candles burning at the front of the church could mark lost pregnancies and children who have died. Red roses might be offered as memorials of mothers who have died. An old adage says that sorrows shared are sorrows halved. Incorporating acknowledgements of loss in church life is a way of carrying the burden of sorrow with those who grieve.

Women need permission to avoid community events that rub their wounds raw. Child-parent dedications and baby showers can

be excruciating. Women benefit from reminders that their value does not depend on their capacity to have children. Pastors need to guard against conveying the message that women are best fulfilled as mothers, or that mothers are more valuable than women without children. Biblical texts that reflect such views should be used with great sensitivity. Pastors should affirm our human capacity to bring to life things other than children, highlighting other ways to create and care and nurture, such as art and craft, volunteer work, participation in church and community organizations, and sharing financial resources.

Pastors are not responsible to fix anyone's pain. The hurt of those who have experienced miscarriage *is* pain, and should be respected as such. Knowing that it is *only* pain helps us put boundaries around it and see that life holds other things as well.

Pastors may be able to help people bring resolution to old hurts. In a cultural and religious climate that allows greater acknowledgement of personal losses, people may benefit from the opportunity to revisit deaths of long-ago and mark them in a way that was not possible earlier. One pastoral couple recently helped a family "bury" their daughter, who had died five years earlier after her premature birth. In another situation, a pastor, at the request of the eldest daughter, was able to help a family acknowledge and grieve a lost pregnancy that occurred twenty years before. In both cases, pastors were key in helping family members find some healing for old hurts.

Pastors may have their own experiences of loss that affect their response to parishioners. In one congregation, a group of women prayed their pastor, who was dealing with infertility, through her leadership of parent-child dedications. They gathered before and after the ritual for prayers, hugs, and tears. Pastors are better able to care for others when they have found support for their own needs.

For some people, the consequence of miscarriage is chronic grief, which may take years to resolve, or may never fully be resolved. Our theology often reflects our culture, which makes "getting over it" a priority. We have a hard time knowing how to respond to those who have chronic conditions, degenerative diseases, slowly progressing terminal illnesses, or persistent mental

health problems. Pastors and church members can benefit from cultivating an awareness that some issues do not resolve. Congregations can help by developing a tolerance for grief that persists, and an ability to stay with people who live with chronic grief.

Pastors and congregations need to remember that they are not responsible to fix anyone's pain. The hurt of those who have experienced miscarriage *is* pain, and should be respected as such. Knowing that it is *only* pain helps us put boundaries around it and see that life holds other things as well. A pastoral response that acknowledges pain and offers sensitive companionship may be one of the best ways to convey God's healing presence and to invite grieving people to journey on with God, who's "got the whole world in his hands."

Notes

[1] Michaelene and Linus Mundy, "Mourning a Miscarriage," *CareNotes* (St. Meinrad, Ind.: Abbey Pr., 1998), 1.

About the author

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A service to mark a miscarriage

Melissa Miller

Preparations

Set a time and place for the service, and invite participants: mother, father, family and friends who were supportive to the parents during the pregnancy and loss. Invite parents and others to bring mementos, such as ultrasound pictures and baby clothes.

Invite all participants to bring a symbol of the lost pregnancy, something they may wish to bury. Line a basket with a cloth or small blanket to collect symbols.

Select something to plant: a flowering plant, a shrub, a tree. Gather planting supplies: a shovel, water, fertilizer. Decide where the plant will grow and dig a hole big enough for the symbols and the plant.

Have plenty of tissues on hand.

Arrange for music (live or recorded) to play quietly as people gather.

If you plan to conclude with a meal, ask participants to bring soup and bread to share.

Music for gathering

Welcome

Opening prayer

The pastor prays.

"Loving Mother/Father God, we ask that your presence embrace us today. We come with heavy hearts as we gather with [names of parents], to mourn the loss of their child, [name of child]. The new life you gave brought promise and joy to them, and they had already begun to plan for the ways this child would change them. Suddenly that life ended and they are left with an empty space in their homes and their hearts. We share their confusion, their sadness, and their anger that such a fragile life with so much possibility was taken so suddenly. We are helpless to know how to find answers to our questions. Be with us as we lay this young life and its possibilities to rest. Amen."

Song

The group sings one of these songs, or another of the parents' choosing.

My shepherd will supply my need

Children of the heavenly Father

Scripture

A reader reads one or more of these texts, or others of the parent's choosing.

Psalm 139:1–6, 13–16

Ecclesiastes 3:1–8

John 14:1–4

Naming the Loss

If parents have indicated in advance that they would like to speak, invite them to talk about their experiences with this child, about their hopes and feelings about the pregnancy and the miscarriage, and about the mementos they have gathered. If they prefer not to speak, observe a time of silence, or have someone read a statement that the parents have written or that in some way conveys their feelings.

The parents place in the basket the symbols they plan to bury.

Others may speak briefly, offering their memories and expressions of sympathy.

Participants place in the basket the symbols they plan to bury.

The pastor prays.

"We name this loss in your presence, loving Lifegiver. We looked forward to having this child in our midst, and we thank you for the joy this brief life brought to us. We now ask for your strength and healing in our time of sorrow. Amen."

Burial

The group moves outdoors, taking the memorial plant and the symbols wrapped in the cloth or blanket. The pastor says:

"We bury these symbols to acknowledge that we have been touched by this young life, we have loved and been loved in our hope. We give this life back to God, recalling that Jesus, through his death and resurrection, has overcome death."

The symbols in their blanket are placed in the hole where the tree will be planted.

Planting
The pastor says:
"We plant this tree in memory of the child who came to [parents' names], and as a symbol of the new life we hope for and ask God to give them."
The tree is planted.

Prayer
Participants link hands in a circle around the tree. The pastor prays.
"As we encircle this memory tree, we know we are encircled by your love, gracious God. Help [parents' names] release this little life back to your care. May the tree that we plant today grow strong and bear fruit and be a symbol of the new life that you provide to each one of us, especially to [parents' names]. Amen."

Song
The group sings one of these songs, with appropriate verses.
Kum ba yah (someone's crying, singing, praying)
God is so good (God heals our pain, God brings us life)

Affirmation of life
The group shares a simple meal of soup and bread, or participants give parents a hug or words of sympathy and affirmation before departing.

Hannah
Her story

Rachel Miller Jacobs

You probably already know this story. It's an old one. A woman is loved by her husband but has no children. In that one sentence there is a whole lifetime of sorrow. Each time the story is told the names change, but the results are the same. Every month, hopes for a pregnancy build up and are dashed. Every year, empty arms cradle the air where a baby should have been.

I could picture my son in complete detail: fine, brown hair, like mine; Elkanah's nose, but smaller; my mother's eyes; tiny perfect fingers and toes; the sweet baby way the back of his neck would smell as I held him against my shoulder. But my son never lived anywhere except in my imagination. I cried out to God, and nothing happened. I prayed, but God didn't listen.

I could picture my son in complete detail. But he never lived anywhere except in my imagination. I cried out to God, and nothing happened. I prayed, but God didn't listen.

Eventually, Elkanah took another wife. No one asked me what I thought. It wasn't for me to decide. Elkanah's new wife was pregnant within the year, and every couple of years after that. You can imagine what that was like: babies everywhere I turned, and none of them mine. It seemed like the whole world was pregnant. With each new baby, a little of my own life drained away. Many nights I cried myself into a restless sleep and got up in the morning more tired than I'd gone to bed.

And I couldn't help but hear what people called us, the nicknames they gave us. For me, *Hannah*, "charming, attractive." My beauty, such as it was, the only thing worth mentioning. For her, *Peninnah*, "fertile, prolific." Her childbearing the only important thing about her. It's a terrible thing to do to people, to make them nothing but one thing, as if charm or fertility defined us entirely. You see, I was a good weaver, and she could do

numbers in her head better than anyone else in the village. Between the two of us, we made our husband a wealthy man. But we lived like Rachel and Leah, each wanting what the other had, taking out on each other our grudges against God and our husband.

So our lives went, season after season. Babies for her, empty arms for me, work for both of us, each day the same as the one before. There was one high point in the year, though. Every spring, Elkanah took us all to sacrifice at the house of the Lord, at Shiloh. He liked to make a trip of it. I suppose it was both a sort of vacation and an opportunity to show off his children. It was a lot of work, though, getting ready. You know how that is. Even if you're looking forward to a trip, getting out the door is so tiring, you'd almost rather stay home.

The children whined about the walking, and feeding everyone took more time than usual, because we didn't know where to find water or firewood. Peninnah was usually pregnant or nursing, and she'd complain about how exhausted she was and leave most of the work to me. The people meeting us on the road would comment about all the children, repeating the same old saying about how good it is for a man to have a quiver full of arrows. The women would murmur to me, "How fortunate you are," and then, miraculously, Peninnah would be filled with energy and cut in, "But these are all mine. Hannah is barren." Everyone's eyes would get big to see so many children from one woman, and they would glance in my direction with pity, too embarrassed to say another word.

Even making the sacrifice at Shiloh pointed out my childlessness. Elkanah gave Peninnah a sacrifice portion for herself and one for each of her children, more portions every year. But I always received only one portion. So even in worship I was all alone. Peninnah would look at me pityingly and say, "Poor Hannah," not really meaning it.

One year it was too much. Each step bringing me closer to the shrine was harder than the last, until finally I could barely put one foot in front of the other. Peninnah was in a terrible mood. Her youngest was teething and she was pregnant again, and this time the pregnancy was eating her from the inside out. Her eyes were rimmed with dark circles, her hair dull, her ankles swollen, and

her back ached constantly. Everyone was giving her and her sharp tongue a wide berth.

As we were finishing the sacrifice, Peninnah sidled up to me. "You think you're so perfect," she hissed. "But it's me that's the real woman, me that's the real wife. You're just a plaything for Elkanah. What good is a woman who can't bear children? It's only because he's got such a soft heart that he hasn't divorced you."

At her words, something inside me broke open. I started to cry, and it was as if every tear in the universe had somehow collected in my body and was rushing to get out. I cried until I thought it wasn't possible to cry any more, and still tears ran down my cheeks. My voice got hoarse from wailing, my nose burned from wiping it on my sleeve. At the evening meal, I couldn't even stand to look at food. "Baby," Peninnah jeered, disgusted. "You're just a big baby. I don't know what he sees in you."

"If you finally see my suffering and remember me, and if you give me a son, I will dedicate him to your service for his whole life." It is a terrible thing to plead for a child, to beg, to cry out like that. But I did it. I was desperate.

Elkanah was no better. "Hannah," he said, "why are you crying and not eating? Why are you so sad? Am I not more to you than ten sons?" What I longed to hear was that *I* was worth more to *him* than ten sons. But he'd had a long walk and was hungry, and he had the sons he wanted.

I left them both and ran back to the sanctuary, flinging myself to the floor. "How can you forget me, O Lord of Hosts? If you look on me, if you finally see my suffering and remember me, and if you give me a son, I will dedicate him to your service for his whole life." No woman should have to bargain with God to become a mother. It is a terrible thing to plead for a child, to beg, to cry out like that. But I did it. I was desperate.

As I was praying, the priest, Eli, tried to hustle me out. "Stop making a drunken spectacle of yourself, woman! You should be ashamed of yourself for mocking the name of the Lord with your rantings!"

When I look back on it now, it amazes me that I could even answer him. Was everybody against me? "You're wrong," I said. "I'm not drunk. In fact, I've had nothing to drink. I've been *praying*—pouring out my heart to God."

"Oh," Eli said. I think he was embarrassed. When he actually looked at me, he could tell I was what I said, a righteous woman, come to the sanctuary to pray. "Then go in peace," he said, "and may the God of Israel grant what you asked."

So I left, and I broke my fast, and I waited to see what God would do. Something had changed inside me. I'd been honest with God, and God had received what I said. There was no miracle, no sudden lifting of depression, no heaven-sent joy. Just a kind of letting go. And I conceived.

Some will say I got pregnant because I relaxed, or because I gave God my problem, or because it wasn't God's will any more for me to be barren. And I'm telling you, none of it's true. I still wanted a baby. It wasn't a matter of relaxing. God didn't love me any more after that trip than before I left home. And God could have done whatever God wanted to do without my becoming pregnant. This doesn't mean, though, that God had nothing to do with what happened to me. It's just that I don't believe God was involved in any way you or I could imagine or explain. So I don't try to explain any of it. I try to accept it.

My pregnancy was uneventful. Things went as smoothly for me as if I'd been young, and when my time came I gave birth to a healthy son. When the midwife lifted him up to me, and I held him for the first time, I wept for all the children that had never been, and for this little one who finally was. And I named him *Samuel,* because I asked God for him.

Samuel was born a couple months before our annual trip to Shiloh. Elkanah asked if I wanted to go along, but I said I was staying home. "I'm not taking the baby until he's weaned, because once he's been presented at the shrine, he'll be staying there for good." Elkanah agreed.

So I nursed my Samuel until he was fully weaned. And the year of his third birthday, he and I made our trip to Shiloh with the others. Along with our usual sacrifices, we took along three bulls, one ephah of flour, and a jar of wine. When we had slaughtered the bulls, Elkanah and I brought our son to Eli. And I said to the old man, "I'm the woman who stood here four years ago, the one you thought was drunk. It was this boy I prayed for, and God granted me what I asked. So I'm lending my son to the Lord. As long as he lives, he is lent to God." And we bowed down very

low, our faces to the ground. Then we left our son, our Samuel, at the shrine at Shiloh. He was never really ours anyway. God lent him to us, and we lent him back. And we returned home.

Samuel is eleven now, and every year when we go to Shiloh, I bring him new clothes I've sewn for him, bigger each time. He's a handsome boy, and bright, too, but somehow distant from us. God's hand is on him, and it's as if there is a veil between us. He isn't like other boys. I know, because I've had three other sons, and two daughters, too, in the years since his birth. I only had to beg for my first child. The others have come to me easily, although living with them is another story. You know how that is. They are good children, and I'm glad they're mine. But I keep being surprised by how different it is to be a mother than to imagine being a mother. I learn something new every day.

Peninnah and I have made a sort of peace with each other. Having children loosened my hold on Elkanah, making some room for Peninnah in our household. I see more clearly now how much she too has suffered. But she is old before her time from so much child-bearing, and I am made young by my children, so the old jealousies die hard. It isn't easy to be a woman.

Here's what I know. I know that God isn't just interested in famous men and important events. God's grace takes unlikely paths, catching us by surprise, using ordinary people like me to bring new things to birth.

And I think a lot about what happened to me, turning it over and over in my mind, trying to make sense of it. How can I explain such sorrow, and such joy? But here's what I know. I know that God isn't just interested in famous men and important events. God's grace takes unlikely paths, catching us by surprise, using ordinary people like me to bring new things to birth. I think often of Sarah, whose son, born in her old age, became the father of our people. Who would have guessed it, all those years ago, when it looked like she would die without descendants? That's how God is. God surprises us. We think we have it all figured out, but when it feels hopeless, when it seems like nothing can change or no good can come from a situation, God is there, making a difference.

And something else, too. It's not just that God likes to surprise us. It's that when God gets involved, everything turns upside

down. I, a barren woman, became a mother. And I'm not the exception, either. Look around you, and you'll see plenty of evidence that God is working in unlikely places and through unlikely people. I mentioned Sarah, who, like me, became a mother in her old age. There's also Miriam, Moses the stutterer's sister, who outwitted the Pharaoh to preserve her brother's life. And Deborah, the prophetess, who became one of the greatest judges in Israel, advising military rulers. And Ruth, the foreigner, who became one of the mothers of our people. The list goes on and on. We prevail not by our strength alone, but also by the power of God.

I look around at you, women of a time and place far from mine. I see that, like me, you will not arrive to old age strangers to grief or suffering. I know you will live long lives and remember times when you cried out to God in anguish. I look at you—you seem like ordinary women, too—and I wonder how God will use you to bring something new to birth. What will you plead with God for? What promises will you make? What surprises lie in store for you? I don't know the answers to these questions. But I do know that God is faithful, and my heart rejoices.

About the author

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Reflections on prenatal diagnostic testing

Sherry Wenger

Our second child, Elise, was born at Thanksgiving in 1998. I was thirty-nine years old and the pregnancy had been difficult. Within minutes of her birth, Curt and I were told that she had Down syndrome (DS), an assessment based on clinical features including her almond-shaped eyes, flat nasal bridge, and the single crease on each of her palms. A heart defect required surgery within a few months. Illnesses, feeding problems, and growth issues necessitated more hospitalizations. In addition to medical specialists, many therapists have worked with Elise. Despite intense challenges, she has thrived and has brought immense joy and meaning to our lives. God has been present in our journey. Now a relatively healthy preschooler, she is learning all the usual things, at her own relaxed pace, and we stand amazed as God uses her to work out his purposes.

At its best, the church embraces each new life as precious, feels gratitude for every child's gifts and talents, and watches for God's purposes to unfold in each child's life.

"Did you know?"

Since Elise's birth I have been involved with a local DS parent support group and the local early intervention board. As a result, I have interacted with many families with children who have special needs. I am always interested in hearing their stories about when and how they learned they had a child with special needs. In the support group, when a new mom joins, the others ask, "Did you know?" The time of awareness is a pivotal point in the journey, and we identify each other according to whether we chose to know before the child's birth and why or why not.

At the usual time, during the second trimester of my pregnancy, my nurse midwife offered a standard prenatal screening test. Prenatal screening tests measure levels of substances in a

small sample of maternal blood to indicate if the baby is at higher risk for neural tube defects such as spina bifida,[1] and chromosomal abnormalities, including Down syndrome. For several reasons I declined to be tested, as I had two years before when I was pregnant with our first daughter, Olivia. My convictions about the sanctity of life meant that I would not have an abortion even if I knew that my baby had a birth defect. As a nurse, I also knew that this test is not diagnostic and has a high false positive rate: many women who have abnormal levels of the substances measured will deliver healthy newborns. Several of my friends had abnormal test results and spent much of their pregnancies worrying; one even delayed bonding with her baby as a result.[2] Finally, the test could only give me the limited information that my risk of having a baby with one of these abnormalities was higher than usual, but I already knew that it was. At age forty, a woman's odds of having a child with DS are about one in a hundred, compared to one in a thousand at age thirty or lower.

When a new mom joins the support group, the others ask, "Did you know?" The time of awareness is a pivotal point in the journey, and we identify each other according to whether we chose to know before the child's birth and why or why not.

Finding out whether a fetus actually has one of the birth defects for which this test screens requires a further procedure, such as an amniocentesis or a biopsy of fetal tissue.[3] The initial screening test and the subsequent diagnostic test should not be thought of independently but as part of a protocol. The assumption built into the design of the testing is that if the results of screening indicate that the baby is at higher risk, then the mother will proceed with one of the diagnostic procedures. The second test will then determine whether the baby does in fact have one of these genetic or neural tube problems.

Prenatal screening is routine in many doctors' offices. With technology readily available to provide specific genetic and chromosomal information, it seems reasonable to start the process of checking to make sure the baby is developing as it should. After all, isn't testing just part of good prenatal care? However, some women are not adequately informed about the purpose of the screening test, and they are unclear about what to do with the

results. Some choose to have the screen but refuse the diagnostic test, so they lack accurate and complete information. In other words, they may have just enough information to make them worry and not enough to reassure them. As a result, they spend their pregnancies in a heightened state of anxiety.

As is the case with most medical testing, the diagnostic tests have financial and other costs associated with them, as well as certain risks of harm. Unlike the simple screening test, both of the diagnostic procedures are invasive and entail a risk of miscarriage (approximately one in a hundred for biopsy, one in two to four hundred for amniocentesis). These and other risks should be weighed carefully against possible benefits. Additionally, women should ask themselves whether having the information will change something about how they proceed. If it won't, any cost or risk is unacceptable and makes proceeding inadvisable.

Why would you choose to know?

As the possibilities in the world of technology increase, societal expectations change: people uncritically assume that if tests can give us information, we should avail ourselves of the opportunity to know. Information can indeed be liberating and empowering. It isn't always. Whether a couple should undergo prenatal screening and diagnostic testing is a matter for careful consideration.

Making a good decision about whether to have prenatal testing requires clarity about its purposes. One clear purpose is to identify the presence of a chromosomal or genetic problem, to gain information. One could argue that a possible benefit of declining testing is the bliss of ignorance, an innocence and freedom from interference with one's hopes and dreams for one's child. In the absence of disappointing information, a woman can concentrate wholly on developing the emotional bond necessary for caring for her baby. She is free to enjoy this special time in their life together.

Alternatively, a possible reason to know before the birth is to prepare oneself intellectually and psychologically to receive and care appropriately for a child with special needs. Many couples use the time before their baby arrives to learn about the disability, to set up the supports they need, and to begin grieving the loss of the "perfect" baby they had expected. Several of my friends who

knew about their baby's disability before birth say the knowledge made the pregnancy difficult, but they were grateful for the opportunity to grieve and prepare so that they were emotionally ready when the baby arrived.

For other people the psychological costs of knowing their baby has a disability may be substantial and may seriously impair the bonding process. Some families recognize that they do not want to parent a child with a disability, or do not have the resources (financial, emotional, or other) to care for a child with special needs, and they choose to place their baby in adoption. Knowing before the child's birth allows time for adoption procedures, which can be lengthy. It also reduces the need for foster care, which delays bonding between the infant and the adoptive parents. Many families want to adopt babies with special needs; in the case of babies with DS, there are national waiting lists.

In certain circumstances, other preparations may also be warranted. Prenatal testing could identify a serious medical condition that may affect the way the delivery is handled. For example, the presence of spina bifida may mean that delivery by Caesarean section is safer for the baby. Forty or fifty percent of babies born with DS have heart defects. Some of these defects are so severe that if untreated they will cause death soon after birth. Elise's defect was serious enough that we were referred out of state for consultation. When her diagnosis was confirmed, she was scheduled for surgery within two weeks. During the seven hours of her surgery we sat in the hospital waiting room with a potpourri of people from many parts of the world. Later I learned that these families had traveled to this hospital to entrust their babies to the care of a particular cardiovascular surgeon. Some of these children were alive because, as a result of prenatal diagnostic testing, they were born in a medical center that provided such specialty care. In such circumstances, the result of not knowing could be more serious than merely missing an opportunity to prepare oneself; it could cost the baby's life.

Some women opt for prenatal diagnostic testing to enhance their reproductive choices. Many decide to have an abortion when they learn that the fetus has a chromosomal defect. One study estimates that nearly 90 percent of such fetuses are aborted.[4] Noreen and Samuel Glover point out that the laws

governing abortion are different (in some states, quite dramatically) for fetuses diagnosed with DS than for normal fetuses. "Ordinarily, the stage of fetal development is an essential factor in whether a woman carrying a healthy fetus can obtain a legal abortion. However, if the fetus has DS, a woman may obtain a 'therapeutic' or 'medically necessary' abortion much later, even after viability."[5] The authors note that although the public is about evenly divided between those who support and those who oppose abortion, the numbers shift dramatically when the fetus has a defect. Even people "who otherwise describe themselves as pro-life advocates may make an exception in the case of a fetus with a disability. In one case, as many as 78% expressed a belief that abortions should be legal."[6]

A possible reason to know before the birth is to prepare oneself intellectually and psychologically to receive and care appropriately for a child with special needs: to learn about the disability, to set up supports, and to grieve.

I believe this approach is discriminatory. Many people seem unable to recognize that a person is more than an individual trait, more than their disability. A person with Down syndrome has other traits, gifts that can contribute to society and enrich our world. A *Hastings Center Report* contends that "prenatal testing depends on a misunderstanding of what life with a disability is like for children with disabilities and their families."[7] Because our society sees life with disability as a less than worthy existence, and because it seems "unfair" to allow a child to "suffer," many people believe abortion is best for both baby and family. Some physicians discourage women from continuing their pregnancy after a positive diagnostic test, even suggesting that it is irresponsible to bring a child with a serious anomaly into the world.

Yet professionals lack consensus on what constitutes a serious anomaly.[8] People assume that those "with disabilities lead lives of relentless agony and frustration and that most marriages break up under the strain of having a child with a disability."[9] Some marriages do break up, but research does not support the claim that most do. In fact, many marriages thrive as a result of personal growth from the experience of caring for a child with special needs.

According to the National Down Syndrome Congress's "Position Statement on Prenatal Testing and Eugenics: Families' Rights and Needs,"[10] couples should be given information that presents the disability from the perspective of a person with it. They need information on community-based service programs and financial assistance programs as well as on special needs adoptions. And they need a summary of major laws protecting the civil rights of people with disabilities. One physician at the New England Medical Center reports that in her practice couples expecting a baby with DS are introduced to families who are raising infants, children, and young adults with DS, so they can be as fully informed as possible. In her practice, "only 62 percent of women who discover they are carrying a fetus with Down syndrome decide to have abortions."[11] Obviously, education plays a crucial role in the choices people make; unfortunately, there is far too little of this kind of education.

It takes a church community . . .

I believe that the issues surrounding prenatal testing are best addressed in the context of a faith community that respects the worth of every human life. In addition to aiding couples in discernment about prenatal testing, pastors and congregations have much to offer people who are expecting and caring for children with special needs. I believe it takes a church community to successfully raise our children. Prayers, companionship, openness to and acceptance of people with disabilities—these are important gifts to families facing challenges and are also potential sources of blessing for congregations.

When a woman learns that the baby she is carrying has a chromosomal or genetic defect, she and her partner will likely grieve the loss of hopes and dreams, and they may need help to move through the grief process toward a place of acceptance. People's responses vary: some will get through this stage more easily; others will circle back to it again throughout their lives. Some will struggle intensely with faith and will need help to deal with anger toward God. Many will experience denial, sadness, grief, isolation, panic, and guilt.[12] Pastors and church families can offer patience, understanding, and a willingness to walk with couples. Pastors must be ready to give support and sensitive

counsel, recognizing that the marriage relationship may be strained, especially if the wife and husband disagree about having diagnostic testing or respond differently to the results.

Knowing their congregation will be there with acceptance and support can ease the way for couples facing the birth of a child with special needs. A church sends a positive message to such couples when it is attuned to needs of those who are disabled and is willing to journey with families. Important help can come in the form of caring teams, respite care, and special provisions for nursery care and Sunday school. Pastors and congregations need to be aware of overt or covert messages they may be sending that indicate a lack of support for or intolerance of those with special needs in the church. Ministering to those among us with special needs is an important mission of the church, and it can begin even before the baby is born, through careful examination of attitudes, policies, programs, and facilities in our congregations.

The words we use are powerful and can reflect whether and how we value others. Sometimes words intended to encourage or comfort may offend. Even some Scripture passages may be used in hurtful or confusing ways. It is usually unhelpful to try to explain why God would allow a child to have a disability. Equally unhelpful are statements that suggest the couple must be special to have been assigned the challenge of parenting a child with a disability; also problematic are comments that special children are gifts from God. All children are precious gifts from God. Pastors and congregations can play a key role in conveying this message.

Since Elise's birth we have been surrounded by the supportive and encouraging words of friends and family, and we accepted and loved her from the start. We were full of joy, not grief, when she was born. We never heard condolences; people did not offer platitudes suggesting that her disability was a test of our faith, a punishment for our sin, a lesson we needed to learn, or God's plan intended for our good. We were aware of God's presence with us from the beginning, giving us courage, strength, and wisdom to accept the unexpected news about Elise. As a result we saw her as a gift, just as her older sister was a gift, though her challenges and journey through life are undoubtedly different.

When Elise was two years old, we attended a weekend reunion with friends. One evening we were in a large room. A man was

lying in the back of the room on a cot. Because of a serious degenerative disease, he was in pain. Many young children played near him, but it was Elise who noticed him and went to his side. As she patted him, stroked him, and gently mumbled to him, he was moved to tears. She was the only child who had reached out to him that weekend. Through her care, God touched this man's heart in a way that none of the rest of us could.

At its best, the church embraces each new life as precious, feels gratitude for every child's gifts and talents, and watches for God's purposes to unfold in each child's life. God can use each of us to fulfill his purpose. The presence of an extra chromosome does not change our worth in God's eyes. In fact, his power is made perfect in our weakness, as he uses our imperfections for his glory.

Notes

[1] Spina bifida is a defect of the spinal column resulting from the failure of the spine to close properly in the first month of pregnancy.
[2] Sometimes the screening test result is a false negative: the levels are normal although the baby has one of the defects.
[3] In this procedure, called chorionic villus sampling (CVS), samples of cells that line the placenta are removed and tested.
[4] Noreen M. Glover and Samuel J. Glover, "Ethical and Legal Issues regarding Selective Abortion of Fetuses with Down Syndrome," *Mental Retardation* 34 (August 1996): 207–14.
[5] Ibid., 209.
[6] Ibid., 208.
[7] E. Parens and A. Asch, "The Disability Rights Critique of Prenatal Testing: Reflections and Recommendations," A special supplement to the *Hastings Center Report* 29 (September–October 1999): S1–S22.
[8] Ibid., 10.
[9] Ibid., 7.
[10] *Down Syndrome News: The Newsletter of the National Down Syndrome Congress* 17, no. 7 (September 1994), 3.
[11] Parens and Asch, "The Disability Rights Critique," 9.
[12] Peter and Mary Graber, *Lessons from Emily* (Goshen, Ind.: Mennonite Mutual Aid, 1993).

About the author

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Exploring promise and problems in embryonic stem cell research

George B. Stoltzfus

In recent years, under the auspices of the Anabaptist Center for Healthcare Ethics,[1] I have met with people throughout the Mennonite Church in North America to talk about embryonic stem cell research. I believe that such conversation is most fruitful when it holds in tension disparate values, refusing to embrace one value at the expense of others or to set aside important values for the sake of agreement. In the spirit of such conversation, I offer readers some information about what embryonic stem cells are, and some reflections on the potential and problems of research using them.

Embryology for the non-embryologist

The embryonic stem cells used in research are cultured from human fetal tissue, from embryos that began their development either *in vivo* or *in vitro*. One way to illustrate the meaning of these Latin terms is to describe an experiment I did as a student in a physiology class. We placed a chick embryo on an agar plate, and then following the development of the baby chick through a series of steps including the formation of the circulatory system with a pulsating heart. The fertilization of the chick happened in vivo ("within a living organism"); the chick's early development was in vitro ("in glass").

Whether it happens in vivo (in a woman's body) or in vitro (in a fertility clinic or laboratory), the union of human sperm and egg leads to the formation of a clump of cells. This clump then begins the division and specialization process that eventually leads to the formation of an adult human. Soon after the union, the clump of cells shows microscopic changes that point to future function. The cells of the blastocyst are well along the way to differentiating to their final forms. One portion of the blastocyst will become the placenta, umbilical cord, and amniotic sac. These tissues support

pregnancy and the developing embryo, and are discarded when pregnancy ends. This portion of the blastocyst does not produce stem cells that are useful for research. Another group of cells is identified as the inner cell mass. It is from this group that pluripotent stem cells are taken, the embryonic stem cells that hold greatest promise for research.

Stem cell research holds promise

Research on these embryonic stem cells has the potential to increase knowledge of human development and improve treatment of a number of diseases and injuries. Almost weekly, news stories express boldly optimistic views of future possibilities for this technology. Areas of promise include improved drug testing, enhanced gene research, and new treatments for a variety of injuries and diseases.

Drug testing. Before drugs and other therapies are available to the public, they undergo a long process of study and testing. An estimated average of ten years passes before a drug can be introduced to the market. The factors that delay introduction are many and include concerns about toxicity and side effects. Much of the information necessary to assure safety can be gathered by testing drugs in animals, but eventually drugs must also be tested on human subjects. Animal testing is never a complete predictor of the way humans will metabolize and tolerate a particular drug.

Research using stem cells enables assessment from the outset of the new drug's impact on human cells. Furthermore, researchers can test the drug on the specific human tissue that it is intended to target. Stem cell testing will not eliminate human and animal testing, but it will make such testing much safer. Scientists can subject stem cells to situations and risks under controlled conditions and conduct tests that would be impossible or unethical if applied to animal or human subjects.

Gene research. When stem cells become skin or bone or hair, the process is essentially the result of turning on or turning off each of the 60,000 or so genes that make up the forty-six human chromosomes. At each step along the way from unspecialized to specialized tissue, the cells follow a preprogrammed process, or respond to changes in the environment. In the laboratory, researchers will be able to slow or stop this process and study it in

detail. They can observe the conditions under which changes take place, and acquire knowledge about how to arrest or alter the specialization. This study will lead to a vast expansion of knowledge about how genes function, and potentially of how they can be turned on or off. This information will help us understand how normal development occurs at the genetic level, and what happens when things go awry.

Treatment for diseases. Stem cells have the capacity to become any human tissue. When undifferentiated cells are added to an area of need, they may, under the influence of local agents, become differentiated into cells of the local type. Stem cells can be prompted to become bone marrow or nerve cells or heart muscle, to replace damaged or destroyed tissue. Stem cells may eventually be used to treat debilitating diseases such as diabetes and Parkinsonism.

We cannot predict when or how or whether these promises will come to fruition. My guess is that, given money and time, a vast array of future developments will show the vision I have described to be pale and constricted.

Questions we should ask

While there is much that we don't know about the future of stem cell research, what we do know is that it has the potential to dramatically alter our lives, our health, even our life span. These revolutionary possibilities challenge us to pose questions, because no technology is without risks. I offer the following questions not as a rejection of the technology but because only naïveté or arrogance would prompt us to move into this new frontier without contemplating the implications and possible impact of the new technology.

Stem cell research has the potential to dramatically alter our lives, our health, even our life span. These revolutionary possibilities challenge us to pose questions, because no technology is without risks.

Should stem cell research be a priority in our society? To spend money on one project is not to spend it elsewhere. Stem cell research will require significant investment. An inordinate amount of health care expenditure in the U.S. goes to treatment of exotic problems while basic infrastructure issues remain unaddressed. Growing numbers in the U.S. have no health

insurance, while others have access to highly specialized and expensive services. Some argue that we have already passed the point of spending more on "medical progress" than we should. Is stem cell research another example? How do we explain to those who lack the basics that spending money on this research is more important than providing primary health care services to everyone in our nation?

Does stem cell research conform to our convictions about international justice in health care? Every measure we take to extend the frontiers of technology widens the massive gap between the health care middle-class Canadians and Americans receive and the care available to our Anabaptist sisters and brothers and other people elsewhere in the world. At Mennonite World Conference World Assembly this August, how will we explain to our friends in Zimbabwe that we cannot help them address the AIDS epidemic in their country,[2] as we spend more and more on our health care?

If we are critical of abortion and the fertility industry, can we condone research on stem cells harvested from these sources? The stem cells used in research are cultured principally from tissues harvested from two sources: fetuses aborted at between five and nine weeks' gestation, and "extra" embryos left over from the in vitro fertilization that is part of artificial reproductive technology used in fertility clinics. Coexisting with a rate of about 300 abortions per 1,000 live births, the U.S. has developed an industry whose sole function is to enable infertile couples to produce biological offspring. At the same time that many embryos conceived in vivo are aborted, many other embryos are produced as a result of in vitro fertilization (IVF) in the context of fertility treatment. IVF, in practice, results in unused developing embryos, which may be stored for years under controlled conditions. Eventually, the "parents," the sperm and egg donors, may release these embryos.

The Mennonite Church's confession of faith notes that the practice of abortion does not conform to our understanding of God's will.[3] Mennonite writers also question some of the values and practices of the fertility industry, including the absolute value it seems to attach to biological procreation. Ann Krabill Hershberger has observed, "The Bible message is that the family is to be held in great esteem with God's blessing. . . . An even

stronger message from the Bible . . . is that the family is not the only or even the most important dimension of human life."[4] If we question abortion and advocate limits on use of artificial reproductive technologies, must Mennonites not also be willing to question the ends that follow from these practices? Should we not express doubts about research on stem cells cultured from tissues harvested from aborted fetuses and abandoned embryos?

If stem cell research enables genetic engineering, where do we draw the line? Recently I read about a geneticist who carries a gene for early onset Alzheimer's disease. For her second pregnancy she chose to use IVF, not because of infertility, but because doing so enabled her to screen and discard embryos carrying the early onset Alzheimer's gene: she ensured that her child would be free of this defect. Is her achievement laudable? If so, at what point in the screening process should we stop? Should all embryos be checked for a host of genetic diseases? Why not do prenatal/pre-implantation screening on all pregnancies and in the process avoid the ones that will yield "defective" babies?

If we question abortion and advocate limits on use of artificial reproductive technologies, should we not express doubts about research on stem cells cultured from tissues harvested from aborted fetuses and abandoned embryos?

As I have met in small groups with Mennonites across the church, I have often conversed with folks who care for people with developmental and other disabilities. What I have heard is a call to care for the disadvantaged, for those who are marginalized and weak. I have heard a call to recognize how much our own growth is enhanced when we "normal" people participate in care of those we consider abnormal. Caregivers call us to recognize how much our own expression of humanity is bound to the care we offer those who need us. If we pick only the "best" embryos, we are unlikely to choose children with Down syndrome or a clotting disorder or carrying a hundred other known genetic diseases. How do those choices reflect the kind of community we are? What effect will those choices have on the kind of community we become?

How do we respond to those for whom stem cell research offers the hope of healing? What do we say to those whose lives could be enhanced by new technologies? Sisters and brothers in the church

offer a variety of responses. Some emphasize the need for caution, and some are enthusiastic about the possibilities stem cell technology offers for their healing. Lutheran pastor Russell Saltzman, a diabetic, tells the story about the man who died in a flood:

> *A Red Cross boat had come by earlier when the water was above the window sills, but the fellow refused rescue saying, "The Lord will save me." A second boat came when the water was to the eaves and the man was hanging from the gutters. But again he refused rescue. "The Lord will save me," he declared. Scrambling onto his roof ahead of the ever-rising waters the man spied a helicopter heading his way. A rope was lowered from the copter, but the obstinate guy batted it away and shouted over the din of the rotors, "The Lord will save me." Of course he drowned. He arrived at Heaven's throne perplexed, hurt, angry, and dripping wet. "Why," he shouted at God, "didn't you save me?" "Give me a break," sighed the Lord God Almighty. "I sent two boats and a helicopter."*[5]

Saltzman goes on to describe the losses his diabetic friends have sustained, losses of limbs and mobility, among others. He articulates the dilemma for those who suffer from diseases stem cell therapy might some day be able to cure:

> *There is something supposedly just over the horizon that sounds for all the world like two boats and a helicopter, and if I don't grab it, maybe I'm the fool? The promise is fetal stem cell therapy. . . . When this research is perfected and receives FDA approval, all I have to do to benefit from it is give up my opposition to abortion and most forms of embryonic research, swallow a little pride, take a shot or two, whatever's called for, and pretty soon I'll be eating like a regular guy, all my body parts intact. Why, after all, should we let a perfectly good embryo, one that is not a candidate for implantation in a vacant womb, go to waste?*[6]

Saltzman graphically portrays the struggle between the immense promise of embryonic stem cell research and the ethical issues created by its use of aborted fetuses and discarded embyros. Saltzman concludes that he cannot support most forms of stem cell research because of his convictions about the moral status of embryonic and fetal life. The dilemma that he highlights constrains me from taking such a definite position. I prefer to remain in the uncomfortable middle ground where the answers are not always clear and the questions only seem to multiply. I don't know how to explain rejecting such research to those whose lives could be enhanced by its results. I do know I need to continue to ask the questions on their behalf and in behalf of the church.

Sometimes the act of posing a question has the effect of pointing to a preferred answer. My intent has not been to ask questions about stem cell research in a way that takes a position either in favor of or against using embryonic stem cells. It is not evident to me what position we should take. I am convinced, though, that if we as Christian health care practitioners and pastors either take dogmatic positions or fail to ask honest questions, we have failed in our leadership roles.

Note that I have not addressed the question of when human life begins. I have not addressed the question of the personhood of the blastocyst because I consider it to be unanswerable from a theological or a scientific point of view.[7] We may disagree about the personhood or the soul of the clump of cells called a blastocyst, but we should be able to agree that it is not just any clump of cells.

Attributes for living in the gray area

Living without definite answers to the questions highlighted above is difficult. A willingness to live with some ambiguity may also allow space for innovation and creativity. It may open the way to outcomes we may otherwise not imagine. It also may lead us to foster new expressions of some important attributes.

When we are prepared to live in the gray area, we have freedom to be honest in ways that are not possible when we insist on quick resolution. We can struggle authentically with those who suffer the devastation of diseases such as Parkinson's and diabetes. We can weigh possibilities for good in the treatment of suffering

against the possibility that in reaching for this good we may be giving up God's best.

Admitting that I live in the ambiguous middle is profoundly humbling. At the same time I experience the release that comes in acknowledging the vast frontiers of my unknowing. For all that we know and for all that we want to believe we know, we do well to recognize that being "fearfully and wonderfully made" suggests complexities that will frustrate even the most adroit scientists in their desire for knowledge and control.

Having spoken of humility, I now offer words of confession. When I consider the vastness of the problems of access to care in my country, and the even larger needs for health care on a global scale, it is hard for me to become exercised about embryonic stem cell research. Ethicist Laurie Zoloth points to the danger of asking questions about the exotic when what we most need are things close at hand: "We tend to think about bioethics, even health care justice and access, as a problem of the highest tech medicine, the access to the scarcest commodity, rather than the access to what we could have much of: human touch, conversation, responsibility for attention, a relationship of simple, practical nursing."[8]

I affirm the value of deliberation about the morality of stem cell research. Its value should not, however, be placed on the same scale of importance as the value of providing basic health care to all members of society. Nor should deliberation about stem cell research distract us from the task of bridging the chasm that lies between our technological privilege as middle-class Canadians and Americans and the dearth of technology that is a fact of life for many millions in the world.

By concluding between the extremes of certitude, I end where I began, but with even more questions. The fact that these questions remain requires that I proceed with caution, counsel with grace, and refuse to pass judgment on those with whom I disagree.

Notes

[1] For the full text of the vision and mission statements of ACHE, see www.mennmed.org/ache2.htm.

[2] Doris Dube, "What Should the Church Do about HIV/AIDS? The Brethren in Christ of Zimbabwe Face the Problem," *Courier,* 17, no. 1 (2001), 3–5.

[3] *Confession of Faith in a Mennonite Perspective* (Scottdale, Waterloo: Herald Pr., 1995), 82. A draft of a new Mennonite Church USA statement on abortion can be found at www.MennoniteUSA.org.
[4] See Anne Krabill Hershberger, "Procreation: Extraordinary Means," in *Medical Ethics, Human Choices: A Christian Perspective,* ed. John Rogers (Scottdale, Kitchener: Herald Pr., 1988), 100. See also Dan Epp-Tiessen, "Does God Care That We Make Babies?" in this issue, pages 6–15.
[5] Russell E. Saltzman, "Two Boats, a Helicopter & Stem Cells," *First Things: A Monthly Journal of Religion and Public Life* 96 (October 1999): 13.
[6] Ibid., 14.
[7] See Richard B. Hayes, *The Moral Vision of the New Testament: A Contemporary Introduction to New Testament Ethics* (San Francisco: Harper San Francisco, 1996), 455.
[8] "Heroic Measures: Just Bioethics in an Unjust World," *Hastings Center Report* 31, no. 6 (November-December 2001): 35.

About the author

George Stoltzfus recently completed his assignment as staff consultant for the Anabaptist Center for Healthcare Ethics. He now serves as chief executive of Friendship Community in Lititz, Pennsylvania, a church-related organization devoted to the care of developmentally disabled adults. He anticipates that this setting will offer new opportunities to pursue his interests in health care ethics.

Bioethics and the church

Technology, martyrdom, and the moral significance of the ordinary

Chris K. Huebner

This essay examines the question of ethics at the beginning of life by bringing together three areas of consideration not normally associated with each other. The approach I will be defending turns on an appreciation of the close connection between the three references that converge in the subtitle: technology, martyrdom, and the moral significance of the ordinary. I will draw attention to the fact that technology is central to contemporary bioethics and will suggest that we need a better appreciation of the way our many technological investments in medicine imply deeply held moral convictions that often go unrecognized. The reference to martyrdom is meant to suggest that we will make little progress in thinking about ethics at the beginning of life unless our thinking on this matter is informed by reflection on the end of life. Martyrdom is significant in this regard, as it captures a particular understanding of what it means to die well that has been central to Christian tradition. And finally, I am suggesting that in order to better appreciate how these first two themes are in fact connected, we require a greater appreciation of the moral significance of the ordinary.

We have learned to associate ethics with a breakdown in the fabric of everyday life. The very idea of the ethical has become "exoticized" to the extent that we assume it deals with what is out of the ordinary.

Many beginning-of-life issues—abortion, in vitro fertilization, stem cell research, to name a few—fall within the domain of the relatively new discipline of bioethics. The beginning of this discipline's life is sometimes traced to 1962, when a special committee of experts in Seattle was formed to determine which patients would be eligible to receive newly available chronic kidney dialysis treatments.[1] The problem these ethicists wrestled with was a situation in which the demand for dialysis technology exceeded the

available supply. The committee deliberated about how to allocate these limited resources to people whose lives depended on them. From its origins, then, contemporary bioethics has been concerned with technology. The discipline was invented to deal with new medical technology, which creates new therapies but simultaneously introduces a new and troubling set of problems.

Notice that this narration of the birth story of bioethics is built on certain assumptions about both ethics and technology. One of the defining characteristics of life in contemporary liberal democracies is that we have learned to associate ethics with a breakdown in the fabric of everyday life. Ethics is thus understood as taking the form of an emergency response, usually to something we attribute to the complex character of contemporary existence. Put differently, the very idea of the ethical has become "exoticized" to the extent that we assume it deals with what is out of the ordinary.

Furthermore, we assume that ethics is primarily concerned with telling us what to do in these extraordinary situations. The debate about what to do with respect to our paradigmatic moral dilemmas—abortion and stem cell research, for example—appears interminable, admitting of no clear and easy answers. Still, we tend to assume that with more impartial, rational reflection, and better, more historically informed biblical interpretation, we could identify ethical principles that would enable us to resolve these dilemmas.

The discipline of bioethics reflects these pervasive assumptions about ethics in general. We expect it to help us respond to—make decisions about—certain problems generated by medical technology. The need for bioethics grows out of the perception that a new space is opened up because technological possibilities outrun the capacity for ethical judgments. Bioethics comes to name a process whereby that space might be filled in. As Donald Kraybill has written,

> *We are caught in the lurch—in an ethical gap—as technology races far ahead of our ethical formulas of bygone years. Ironically, as the technological precision increases, the moral precision wanes. The old answers that prescribed the boundaries between right and wrong, good and evil, are suddenly blurred by the provocative questions stirred by the spiraling genetic technology. After four decades of playing theological catch-up with the nuclear age, we finally have*

> *realized that the old "just war" formula is archaic for fighting nuclear wars. Now we face a new game of ethical catch-up as we try to maintain stride with the technological leaps in genetic engineering.*[2]

Kraybill's words about genetic engineering also typify how bioethics often responds to beginning-of-life issues, when our standard ethical and theological responses do not seem to apply directly to technological innovations such as in vitro fertilization and stem cell research. Ethics is seen as a distinct realm into which we step when the rest of life somehow cracks under the pressure of certain "non-moral" facts, such as our inability to have biological children, or the realization that we are about to have a child who is not wanted. We name in vitro fertilization and abortion as ethical issues because they represent difficult decisions that must be made when the ordinary way of having children does not work.

Just as the story of the birth of bioethics makes certain assumptions about the nature of ethics, it also makes assumptions about the nature of technology. Donald Kraybill's words, quoted above, suggest that ethical questions do not apply to technology itself, but only to the new situations made possible by technological developments. When ethics is defined in terms of extraordinary problems, such as those generated by new technologies, the implication is that the technology itself remains morally neutral.

This assumption misses the sense in which technology in general and medical technology in particular presuppose a set of specific moral convictions. Technology, in other words, gives expression to a conception of the good life: the goal of technology is to master contingency. It promises the capacity to escape from luck, finitude, and vulnerability. Medicine harnesses technology to provide us with a means to exercise ever greater and more efficient control over our lives. As Gerald McKenny puts it, the technological imperative of contemporary medicine is "to eliminate suffering and to expand the realm of human choice—in short, to relieve the human condition of subjection to the whims of fortune or the bonds of natural necessity."[3]

Such a conception of medicine is grounded in assumptions about autonomy and radical individualism. Our lives are understood as possessions over which we alone are finally in control. And

technology is seen as a tool that enables us to better satisfy whatever desires we may happen to have. Among other things, these assumptions are reflected in the way we view both doctors and bioethicists as agents of technical expertise. They co-exist in a delicate balance of power designed to ensure that our ability to choose and to exercise control over our lives is never seriously compromised.

The dilemmas that preoccupy bioethics reflect a profound confusion about who we are: Is our identity shaped by the good life as defined by technology, or by the good life as defined by Christian faith?

When we see technology as a morally neutral tool that is merely at the service of individuals, we have bought the self-legitimating story that those captured by the technological imagination have learned to tell themselves. This view of technology is tied up with the creation of a particular kind of people. It produces a people who have come to understand themselves as autonomous individuals who are in need of protection against whatever they see themselves as vulnerable to. Technology is thus not simply a tool for the more efficient satisfaction of desires; it involves a specific ordering of desires. In short, technology names an account of identity that orders human desires toward the ends of mastery, possession, and control.

Technology fosters an account of identity which exists in tension with Christian identity. Understanding how that is so and why it is important is related to exploring the limitations of our society's understanding of the task of ethics in general and bioethics in particular. We misunderstand what ethics is about when we assume that it is primarily concerned with telling us what to do when we face moral dilemmas. Such an approach to ethics presupposes a faulty moral psychology that understands the self as nothing but a collection of discrete decisions. It disconnects what we do from who we are.

A more adequate moral psychology would appreciate the sense in which the self is constituted by histories, stories, and social practices. Such an understanding of selfhood presumes that the stuff of ordinary experience—what happens between, beyond, and under our dilemmas and decisions—is as important, morally speaking, as facing decisions and making difficult choices. Put simply, our decisions and choices flow from somewhere. Ethical issues and moral dilemmas,

not to mention decisions and choices, do not exist in and of themselves, but only as interpreted. And we interpret them by locating them in the context of the larger story of our lives.

It follows that ethical issues are best approached not so much as problems to be solved by the application of principles, but as exercises in self-understanding. Of course, our lives do involve decisions, many of them difficult. My claim, though, is that ethics is primarily about the formation of a character and an identity out of which our decisions flow. Our paradigmatic ethical issues are at least in part the reflection of our identities. They are at least in part the product of moral convictions we all too often fail to acknowledge about ourselves. The issues and dilemmas that preoccupy contemporary bioethics can be read as reflecting a profound confusion about who we are: Are we a people whose identity is shaped by the good life as defined by technology, or by the good life as defined by Christian faith?

Our technological world forms us, often without our awareness, as people with a certain set of desires. The church, too, is involved in the creation of a people with a particular identity, whose character is shaped by a different ordering of desires. To be a Christian is to have one's desires ordered not toward mastery and possession but toward participation in the life of Christ. Among other things, this involves a call to live "out of control." The Christian life is not a possession over which we are masters, but a gift we receive in spite of ourselves, which we are in turn invited to give back. Nor is the Christian life finally that of autonomous individualism. Christian life is shared. It is an exchange of gifts with many others, including God and friends, but also strangers and enemies.

To be a Christian is to have one's desires ordered not toward mastery and possession but toward participation in the life of Christ. Among other things, this involves a call to live "out of control."

It is at this point that the practice of martyrdom is significant. For martyrdom is a way of dying that only makes sense in the context of a larger way of life that characterizes a people who have come to understand that their lives are not finally their own. Too often, appeals to martyrdom have functioned as yet another attempt to secure power and control. This dynamic is at work, for example, when martyrs are turned into heroes who are seen as having

effectively seized power from the hands of their enemies. But the meaning of martyrdom is misunderstood when it is read in this way. Rather, what the practice of martyrdom names is the recognition that life is not a possession to be protected at all costs.

One of the most striking features of contemporary life is that our deaths so often happen in a way that marks a stark contradiction to the way our lives have been lived.[4] By contrast, the martyr is one—though not the only one—whose death is meaningful precisely because it is consistent with the Christian life, marked as it is by the virtues of charity and humility, both of which name a stance of vulnerability to the world of the other.

Martyrdom is a way of dying that only makes sense in the context of a larger way of life that characterizes a people who have come to understand that their lives are not finally their own.

Martyrdom as an intelligible Christian practice is thus correlative to the Christian confession that life is a gift received and given. To say that life is gift is to say that it is not ours to control. But this conviction places the Christian life in direct conflict with the conception of the good life assumed by the technologically-driven medical establishment. Martyrdom is thus significant in that it names a counter-practice to medicine and other practices informed by the technological imperative. It is not accidental, I think, that as the church becomes more and more familiar with technology, it has largely lost the ability to think intelligibly about martyrdom.

Martyrdom is, of course, a way of dying. As such, it may seem irrelevant to a discussion of the beginning of life. But part of the problem underlying our difficulty concerning ethics at the beginning of life is that it has been divorced from an understanding of the end of life. What martyrdom names about the end of life is especially relevant for how it might help us think about ethics at the beginning of life.

We want biological children rather than adopted ones because we feel that they are somehow more significantly ours. We thus invest in in vitro fertilization and other reproductive technologies in order to facilitate the desire to have children of our own. We want prenatal diagnostic testing to ensure that the children we have will not suffer. We support stem cell research because it promises to give us better control in managing other illnesses. I highlight the significance of

martyrdom in an attempt to help us recognize that each of these desires is but the manifestation of an underlying desire to master and control the lives we have been given.

I do not mean to trivialize the profound struggles and painful emotions many of us have surrounding these matters. Rather, I am attempting to recognize that those feelings are to an extent the product of the way our lives exist in the midst of deep tensions concerning rival visions of the good life. In many ways, the confusions we experience can be read as evidence of the church's failure to be the church. In particular, they are the result of a failure of the church to understand that it names a specific way of life, and thus that it is engaged in creating a particular people.

At the same time, the church has failed to be the church to the extent that it relegates these concerns to the private realm, leaving individuals or couples to negotiate these difficult matters on their own. So long as the church sees itself as dedicated to the work of the soul to the neglect of the body, we will make no meaningful progress on thinking ethically about the beginning of life.

Technology uses us as much as we use it. It uses us precisely to the extent that it gets us to see ourselves in particular ways. This shaping of identity happens especially with respect to the kinds of questions that preoccupy contemporary bioethics.

I do not propose that we should do away with technology. Nor am I calling for a church-wide boycott of doctors and other medical professionals. Rather, I am suggesting that we need to be more aware of the fact that medicine and technology are not neutral things that people may use to satisfy whatever desires we happen to have. Technology uses us as much as we use it. It uses us precisely to the extent that it gets us to see ourselves in particular ways. This shaping of identity happens especially with respect to the kinds of questions that preoccupy contemporary bioethics, such as those related to the beginning of life.

Much of our ethical inquiry into the beginning of life misleads us because it fails to understand that the problems with which it deals are the products of cultures and identities. To approach these matters in yet another ethics-as-emergency-measure way is to miss the point. Difficult as these problems may be, their difficulty does not arise from the fact that the rest of life has broken down. Rather they are

questions of everyday life, of identities and cultures we already live in the midst of. And they are difficult because they represent versions of everyday life that we live even as we fail to recognize the extent to which we do so.

The primary task for the church with respect to the beginning of life is not to develop new ethical principles that might enable ethics to keep pace with new technological innovations and the procedures they enable. Rather, the task facing the church is to understand why we ever assumed that technology might save us in the first place.

Notes

[1] For a helpful account and interpretation of this story of the birth of bioethics, see Joel James Shuman, *The Body of Compassion: Ethics, Medicine, and the Church* (Boulder: Westview Pr., 1999), 52–6. See also Carl Elliott, *A Philosophical Disease: Bioethics, Culture and Identity* (New York: Routledge, 1999), 6–7.

[2] Donald B. Kraybill, "Communal Responsibilities," in *Bioethics and the Beginning of Life*, ed. Roman J. Miller and Beryl H. Brubaker (Scottdale: Herald Pr., 1990), 194; quoted in Keith Graber Miller, "Bringing infertility out of the shadows," in this issue, pages 20–21.

[3] Gerald P. McKenny, *To Relieve the Human Condition: Bioethics, Technology, and the Body* (Albany: State Univ. of New York Pr., 1997), 2.

[4] This is the central claim of Joel Shuman's remarkable book, *The Body of Compassion*.

About the author

Chris K. Huebner is assistant professor of theology and ethics at Canadian Mennonite University. He has published several essays on what theology might look like if it were not dedicated to the technological imperative of mastering contingency, most recently "Globalization, Theory, and Dialogical Vulnerability: John Howard Yoder and the Possibility of a Pacifist Epistemology," in *Mennonite Quarterly Review* 76 (2002): 46–62.

A life too brief

A memorial meditation for Adam Daniel Shantz

Gary Harder

> *Neither death, nor life, . . .*
> *nor anything else in all creation,*
> *will be able to separate us from the love of God*
> *in Christ Jesus our Lord. (Rom. 8:38–39)*

Right now that is hard to stomach, Lord.

> *God will wipe every tear from their eyes.*
> *Death will be no more. (Rev. 21:4)*

Right now that is hard to believe, Lord. Right now, Lord, the words that resonate in us are those of the psalmist:

> *You have broken us in the haunt of jackals,*
> *and covered us with deep darkness. (Ps. 44:19)*

Today we know sorrow of a particular sort. We grieve a baby who will not grow among us, whose personality will not develop in our midst. We grieve a child who will not become an adult. For we have laid to rest today what might have been, a potential that will not be realized.

Dreams. Plans. Expectations. Hopes. The first birthday? Will never be celebrated. The terrible twos? Won't be endured. First day of school? No tears to be shed. First date? Nothing to be anxious about. Graduation? No party. Marriage? No grandchildren.

All dreams dashed. This has been a particularly wrenching time for you, Lisa and Marcus, and for your families and friends, for all of us. High hopes. Then anxiety over a traumatic birth. Adam rushed to Mt. Sinai Hospital. Waiting. Worst fears confirmed. No significant brain activity. And then waiting again,

waiting and praying that Adam might die. And a long time he took in the dying. He had spunk, resilience, stubbornness—stuff to be proud of.

And much, much more than agonizing waiting. So much more. Deep loving. Bonding. Holding. Tender caring. A family and a community holding vigil. Praying. Being cared for and held in the love and prayers of others when your own prayers failed to form.

No words

Adam's life was like a book that is too short. The book has a beautifully crafted cover. Physically, Adam looked perfect. The title is boldly written: Adam Daniel Shantz. Proud authors: Marcus and Lisa Shantz. But when the book is opened, no words are written inside. For Adam's brain had ceased to function. And without a brain there can be no thoughts, no reasoning, no words, nothing that makes sense. To him or to us. None of our questions make sense. None of our nice theological answers make sense. None of our groping for meaning leads anywhere.

The book is too short. Period. Adam Daniel Shantz. A cover and no words inside. We don't know how to deal with life without words.

Except that this too-brief life, this too-short book, has had a powerful effect. Many people have read it and are stunned by its visceral impact. Despite no words. No words in the book, no words to describe and explain its impact on us, and no words to offer comfort to the authors who had envisioned so many words, so many sentences, so many chapters. How can such a thin book draw us in so completely and take us to such depths?

Life will never be the same for you, Lisa and Marcus, nor for your families, nor for the rest of us. We have all been profoundly touched. And in that deep touching we have been grounded again in what is basic, ultimate. Our lives and our faith have been tested and deepened.

And through that experience we find the beginnings of hope and the beginnings of healing. For Adam has touched us to the core, and so, I believe, has God, though we may not know how. It is all beyond words.

You have loved and wept and held and nurtured and fallen exhausted to sleep. And in utter weariness and weakness you have

grown, become stronger, expanded your capacity for loving and for praying, even as words have failed you.

The Word

Life is so much more than words, or the lack of them. And Word runs deeper than words.

> *In the beginning was the Word,*
> *and the Word was with God,*
> *and the Word was God.*
> *He was in the beginning with God.*
> *All things came into being through him. . . .*
> *What has come into being in him was life. . . .*
> *And the Word became flesh and lived among us,*
> *and we have seen his glory,*
> *the glory as of a father's only son,*
> *full of grace and truth. (John 1:1–4, 14)*

John claims that Jesus was this Word, who became flesh and lived among us, identified with hurting humanity, loved people with God's kind of love, suffered terribly, and was killed. But God raised him up because such love cannot finally be killed. It cannot die. It rises triumphant, so we believe in resurrection, and have a hope deep within us that cannot be snuffed out, no matter how much we cry out in pain and no matter how much doubt and anger we throw at this Word. This Word cried with Mary and Martha in their grief, and cries with us in our grief, too.

Paul, too, points us beyond words:

> *We know that the whole creation*
> *has been groaning in labor pains until now;*
> *and not only the creation, but we ourselves,*
> *who have the first fruits of the Spirit,*
> *groan inwardly while we wait for adoption,*
> *the redemption of our bodies.*
> *For in hope we were saved. . . .*
> *Likewise the Spirit helps us in our weakness;*
> *for we do not know how to pray as we ought,*
> *but that very Spirit intercedes*

with sighs too deep for words.
And God, who searches the heart,
knows what is the mind of the Spirit,
because the Spirit intercedes for the saints
according to the will of God. (Rom. 8:22–24, 26–27)

Even our praying isn't limited or defined or encompassed by our words, because when our words fail, the Spirit of the Word prays for us. Thanks be to God.

Who will separate us from the love of Christ?
Will hardship, or distress, or persecution, or famine,
or nakedness, or peril, or sword
—or oxygen deprivation?
No, in all these things we are more than conquerors
through him who loved us.
For I am convinced that neither death, nor life,
nor angels, nor rulers, nor things present,
nor things to come, nor powers, nor height, nor depth,
nor anything else in all creation
—not a tangled umbilical cord, or grief,
or unanswered questions, or wordlessness—
will be able to separate us from the love of God
in Christ Jesus our Lord. (Rom. 8:35, 37–39)

The life of Adam Daniel Shantz was far too brief. The words we desperately wished to read will never be written. But the life story is not ended. We will take as promise Paul's affirmation that nothing can separate us from the love of God in Christ Jesus, Isaiah's affirmation that God will wipe every tear from our eyes. Promise. And hope. And maybe even praise. Praise for Adam's brief life and its profound impact on us. He was a gift from God. He was a gift of life. He was a gift of love.

And you, Lisa and Marcus and the rest of your families, held this gift gently, lovingly, tenderly, compassionately, prayerfully, until he could die and return to God, from whom he came. Know that in death Adam is not separated from God's love, but is fully embraced by it. And know that in grief, you are not separated from God's love, but are fully embraced by it. And know that

even praise will come again to your hearts and to your lips, like a welcome dawn after a dark night. Praise will come.

You requested that we end this service by singing "Praise God from whom all blessings flow." You said you would probably not be able to sing it. But you needed your community to sing it to you and on your behalf. Praise is the direction of our lives. Praise of God's faithfulness is the direction of a life of faith even in a time of intense grief.

Praise God, from whom all blessings flow

Dear, compassionate God, from whom we come, to whom we return, in whom we live and move and have our being, we are here today with a particular grief, for the brief life and tragic death of a baby. And in our grief, we give thanks for Adam Daniel Shantz, a gift that was precious and is now returned to you. For Lisa and Marcus, their families and community, we pray. Sustain them and renew them with strength and comfort, love and praise.

See, the home of God is among mortals.
He will dwell with them as their God;
they will be his peoples,
and God himself will be with them;
he will wipe every tear from their eyes.
Death will be no more;
mourning and crying and pain will be no more.
(Rev. 21:3–4)

Praise God, from whom all blessings flow,
praise him all creatures here below,
praise him above, ye heavenly host,
praise Father, Son, and Holy Ghost. Amen.

About the author

Gary Harder has three children and six grandchildren. He serves as pastor of Toronto United Mennonite Church and was for a long time involved in leadership positions in the Conference of Mennonites in Canada. He and his wife, Lydia, are currently teaching a course on pastoral ministry and leadership at Associated Mennonite Biblical Seminary.

Book review

Joshua P. Yoder

Mark, by Timothy J. Geddert. Believers Church Bible Commentary. Scottdale: Herald Pr., 2001.

This year the Revised Common Lectionary features the Gospel of Mark. In preparing sermons I've been reading Timothy Geddert's commentary on Mark in the Believers Church Bible Commentary series.

When I pick up a volume in an Anabaptist commentary series, I expect to hear an Anabaptist perspective compared with other possibilities for interpretation. The commentary should represent differing interpretations of a text fairly, and should identify how Anabaptists tend to view it, and why. I also expect information on how the text shaped early Anabaptist understandings about what it meant to follow Jesus. Was it used to support Anabaptist positions? Where does it appear in Anabaptist sources? Finally, of course, I expect responsible scholarship. I want a faithful survey of the major interpretive issues and the positions different scholars have taken. I don't want an exhaustive scholarly treatment of the texts, but rather one that will orient me and point out possible directions for further exploration.

I have an affinity for the literary approach Geddert takes. He seeks to help us understand what Mark meant to communicate about Jesus, rather than digging behind the text for clues about Mark's sources or about the historical Jesus. Though I value that kind of exploration, I prefer not to have it thrown at me. Geddert strikes the right level of scholarly awareness without scholarly minutiae. I agree with his basic hermeneutical stance that though we might not assume that Mark's portrait of Jesus is 100 percent "historically accurate" (whatever that would mean), in reading the Gospel as Scripture we need to assume that Mark portrays Jesus faithfully and that this portrait is useful for the church universal (16–18).

Geddert shows a sensitivity to what the literary structure of Mark can tell us about the meaning of individual passages. He

explores the use of Greek words in Mark and elsewhere in a way that a reader unfamiliar with Greek can appreciate. Geddert also shows humility in his approach to interpretation. He is willing to leave certain questions unanswered, or to preserve a certain agnosticism when definitive answers do not present themselves.

Although many of the essays in the section of the commentary entitled "The Text in the Life of the Church" are thought-provoking, they are not as specific as I would like. I would like more concrete information about the use of the various texts in the life of the church throughout its history, particularly in the Anabaptist tradition. More often, the essays highlight different points of view on particular topics throughout the history of the church, but do not provide much information on the specific ways that a particular passage has been used. I have found that this lack of information characterizes most of the other Believers Church Bible Commentary volumes I have used.

Alongside Geddert, I have been reading Ched Myers' commentary on Mark, *Binding the Strong Man: A Political Reading of Mark's Story of Jesus* (Maryknoll: Orbis Bks., 1988). Myers raises important issues involving the social setting of first-century Palestine to which Geddert gives scant attention. For example, of Mark 2:23–28, Geddert states, "The disciples are probably not *hungry and in need of food* as David was" (70), and he focuses on how this conflict story establishes Jesus' authority over against the religious establishment. In contrast, Myers writes, "To think the point of this story is Jesus' 'Christological prerogative' . . . is to miss the real issue." The main point is Jesus' preference for mercy over sacrifice: the hunger of the poor takes precedence over religious duty (160). Whereas Myers details how the practices of the Pharisees excluded or inconvenienced those without economic means, Geddert gives no attention to this dimension of the text. Although I do not agree with all of Myers' political interpretations of Mark's Gospel, I do think that commentaries need to point out the sociopolitical aspects of the Scriptures for those of us who live in a very different world culturally, politically, and economically.

About the reviewer

Joshua P. Yoder is pastor of Fellowship of Hope, Elkhart, Indiana.

Book review

Mary H. Schertz

The Nonviolent Atonement, by J. Denny Weaver. Grand Rapids: Eerdmans, 2001.

Mennonite and Anabaptist readers typically have strong reactions to J. Denny Weaver's *The Nonviolent Atonement*. I have heard it described both as a breath of fresh air and as heretical. To his credit, Weaver has done what few authors in our tradition can claim to have accomplished: he has us reading and talking about theology. That in itself is a gift of large proportion.

In *The Nonviolent Atonement*, Weaver takes the position that substitutionary theories of the atonement have not only failed to serve us well but are just plain wrong. He contends that such theories have contributed to some of the major sins of the western world—imperialism, warmongering, and oppression of various kinds. He argues instead for "narrative Christus Victor," a variation of the Christus Victor theory. Narrative Christus Victor is a Christus Victor model because it understands the atoning significance of Jesus' death as rooted in his resurrection victory over the principalities and powers. It is narrative because it is firmly rooted in the biblical story of Jesus' incarnation, life and ministry, death and—especially—resurrection.

Weaver makes the biblical case for Christus Victor by rooting it in the Apocalypse and then working through the Gospels, the Pauline material, the Old Testament sacrificial system, the Epistle to the Hebrews, and the history of Israel. Even his ordering of the material makes clear that he is developing a theological argument from the texts rather than leading his reader through a chronological survey of them. Some readers will find that arrangement disconcerting: why use Revelation to present the case, since it is one of the least historically grounded texts in the New Testament? But it is Revelation that presents the most developed imagery of Christus Victor.

The heart of the book is chapter three, where Weaver spells out some implications of narrative Christus Victor for

understanding sin and salvation in their individual and corporate dimensions. Far from taking sin and salvation less seriously, as he has sometimes been charged with doing, Weaver sketches out a rigorous and demanding understanding of our need to repent of the evil we have committed against the reign of God and accept the power of that reign by answering Jesus' call to follow him (76–7). Reorientation as a salvation motif is one of the strengths of the book. After pointing out that Jesus' life and teaching are irrelevant to the substitutionary theory of atonement, he notes tellingly: "Without the narrative depiction of Jesus in narrative Christus Victor, one does not know what the reign of God looks like nor how those who would be Christian would orient themselves in the world" (80).

I am immensely grateful to Weaver for the work he has done here. He offers a long overdue critique of substitutionary atonement theory and the sway it has held over the church. I have participated in congregational discussion of his book and have used it in my own classroom. In both settings, *The Nonviolent Atonement* has sharpened our conversation and clarified our thinking. For that reason, I heartily recommend it to pastors and other church leaders.

But I am also cautious. With Christopher Marshall, I think Weaver is "correct in what he affirms but wrong in what he denies" ("Atonement, Violence and the Will of God," *Mennonite Quarterly Review* 77 [January 2003]: 82). Weaver's assertions that the resurrection, not the cross, is salvific, and that God did not will Jesus' death disregard important New Testament voices about the cross and God's role in it. That substitutionary atonement theories have unduly dominated the theological scene from Anselm forward seems a necessary and timely critique. Weaver's contention that these ideas have little root in New Testament thinking seems a denial of biblical reality. Weaver's book, surely not heretical, would have been more helpful with a more nuanced understanding and use of the New Testament writings.

About the author

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