

FOCUS<sup>ON</sup> THE FAMILY<sup>®</sup>



*Sanctity of Human Life Guide*



# Sanctity of Human Life

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## *1. Introduction*



# Sanctity of Human Life

## The Sanctity of Human Life

*By Carrie Gordon Earll*

*Senior Director, Public Policy, Focus on the Family*

The sanctity of human life is a core principle for Focus on the Family. We believe that human life is of inestimable worth and significance in all its dimensions, including the preborn, the aged, the widowed, the mentally and physically challenged, the unattractive and every other condition in which humanness is expressed from the single-cell stage to natural death. In short, human life is sacred and respect for human life should be at the center of all we do. In order to put the life ethic into words and practice, it helps to consider where it comes from, what it looks like and how can we incorporate it into our daily lives.

### Where does it come from?

The Bible establishes that human life is sacred in Genesis 1:27 - "So God created man in his own image, in the image of God he created him; male and female he created them."

To be created in the likeness of God means that each human bears His image and with it, a value beyond our unique characteristics or individual attributes. Nothing else in God's created order has the distinction of reflecting His image; it's a privileged status reserved only for humankind.

This is a bit of a mystery as God's image in us isn't something tangible we can see, taste or feel; yet it establishes our significance and worth at the highest level. The Bible says we are "fearfully and wonderfully made" (Psalm 139:14). From the miracle of life in the womb to the body's ability to regenerate cells and tissue for healing, we see God's amazing fingerprint at work. Humans are breathtaking creatures embodying a touch of the Creator Himself and reflected in the wonder of human life.

### What does it look like?

Contrary to cultural messages, our value isn't determined by our ethnicity, race or gender; nor by our age, ability or location. It's our divine membership in the human family that sets each of us apart as sacred. Men, women and children (including preborn children in the womb) should be respected, regardless of their mental capacity, physical ability, or social position. Some people may not exhibit attributes of God or behave in ways that recognize their own value yet their intrinsic worth remains.

The concept of human dignity comes from the sanctity of human life. Since humans are made in God's image, we hold a distinctive status that sets us apart. Human dignity is

bestowed upon us by God. It's not based on our ability to care for ourselves or competence to complete the task. Dignity is not a concept that can be forfeited, so being dependent on others cannot cause us to lose our dignity.

Our failure to recognize and honor human dignity is apparent in phrases like "quality of life." Dependency is viewed as the ultimate weakness and as a result, some people would rather die than continue living if it means living with a disability. This attitude increases pressure for the acceptance of physician-assisted suicide or euthanasia, instead of providing a compassionate response to those who are disabled or face a terminal illness.

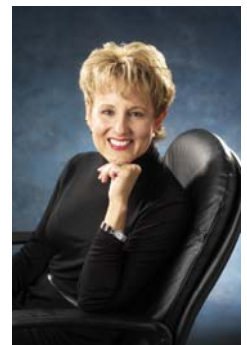
A common fear among the disabled or terminally ill is that of becoming a burden. We help restore human dignity through our witness of caring for each other, especially in our times of dependence and need. The sanctity ethic reminds us that God is ultimately sovereign over the affairs of our lives, including our frailty and infirmity.

### How can we incorporate this into our lives?

The cornerstone of living out this fundamental truth is to recognize the value of our own lives and the lives of others. In fact, knowing who you are is a big part of understanding the sanctity of human life. Do you value your own life as sacred? Do you embrace your worth and significance as one who bears God's likeness? Comprehending this is the first step in embracing the truth of who we all are!

The second is in the way you view others. Do you see others through God's eyes? Does your gaze stop at their physical appearance or ability, or do you look deeper to try and see the image of God in each life? Hidden heart attitudes of pride, superiority and contempt prevent us from seeing others with the respect and significance they deserve.

Finally, to live out the sanctity truth requires at action: to remind those around us of the value of all human life by speaking out for "those who cannot speak for themselves" (Proverbs 31:8). Look for opportunities to talk about and act upon your pro-life views. Teach your children and grandchildren to respect all human life and demonstrate that respect in your own word and actions. Together we can live out and communicate the beauty, wonder and reverence our Creator intended for each person in the human family.





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## What's the Debate About?

Most of the issues brought up in the abortion debate are mere smoke screens. Find out what the real issue is.

*by Francis J. Beckwith*

Abortion is an issue over which Americans are deeply divided, and there is little chance that this discord will be remedied anytime soon. Each side of this cultural divide consists of citizens sincere in their convictions. But the passions that fuel these convictions about abortion often distract us from understanding the issues that really divide us.

Now it may seem odd to say "the issues that really divide us," since it seems obvious to most people that what divides us is in fact only one issue, abortion. But that is misleading. After all, if abortion did not result in the death of an unborn human being, the controversy would either cease entirely or diminish significantly. So, what we disagree over is not really abortion. But rather, our disagreement is over the nature of the being whose life abortion terminates, the unborn.

But there is another issue that percolates beneath the abortion debate: What does it mean to say that something is wrong? Suppose, for example, you are arguing with a friend over the question of whether abortion should remain legal, and your friend says to you, "If you don't like abortion, then don't have one." Although this is a common response, it really is a strange one. After all, you probably oppose abortion because you think it is wrong, not because you dislike it.

This can be better understood if we change the issue. Imagine that your friend is a defender of spousal abuse and says to you, "If you don't like spousal abuse, then don't beat your spouse." Upon hearing those words, you would instantly conclude that your friend has no idea why you oppose spousal abuse. Your opposition is not based on what you like or dislike. It is based on what you have good reason to believe is true: one ought not to abuse a fellow human being, especially one's spouse. That moral

truth has nothing to do with whether or not you like or dislike spousal abuse.

In the same way, pro-lifers oppose abortion because they have reasons to believe that the unborn are full-fledged members of the human community, no different in nature than you or me. And for that reason, the unborn has a right to life that ought to be enshrined in our laws. Thus, in order to defeat the pro-lifer's point of view, the abortion advocate must show that the unborn is not a full-fledged member of the human community. At the end of the day, the abortion debate is not about likes or dislikes. It is about who and what we are, and whether the unborn is one of us.

## Is the Unborn One of Us?

There is no doubt that the unborn is a human being from conception, the result of the dynamic interaction, and organic merger, of the female ovum (which contains 23 chromosomes) and the male sperm (which contains 23 chromosomes). At conception, a whole human being, with its own genome, comes into existence, needing only food, water, shelter, oxygen, and a congenial environment in which to interact. These are necessary in order to grow and develop itself to maturity in accordance with its own nature.

Like the infant, the child, and the adolescent, the unborn is a being that is in the process of unfolding its potential — the potential to grow and develop itself but not to change what it is. This unborn being, because of its nature, is actively disposed to develop into a mature version of itself, though never ceasing to be the same being. Thus, the same human being that begins as a one-cell zygote continues to exist to its birth and through its adulthood unless disease or violence stops it from doing so. This is why it makes perfect sense for any one of us to say, "When I was conceived ..."

Abortion advocates typically do not dispute that the unborn is a human being during all or most of its time in the womb. For example, philosopher David Boonin, in his book *A Defense of Abortion* (Cambridge University Press, 2002), writes:

On the desk in my office where most of this book was written and revised, there are several pictures of my son, Eli. In one, he is gleefully dancing on the sand along the Gulf of Mexico, the cool ocean



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breeze wreaking havoc with his wispy hair. ... In the top drawer of my desk, I keep another picture of Eli. The picture was taken September 7, 1993, 24 weeks before he was born. The sonogram image is murky, but it reveals clearly enough a small head tilted back slightly, and an arm raised up and bent, with the hand pointing back toward the face and the thumb extended toward the mouth. There is no doubt in my mind that this picture, too, shows the same little boy at a very early stage in his physical development. And there is no question that the position I defend in this book entails that it would have been morally permissible to end his life at this point. (xiii, xiv)

Why does Professor Boonin hold this view? Like some other philosophers, Boonin maintains that the unborn, though a human being, lacks characteristics that are necessary for it to have a right to life. These characteristics typically include having a self-concept, a particular level of higher brain activity, and/or a desire for a right to life. But there are problems with this approach.

Consider first this example. Imagine that your father was involved in a car accident that put him in a temporarily comatose state. His physician tells you he will awake from the coma in nine months. His conscious experiences, memories, particular skills and abilities will be lost forever and he will have no mental record of them. This means that he will have to relearn all of his abilities and knowledge as he did before he had any conscious experiences. But they would not be the same experiences and desires he had before. That is, he is in precisely the same position as the standard unborn child, with all the basic capacities he had at the beginning of his existence. Thus, if your father has a right to life while in the coma, then so does the standard unborn child.

Another problem with the Boonin-type view is that it provides no real moral reason to oppose seemingly immoral experiments on the unborn. Imagine that there is a scientist who is able to alter the unborn's brain development in such a way that the higher brain and its functions are prevented from arising. And thus, when the child is born, it never develops a self-concept or a desire for a right to life. In fact, its organs are harvested and donated to needy patients.

## Conclusion:

### It's All About Who and What We Are

In the July 9, 2000 edition of the Los Angeles Times (Orange County edition), abortion advocate Eileen Padberg claimed that an implication of the pro-life position is that the unborn child "has more rights than" our "wives, sisters, and daughters."

Ironically, by excluding the unborn from the human community, Ms. Padberg diminishes, and puts in peril, the very rights she jealously, and correctly, guards. For she is saying that the government may exclude small, vulnerable, defenseless, and dependent unborn human beings from its protection for no other reason than because others consider the unborn's destruction vital to their well-being.

But Ms. Padberg would surely, and correctly, protest a government policy that allows for the exploitation and destruction of wives, sisters, and daughters by powerful people who believe they will live better lives by engaging in such atrocities against these women. So, if the unborn is one of us, then whatever is true of our worth and dignity is true of theirs as well.

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## How to be a 21<sup>st</sup> Century Pro-lifer

by Scott Klusendorf

What does it mean to be pro-life in the twenty first century? The Biblical view of human dignity is under assault in ways barely imagined a decade ago. The problem is that human nature is up for grabs. Consider these examples:

### A. Human/animal hybrids

Research labs **are moving forward** on the creation of embryos that will be part human and part animal. Three groups eagerly await the arrival of these hybrid embryos:

- **scientists** who will use them for grisly medical research,
- **transhumanists** who wish to alter the biological nature of human beings in hopes of radically advancing our evolutionary development, and
- **radical animal rights advocates** who consider any claim of human exceptionalism to be dangerous and intolerant and who look to the creation of these hybrids to knock humans off their privileged perch.

### B. Scathing attacks on human dignity, once restricted largely to academia, are now featured prominently in popular media.

**Peter Singer**, who thinks killing disabled newborns is only wrong if it adversely impacts other interested parties, writes in **The Dallas Morning News**: "During the next 35 years, the traditional view of the sanctity of human life will collapse under pressure from scientific, technological and demographic developments. By 2040, it may be that only a rump of hard-core, know-nothing religious fundamentalists will defend the view that every human life, from conception to death, is sacrosanct."

Meanwhile, Wesley J. Smith **cites** a *New York Times* editorial writer as saying, "We are all of us, dogs and barnacles, pigeons and crabgrass, the same in the eyes of nature, equally remarkable and equally dispensable." There you have it: Darwinism proves humans are no more and no less valuable than barnacles.

And who can forget PETA's Ingrid Newkirk saying that a rat is a pig is a dog is a boy is a roach? I guess eating a man is no different than eating a steak.

### C. Scientism is trumping morality in debates over cloning and embryonic stem-cell research (ESCR).

Make no mistake: The public **supports** ESCR. The idea is that if we *can* do it, we *should* do it. Even some so-called 'pro-life' politicians are falling for this dangerous idea. For example, Senator **Orrin Hatch**, defending ESCR, writes, "It would be terrible to say because of an ethical concept that we can't do anything for you." Does Senator Hatch realize what he just said? If science trumps morality, how is he going to condemn the Tuskegee Experiments where black men, suffering from Syphilis, were promised a cure only to have it secretly withheld so scientists could study how the disease kills people? How will he decry the medical holocaust of Jews in Nazi Germany?

### D. The 'new atheism' treats all religious truth claims as harmful and intolerable.

Its atheism with attitude and its principal goal is to drive metaphysics--including belief in human exceptionalism--from the public square. While the arguments presented by Richard Dawkins and Christopher Hitchens (to name a few) are **shallow and bombastic**, the field of bioethics is not immune from the influences of this new atheistic attitude. The case against ESCR, **we are told**, is nothing more than an attempt to force irrational and intolerant religious **absolutism** on an unsuspecting public. Thus, it must be squashed.

### E. Radical environmentalists view humanity as a curse on the planet.

"This myth [of human exceptionalism] is at the root of our environmental destruction--and our possible self-destruction," writes University of Washington psychology professor **David P. Barash**. If that weren't bad enough, **TIME** quotes abortionist and anthropologist Warren Hern of the University of Colorado calling our species an "ecotumor" or "planetary malignancy" that is recklessly devouring its host, the poor Earth.



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## F. Personhood rights are replacing human rights.

As Smith points out, most bioethicists do not believe that membership in the human species gives any of us value. Rather, what matters is whether any organism--animal or human--is a 'person,' a status achieved by having sufficient cognitive abilities. Thus, a self-aware puppy has more value than a day-old infant. Peter Singer writes, "The fact that a being is human does not mean we should give the interests of that being preference over the similar interests of other beings. That would be *speciesism*, and wrong for the same reasons that racism and sexism are wrong. Pain is equally bad, if it is felt by a human or a mouse."

## G. The acceptance of personhood theory meant a majority of Americans strongly favored the direct killing of Terri Schiavo simply because her cognitive abilities were less than our own.

The whole ordeal put in place a premise that it's okay to kill people who don't improve. Truth is, Terri had no duty to get better. Pro-lifers failed to make that case and we're still paying for it. Politically, anyone who thinks pro-life lawmakers weren't punished in 2006 for intervening on her behalf is living in a dream world. Further punishment likely awaits them in 2009.

## H. For many Americans, clear thinking on abortion is eclipsed by personal experience.

Over 80 million of them have participated in an abortion-related decision (if you include boyfriends, husbands, parents, etc.), and many of those same people are in our pews. The numbers are most likely increasing: The Guttmacher Institute reports that 18% of all abortion patients identify themselves as "evangelical" or "born-again" Christians--up from 16% in 1987.

Take a close look at your pro-life advocacy in the face of these assaults on human dignity. What are we, as Christians, doing right now to respond biblically and persuasively? The question is crucial, because Christians who ignore current debates over abortion and embryo research may soon face even tougher challenges.

## Given current assaults on human dignity, pro-life Christians must commit to three essential tasks:

- First, advocate a biblical view of human value and apply that view to abortion, embryonic stem cell research, cloning, physician-assisted suicide, and other assaults on human dignity.
- Second, engage the culture with a persuasive defense of the pro-life view.
- Third, communicate redemption to post-abortion individuals and point them toward healing resources.

## Task #1: Advocate a biblical view of human value.

We don't need Scripture to expressly say elective abortion is wrong before we can know that it's wrong. The Bible affirms that all humans have value because they bear God's image. (Gen. 1:26, 9:6, Ex. 23:7, Prov. 6:16-17, James 3: 9.)

The facts of science make clear that from the earliest stages of development, the unborn are unquestionably human. Hence, Biblical commands against the unjust taking of human life apply to the unborn as they do other human beings.

Moreover, if humans have value only because of some acquired property like self-awareness—as critics of the pro-life view assert—it follows that since this acquired property comes in varying degrees, basic human rights come in varying degrees.

Theologically, it's far more reasonable to argue that although humans differ immensely in their respective degrees of development, they are nonetheless equal because they share a common human nature made in the image of God. (For more on these points, [go here](#).)

## Task #2: Engage the culture with a persuasive defense of the pro-life view.

Scientifically, pro-lifers contend that from the earliest stages of development, the unborn are distinct, living, and whole human beings. True, they have yet to grow and mature, but they are whole human beings nonetheless. Leading embryology textbooks affirm this.



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Philosophically, pro-lifers argue that there is no morally significant difference between the embryo you once were and the adult you are today. Differences of size, level of development, environment, and degree of dependency are not relevant in the way that abortion advocates need them to be.

For example, everyone agrees that embryos are small—perhaps smaller than the dot at the end of this sentence. But since when do rights depend on how large we are? Men are generally larger than women, but that hardly means they deserve more rights. Size does not equal value. Pro-lifers don't need Scripture to tell them these things. They are truths even atheists and secular libertarians can, and sometimes do, recognize.

## Task #3: Communicate redemption to post-abortion individuals and point them toward healing resources.

I once had a Christian woman say to me, "What about people who commit grave moral sins like abortion? Even after repenting again and again, the guilty feelings linger. How can I ever be justified in God's sight?"

Post abortion men and women desperately need redemption and the gospel of Jesus Christ provides it. With it, they live each day assured God accepts them on the basis of Christ's righteousness not their own. They experience unspeakable joy knowing their past, present, and future sins are not counted against them. Instead of ignoring abortion and refusing to show Christians what's truly at stake, we should use this difficult topic to reiterate the great truth of the gospel, which alone frees people to pursue passionate ministry for the kingdom. Confusion about this leads to spiritual depression and, in some cases, years of emotional pain.

However, the good news of redemption only makes sense against the backdrop of God's holiness and man's sinfulness. There really is nothing we can do to turn away the righteous wrath of almighty God. As Paul makes clear in Ephesians 2, people who are "dead" in their sins can't possibly help themselves before the bar of God's justice. Someone else has to take the rap for us and provide the righteousness we don't have.

Thankfully, someone did. The righteousness that God demands is the righteousness that He alone provides through Jesus Christ. Paul is clear: It is God who justifies the ungodly (Romans 4:5; 8:30,33) and He both initiates and completes the salvation process for His people. The

work is totally His. No wonder Paul excludes boasting—for it's by grace we've been saved through faith (Ephesians 2: 8-9).

Tragically, when we ignore the issue of abortion for fear of "laying a guilt trip on people" we distort the redemptive gospel he's sworn to preach. Silence on the issue does not spare post-abortion men and women guilt; it spares them healing: unconfessed sin is keeping these wounded souls from full-fellowship with their Savior.

Those who are wise avoid the twin extremes of heavy-handed (and graceless) "preaching" on one hand, and ignoring sin on the other. Instead, they opt for a Biblical third alternative: they articulate the balanced pro-life perspective that abortion is sinful and then point to remedy - the cross of Christ.

*Scott Klusendorf is President of Life Training Institute and author of "The Case for Life: Equipping Christians to Engage the Culture" (Crossway, 2009)*



*Want more information about communicating the Sanctity of Human Life persuasively, passionately and practically? Need some sample speaking outlines or 5-Minute Pro-Life talking points? Go to: [www.prolifetraining.com](http://www.prolifetraining.com) or [www.caseforlife.com](http://www.caseforlife.com).*





## 2. Beginning of Life



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## What the Bible says about the beginning of life

The Bible is far from silent on the topic of the sanctity of human life, especially in the womb. This resource provides just a few of the Scripture verses that speak to the value of preborn life created in God's image from the moment of fertilization.

### Why should we value life?

"Know that the lord Himself is God; it is He who has made us, and not we ourselves; we are His people and the sheep of His pasture."

—*Psalm 100:3, NASB*

"Thus says the lord, your Redeemer, and the one who formed you from the womb, 'I, the lord, am the maker of all things, stretching out the heavens by Myself, and spreading out the earth all alone.'"

—*Isaiah 44:24, NASB*

"But now, O lord, You are our Father, we are the clay, and You our potter; and all of us are the work of Your hand."

—*Isaiah 64:8, NASB*

### Who is the creator of the preborn child?

"For You formed my inward parts; You covered me in my mother's womb. I will praise You, for I am fearfully and wonderfully made; marvelous are Your works, and that my soul knows very well. My frame was not hidden from You, when I was made in secret, and skillfully wrought in the lowest parts of the earth. Your eyes saw my substance, being yet unformed, and in Your book they all were written, the days fashioned for me, when as yet there were none of them."

—*Psalm 139:13-16, NKJV*

"Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations."

—*Jeremiah 1:5, NIV*



Development of the hands at 7 weeks after fertilization

### Is God concerned with the preborn child?

"But God chose me before I was born. By His loving-favor He called me to work for Him."

—*Galatians 1:15, NLV*

"Praise the God and Father of our Lord Jesus Christ for the spiritual blessings that Christ has brought us from heaven! Before the world was created, God had Christ choose us to live with him and to be his holy and innocent and loving people."

—*Ephesians 1:3-4, CEV*

### Are preborn children human beings?

"When Elizabeth heard Mary's greeting, the baby leaped in her womb, and Elizabeth was filled with the Holy Spirit . . . [saying] 'As soon as the sound of your greeting reached my ears, the baby in my womb leaped for joy.'"

—*Luke 1:41,44, NIV*

The Lord Jesus Christ began his incarnation as an embryo—growing into a fetus, infant, child, teenager and adult. "While they were there, the time came for the baby to born, and she gave birth to her firstborn, a son."

—*Luke 2:6-7, NIV*



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## Who is responsible for life and death?

"Then God spoke all these words, saying, 'You shall not murder.'"

—Exodus 20:1,13, NASB

"I call heaven and earth to witness against you today, that I have set before you life and death, the blessing and the curse. So choose life in order that you may live, you and your descendants."

—Deuteronomy 30:19, NASB

## Are humans permitted to take life before birth?

"If men who are fighting hit a pregnant woman and she gives birth prematurely but there is no serious injury, the offender must be fined whatever the woman's husband demands and the court allows. But if there is serious injury, you are to take life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, bruise for bruise."

—Exodus 21:22-25, NIV

## Should a child conceived as a result of rape or incest be aborted?

"Fathers shall not be put to death for their sons, nor shall sons be put to death for their fathers; everyone shall be put to death for his own sin."

—Deuteronomy 24:16, NASB

## Should a child who might be born deformed or disabled be aborted?

"The lord said to him, 'Who gave man his mouth? Who makes him deaf or mute? Who gives him sight or makes him blind? Is it not I, the lord?'"

—Exodus 4:11, NIV

"Woe to him who quarrels with his Maker, to him who is but a potsherd among the potsherds on the ground. Does the clay say to the potter, 'What are you making'? Does your work say, 'He has no hands'? Woe to him who says to his father, 'What have you begotten?' or to his mother, 'What have you brought to birth?' This is what the lord says—the Holy One of Israel, and its Maker: Concerning things to come, do you question me about my children, or give me orders about the work of my hands?"

—Isaiah 45:9-11, NIV

"But God chose the foolish things of the world to shame the wise; God chose the weak things of the world to shame the strong."

—1 Corinthians 1:27, NIV

## How should a woman view her body and the preborn child growing in her womb?

"Behold, children are a gift of the lord; the fruit of the womb is a reward."

—Psalm 127:3, NASB

"Or do you not know that your body is a temple of the Holy Spirit who is in you, whom you have from God, and that you are not your own? For you have been bought with a price: therefore glorify God in your body."

—1 Corinthians 6:19-20, NASB

## Does God forgive those who have had abortions?

"In him we have redemption through his blood, the forgiveness of sins, in accordance with the riches of God's grace"

—Ephesians 1:7, NIV

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## Human Development

People have marveled at and tried to understand the miracle of life for centuries. It's a mystery how two microscopic cells can unite and become a new human being! This has puzzled and delighted everyone from poets and philosophers to scientists and parents since the beginning of time.

Now, thanks to recent advances in medical science and imaging techniques, we have the unequalled privilege of observing the developing life within the mother's womb. With this technology, we can see the miraculous fusion of two cells that culminates in a fully formed human life in a mere 266 days. Witness this miracle in the making as we journey through the first 9 months of life.

### Dating Your Pregnancy

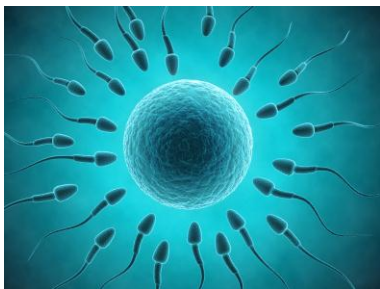
Pregnancy terminology can be confusing. There are two ways of dating pregnancy:

**Gestational age** is the term traditionally used by health care professionals to date pregnancy and refers to how long it's been since the **first day of the mother's last menstrual period (LMP)**. The gestational age (in **bold brown** throughout this section) begins two or more weeks before the fertilization of the egg by the sperm.

**Fertilization age** (shown in **bold teal**) refers to how long it's been since **conception: the fertilization of the egg by the sperm**. Most women ovulate (release a mature egg from the ovary) in the middle of their monthly cycle. For instance, if a woman has a 28-day cycle, she will typically ovulate around the 14th day after her last period began. If a sperm fertilizes the egg, at that moment a new life begins, and this becomes the first fertilization day.

Before a woman even misses her menstrual period, if an egg has been fertilized, this is what occurs in a normal pregnancy.

*[We believe the dates shown, though approximate, to be accurate.]*



### 2 Weeks /

#### Conception day

The egg and sperm most often unite in the fallopian tube (tube from the ovary to the uterus) to form a single cell called a zygote. This tiny new cell, smaller than a grain of salt, contains

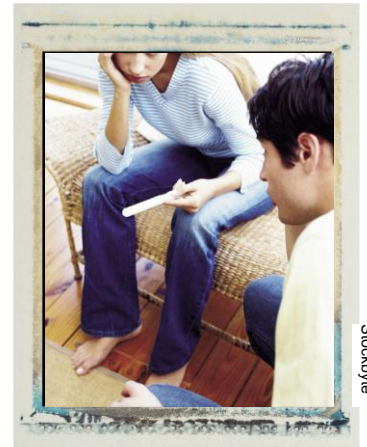
all the genetic information for every detail of the newly created life—the color of the hair and eyes, the intricate fine

lines of the fingerprint, the physical appearance, the gender, the height and the skin tone.

*[The baby's due date can be estimated by taking the first day of the mother's last menstrual period, subtract 3 months, and add 7 days.]*

**Days 2–5** This new life is now called an embryo, and his or her cells continuously divide while traveling down the fallopian tube before arriving at the uterus, around days 3 to 4. Meanwhile, the lining of the uterus prepares to receive this new life.

**3 Weeks / 1 Week** The embryo begins to implant in the lining of the uterus on about day 6. Once this occurs, hormones trigger the mother's body to nurture the pregnancy and prevent her monthly periods. A blood test can show that the mother is pregnant. Around day 8, the baby is about the size of the "period" used in this sentence.



**4 Weeks / 2 Weeks** A pregnancy test taken at this point can measure hCG, the pregnancy hormone in the mother's urine, and tell her if she is pregnant. By now, the embryo is completely attached to the lining of the uterus and draws nourishment from its mother.

**5 Weeks / 3 Weeks** The heart, about the size of a poppy seed, is the first organ to function: it begins to beat just 21 days after fertilization! The first signs of brain development are evident, and the foundation for every organ system is already established and beginning to develop.

**6 Weeks** Just **4 weeks after fertilization**, the baby is growing rapidly and measures 1/8 of an inch long. The basic structure for the entire central nervous system (brain and spinal cord) has formed. The eyes are developing, and the arm and leg buds are now visible. The beating heart can be seen on an ultrasound scan - it's already beating about 80 times a minute!

**7 Weeks** The baby is now 1/3 of an inch long and is making its own blood. Depending on the baby's gender, the testicles or ovaries are beginning to form.

*[You should know . . . Fetal lengths and weights given are merely averages. Babies are measured from the top of the head to the rump, or bottom, before 20 weeks. After that, they are measured from head to heel.]*



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**8 Weeks** The baby is now about  $\frac{1}{2}$  of an inch long. The elbows and fingers can be seen. The embryo can respond to touch by reflex, and some reports show that the embryo can move its trunk and limbs. Lungs begin to develop. Taste buds are forming on the tongue, tooth buds for “baby teeth” are taking shape in the jaw, and eyelids are beginning to form.



## 9 Weeks

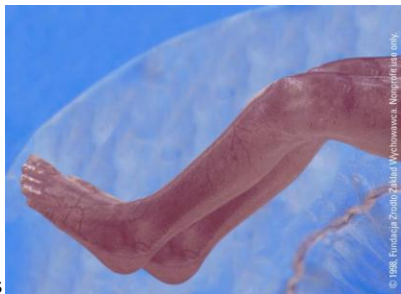
The baby measures  $\frac{3}{4}$  of an inch long and weighs almost  $\frac{1}{4}$  of an ounce. The developing ears and nose are visible, and there is pigment in the retina. Nipples can now be seen on the chest. The limbs and fingers are growing rapidly, and the bones in the arms are beginning to calcify and harden.

## 10 Weeks

Now, for the first time in development, the brain can make the muscles move on purpose. The baby's brain is growing rapidly. Each minute it produces almost 250,000 new neurons! The upper and lower portions of the arms and legs are clearly seen, as well as the fingers and toes. By now the external ear is fully developed. A baby boy begins to produce the male hormone, testosterone.

**11 Weeks** Because the baby has all of the major organ systems and is a distinctly recognizable human being, he or she is no longer called an embryo but is now known as a fetus, a Latin word for “young one.” The baby is about 2 inches long and can yawn and suck. The eyelids are fully formed and closed to protect the developing eyes. During the next several weeks, his or her body will grow rapidly, increasing in weight 30 times and tripling in length!

**14 Weeks** Now  $3\frac{1}{2}$  inches long, the “young one” is coordinated enough to find his or her thumb and suck it. You can see the beginnings of the fingernails and toenails. The baby is able to urinate and swallow. Although these feet have been kicking for about a month, his mother can't feel the movement yet.



**16 Weeks** The heart beats between 110 and 180 times per minute and pumps about 6 gallons of blood each day. The gender of the baby might be seen on ultrasound. If she

is a girl, millions of eggs are now forming in her ovaries. At almost 5 inches in length and weighing nearly 4 ounces, the baby can coordinate the movement of its arms and legs, though his or her mother will not likely feel it yet.

**18 Weeks** In just 2 weeks, the fetus has almost doubled its weight to 7 ounces. The skeleton is hardening and calcifying and is visible on ultrasound. Reflexes such as blinking and frowning are now developed. The baby has its own unique fingerprints and toe prints. Some studies show that the baby can feel pain as early as 18 weeks.

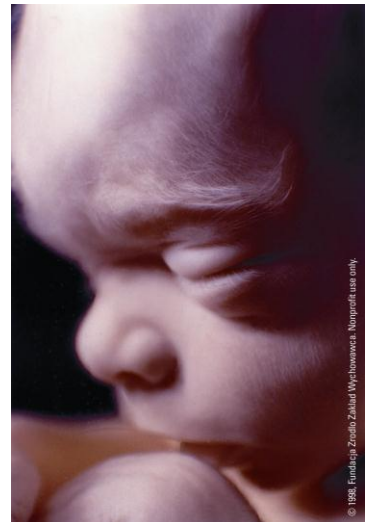
**20 Weeks** The fetus is now about 10 inches long from head to heel and weighs 11 ounces. The baby has unique waking and sleeping patterns and even has a favorite position to sleep in. The pregnancy is about half over, and the mother is beginning to “show.”

**22 Weeks** The baby is about 11 inches long and weighs about 1 pound. If the baby is male, his testicles are beginning to descend from the abdomen to the scrotum. Hair is visible on his or her head and body. From now until about 32 weeks, the baby feels pain more intensely than at any other time in development.

**24 Weeks** The baby now weighs about  $1\frac{1}{2}$  pounds and inhales amniotic fluid in preparation for breathing. The ear has developed to the point where the baby recognizes his or her mother's voice, breathing and heartbeat. About a week ago, rapid eye movements began, an activity associated with dreaming. The baby may have a blink-startle response resulting from sound applied to the mother's abdomen. Some babies born at this stage of development are able to survive.

**26 Weeks** Now the baby weighs almost 2 pounds and he or she can react to sounds outside the mother's body. Eyes can now respond to light and the permanent teeth buds are apparent in the gums. Eyelashes and eyebrows are well-formed and the hair on the baby's head is growing longer.

**28 Weeks** The baby is now approximately 15 inches long and weighs about 2  $\frac{1}{2}$  pounds. With the support of intensive care, a baby born at this stage is capable of breathing air. The brain is developed enough to coordinate rhythmic breathing and regulate body temperature. As the baby continues to gain weight, the skin becomes less wrinkled and more smooth.



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**34 Weeks** The baby is now almost 17 inches long, weighs 4½ pounds, and continues to grow and mature. By this stage of development, the eyes are wide open and if a light were shone into them, the pupils would constrict. The head is covered in hair, the fingernails have reached the tips of the fingers, and the toenails are close behind. The lungs are still developing, so if born at this stage the baby will probably need some assistance breathing.

**40 Weeks** The baby is now around 20 inches long and may weigh 7 to 8 pounds. He or she has a plump body and a firm grasp. Typically, the baby is head down in the mother's pelvis and awaiting birth. Be patient—only 4 percent of babies are born on their due date!

## If You Are Pregnant . . .

It's normal to have questions and concerns about your pregnancy. The single most important thing to do right away is schedule an appointment with a medical professional who takes care of pregnant women—an obstetrician, family doctor or certified nurse-midwife—so that you can get the answers you need.

These caregivers can also help you understand how to make healthy, nutritional choices, and recommend exercise that will keep you feeling fit during your pregnancy and after your baby is born. Scheduling regular prenatal appointments can give you confidence to know that you are taking good care of yourself and your baby.

Of course, babies set their own timetables, and every pregnancy is different, but isn't it amazing to consider the incredible development that happens in the first 9 months of life?

**Facts about fetal development were taken from the following sources:**

### Publications:

- Moore and Persaud. *The Developing Human: Clinically Oriented Embryology*, 7<sup>th</sup> Edition.
- Elsevier Health Services, 2000. Pennsylvania: Saunders, © 2001
- Larson, William J. *Essentials of Human Embryology*. Elsevier Health Services, 1997. New York: Churchill Livingstone, 1998
- Tallack, Peter. *In The Womb*. Washington, D.C: National Geographic 2006
- Campbell, Stuart M.D. *Watch Me Grow!* St. Martin's Press, 2004

### Web sources:

- Mayo Foundation for Medical Education and Research. "Fetal development: What happens during the first (second, third) trimester?" [www.mayoclinic.com/health/prenatal-care/PR00112](http://www.mayoclinic.com/health/prenatal-care/PR00112) (as well as /PR00113 & /PR00114)

- LaRossa, Maureen Mulligan, R.N., and Sheena L. Carter, Ph.D. "Understanding How the Brain Develops." [www.pediatrics.emory.edu/divisions/neonatology/dpc/brain.html](http://www.pediatrics.emory.edu/divisions/neonatology/dpc/brain.html)

### Other:

- Image of female reproductive system from the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. [http://en.wikipedia.org/wiki/File:Scheme\\_female\\_reproductive\\_system-en.svg](http://en.wikipedia.org/wiki/File:Scheme_female_reproductive_system-en.svg)
- Anand, Kanwaljeet, M.B.B.S., D. Phil. "Expert Report of Kanwaljeet S. Anand, M.B.B.S., D. Phil." Expert testimony before the U.S. Department of Justice describing the capacity of the fetus to feel pain.

The photos of the embryo and fetus credited to the Zrodlo Foundation, Krakow, Poland are © 1998 and used by permission, for non-profit use.

This section written by: Vicki L. Dihle, PA-C and Bradley G. Beck, M.D

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# Sanctity of Human Life

## When Does Life Begin?

Many of these quotes are listed on the website of Eternal Perspectives Ministries: [www.epm.org](http://www.epm.org)

When does human life begin? Many people say that this is a philosophical or religious question. Christians maintain that life begins at conception. Does this mean that the question of when life begins is purely religious? In reality, scientists agree on when human life begins.

"In that fraction of a second when the chromosomes form pairs, the sex of the new child will be determined, hereditary characteristics received from each parent will be set, and a new life will have begun."

Kaluger, G., and Kaluger, M., Human Development: The Span of Life, page 28-29, The C.V. Mosby Co., St. Louis, 1974:

"The two cells gradually and gracefully become one. This is the moment of conception, when an individual's unique set of DNA is created, a human signature that never existed before and will never be repeated."

In the Womb, National Geographic, 2005

"Biologically speaking, human development begins at fertilization."

The Biology of Prenatal Development, National Geographic, 2006.

"[The zygote], formed by the union of an oocyte and a sperm, is the beginning of a new human being."

Keith L. Moore, Before We Are Born: Essentials of Embryology, 7th edition. Philadelphia, PA: Saunders, 2008. p. 2

"Every time a sperm cell and ovum unite a new being is created which is alive and will continue to live unless its death is brought about by some specific condition."

E.L. Potter and J.M. Craig Pathology of the Fetus and the Infant, 3d ed. (Chicago: Year Book Medical Publishers, 1975), vii

"Although life is a continuous process, fertilization... is a critical landmark because, under ordinary circumstances, a new genetically distinct human organism is formed when the chromosomes of the male and female pronuclei blend in the oocyte."

Ronan O'Rahilly and Fabiola Miller, Human Embryology and Teratology, 3rd edition. New York: Wiley-Liss, 2001. p. 8

"Genetically the zygote is complete. It represents a new single celled individual."

Thibodeau, G.A., and Anthony, C.P., Structure and Function of the Body, 8th edition, St. Louis: Times Mirror/Mosby College Publishers, St. Louis, 1988. pages 409-419

"It is incorrect to say that biological data cannot be decisive...It is scientifically correct to say that an individual human life begins at conception."

Dr. Micheline M. Mathews-Roth, Harvard Medical School

"To accept the fact that after fertilization has taken place a new human has come into being is no longer a matter of taste or opinion...it is plain experimental evidence. Each individual has a very neat beginning, at conception."

Dr. Jerome Lejeune, "Father of Modern Genetics"

"The exact moment of the beginning of personhood and of the human body is at the moment of conception."

Dr. McCarthy de Mere, medical doctor and law professor, University of Tennessee:

"I am no more prepared to say that these early stages represent an incomplete human being than I would be to say that the child prior to the dramatic effects of puberty ... is not a human being....I have learned from my earliest medical education that human life begins at the time of conception."

Dr. Alfred Bongiovanni, Professor of Pediatrics and Obstetrics, University of Pennsylvania School of Medicine:

"When fertilization is complete, a unique genetic human entity exists."

C. Christopher Hook, M.D. Oncologist, Mayo Clinic, Director of Ethics Education, Mayo Graduate School of Medicine:

"Human life begins when the ovum is fertilized and the new combined cell mass begins to divide."

Dr. Jasper Williams, Former President of the National Medical Association, From Newsweek November 12, 1973 (p 74):

"At the moment the sperm cell of the human male meets the ovum of the female and the union results in a fertilized ovum (zygote) a new [human] life has begun."

Van Nostrand's Scientific Encyclopedia:



# Sanctity of Human Life

## Help at the Point of Need

In God's eyes, there are no surprises. We humans, with our limited perspective, are sometimes stunned by the events He allows into our lives. But God always has both a plan and a provision. When an unintended pregnancy interrupts the "script" a young woman (and her family) has sketched out for her life, many conflicting emotions compete simultaneously for center stage: panic, fear, anger, guilt and others.

The exciting news, which she needs to hear, is that God's



forgiveness will meet her at her point of need, and His sufficiency will abundantly supply. One way He often does that—in fact, the most common way—is through His people.

Pregnancy medical clinics (PMCs) and pregnancy resource centers (PRCs) are on the front lines in most communities. They offer essential services to a woman facing an unexpected

pregnancy, as well as an opportunity to discuss vital alternatives to abortion. PMCs offer pregnancy confirmation through ultrasound, which gives the young mother an opportunity to view the amazing development of her preborn baby. A woman's family members and the father of the baby also struggle through this time, and can find a safe place to deal with their own feelings and responsibilities regarding her pregnancy.

These PMCs/PRCs play a unique role in helping to protect women's health and allowing them to discuss all their options because unlike abortion clinics, these ministries have no financial interest in the choice the woman makes. Typically, PMCs/PRCs offer three kinds of services:

## Intervention

Most PMCs/PRCs provide such services as pregnancy tests, alternatives, childbirth and parenting classes, adoption education, information about insurance programs for which a woman can apply, maternity and baby clothing and supplies—all free of charge and confidential. She is encouraged to include others in her world who may also need to be present, such as the father of the baby or her parents.

Increasing numbers of PRCs have converted into pregnancy medical clinics that operate under the direction of a local physician and on-site nurse manager. A huge advantage to the woman is provision of her first obstetrical ultrasound to confirm that she is truly pregnant. During this exam, the young mother has the opportunity to come face to face with her preborn child. Many babies have been seen to suck their thumbs, have hiccups, and even jump while on the screen.



These services ensure that women have accurate information and the knowledge of the help available before they make the irreversible decision of abortion. Based on reports from pregnancy medical clinics that have received ultrasound grants from Focus on the Family since 2004, **more than 100,000** abortion-minded women have decided to carry their baby to term after seeing an ultrasound and receiving counseling. Surely, a woman has a right to this kind of information *before* making an irreversible decision about her pregnancy. Some pregnancy medical clinics also offer free testing and treatment for sexually transmitted infections and prenatal care.

## Prevention

Clinics/centers often provide abstinence education in both public and private schools, churches, and community organizations to help teens avoid behaviors that lead to unintended pregnancy and sexually transmitted infections. These programs are extremely effective in helping teens make healthy choices for their lives until marriage.

## Reconciliation

For a woman (or a man) who has undergone an abortion, the devastation can be real and ongoing if she (or he) doesn't receive help. Bible studies designed to bring these individuals to God's forgiveness and healing are offered in most clinics/centers and allow an opportunity for people to understand that they are not alone in their feelings, and to experience the freedom that comes from knowing that abortion is not the "unforgivable sin."

If a woman (or man) does not feel comfortable in a group setting, most PMCs/PRCs offer an opportunity for one-on-one support. To find the pregnancy resource center in your area, look in your local Yellow Pages directory under the heading "Abortion Alternatives," go online to visit [www.optionline.org](http://www.optionline.org).



# Sanctity of Human Life

## The Journey of a Lifetime . . .

*By Tammy Tate, R.N.*

On a rainy July afternoon, a young mother called me. The trembling voice on the phone asked, "Are you the hospice nurse?" Before I could answer she said, "My baby is going to die and I really need your help."

Julie was approximately 20 weeks pregnant when her unborn baby girl was diagnosed with Trisomy 18, a lethal chromosome abnormality. At the time of diagnosis, Julie was given the option to terminate her pregnancy, but she and the baby's father, Joey, chose instead to proceed with her pregnancy. Her desire was to honor and cherish whatever time she had with her daughter. Only now, she found herself alone with little support or direction.

### Heartache

Few events in a family's life bring more excitement and joy than the anticipation of a new baby. Suddenly, conversations are all about babies. Baby names, nursery themes, baby showers and the list goes on. But for some parents, joy can suddenly be replaced with heartache and despair when the unexpected news comes that their much loved unborn baby has a serious medical condition that will likely result in death. In a moment, lives are changed, dreams are shattered, and the family is caught up in a whirlwind of uncertainty and grief; parents find themselves facing difficult decisions with no simple answers.

Because of the advances in prenatal testing, parents are finding out much earlier when there is a terminal diagnosis. Traditionally, the treatment or option most often advised is termination of the pregnancy. But for many, termination is not the desired option and thus, the need of supportive programs for this newly identified parent population has surfaced.

### Another Choice

Perinatal hospice, a relatively new concept of care, is being offered as a viable option for parents who choose to carry their baby to term. This care incorporates grief support and education from the time of diagnosis, throughout the pregnancy, and then through the bereavement period.

Perinatal hospice involves a team approach of physicians, nurses, social workers and bereavement counselors - everyone working together - helping to ease the emotional suffering while preserving the dignity and integrity of the family as they make meaningful plans to honor the life of their baby.

As Julie sat in my office and shared her story with me, I listened closely to her dreams for her daughter. We talked a lot about the grief and emotions that would accompany her on this journey, not just for her, but her family as well,



and then we discussed her practical needs. I presented Julie with a written guidebook for helping her to make preparations - a guidebook filled with educational resources and tools that offered her options to create the experience she hoped for. Encouraging her and her family to be involved in decisions and planning made her feel she had some control in an out-of-control situation. It allowed her to parent.

### Birth Plans

One of the many roles of perinatal hospice is providing practical guidance, and probably the most important task we assist parents with is the creation of a birth plan. It is essential and its purpose is two-fold. First, it provides the details of the medical preferences the parents have for delivery, such as pain management and medical interventions desired for their baby. Second, it gives parents the opportunity to briefly share the story of their personal journey and what their precious baby means to them. When birth plans are in place, there are no questions as to the parents' wishes. Doctors and nurses say birth plans are a key element in seeing that the wishes of the parents are fulfilled.

### Family Keepsakes

Another focus for the parents is the collection of keepsakes. Collecting and finding ways to validate their baby's life is very important to all parents. Whether it is taking family pictures of mom's pregnant belly or journaling the details of the pregnancy, these mementos provide tangible evidence that affirms the lifetime and special significance of their baby and will be comforting to the family for years to come.

Sometimes this involves referrals to The Now I Lay Me Down to Sleep Foundation, which offers the services of professional photographers across the country who volunteer their time and talent to help provide keepsake photos for families experiencing the death of a newborn.

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## Support

Perinatal hospice involves much more than just birth plans and keepsakes. Other options offered might include:

- Assisting with memorial service plans
- Attending delivery as a patient advocate and emotional support for the family
- Facilitating family referrals for spiritual support as requested
- Providing follow-up bereavement support

Regardless of how much strength or courage a family has, the decision to carry a baby to term with a lethal diagnosis is not easy. The journey is difficult and painful. But parents who have done so have said they found peace and comfort in knowing they did everything possible to give their baby the best chance at life. Their initial feelings of despair were replaced with new found hope of sharing in their baby's life regardless of the time they had.

## A Gift of Time

As for Julie and Joey, their precious baby daughter Rabecca was born on October 1, 2007. They prayed that Rabecca would be born alive and their prayers were answered. They prayed for more time to spend with her and their prayers were answered again! The sixty-seven days Rabecca lived were a gift, and they lived every one of those days building memories of her lifetime. Julie shared this about her experience with perinatal hospice.



*"Before I walked into that office I had no idea how badly I needed help. I don't know how I would have made it through alone. I wanted to give my little girl the best chance possible at being born alive. I am so grateful that I had someone there to support the decision that I had made to carry her to term. Each and every detail and wish that I had for the birth of my daughter was paid attention to and respected and 67 days later when my baby got her angel wings, my support was there in my room holding my hand."*

*"How do you do that alone? You don't, not when there are programs available to assist you like perinatal hospice. I am so thankful for everything that you did for me and my family. You helped make this transition so gentle and loving. I could not have gone through this without you!"*

## Comfort Care

Perinatal hospice offers reassuring comfort to the family, but they are not the only ones who appreciate this approach to caring for families who find themselves having to make extraordinary health care choices, as one neonatologist said to me:

*"Although I have worked in several prestigious perinatal centers (Emory and Duke University, I was unfamiliar with the concept of perinatal hospice. My patients have expressed to me the great comfort they have experienced in having a team of health care professionals who understood the complexity of their baby's diagnosis and the lethal nature of her defects. They greatly appreciated the careful counsel they received in developing a health care plan that focused on comfort care. This was very reassuring to me as a clinician. And for the family it made a huge difference."*

When little Rabecca passed away after over two months of being loved and tenderly cared for by her parents, her doctor had this to say, "Rabecca's life has really been a miracle and she has taught all of us that medical knowledge is not perfect and that we should proceed with great caution when we try to predict the outcome of neonates with severe defects."

The journey of love and loss continues toward healing one day at a time for Julie and Joey. But they have no regrets and have said to me many times; "Rabecca taught us a lot about life and to cherish every moment and every breath God gives us. Without ever uttering a word, her life changed ours."

Tammy Tate, R.N. is the CEO and co-founder of Carolina Perinatal Support Network in Greenville, SC. She is the author of, **The Journey of a Lifetime: A Parent's Guide to Planning and Celebrating a Baby's Brief Life**. Full of practical ideas, helpful tools and templates, this guide will empower parents to create a memorable and loving experience for this unforgettable journey. It is also a welcome resource for physicians who have limited or no perinatal hospice resources available and to help perinatal hospice programs to enhance the care of their families. Learn more about Tammy's work at [www.perinatalcomfortcare.org](http://www.perinatalcomfortcare.org)





# Sanctity of Human Life

## One Family's Story

### Pearl

by Laura Huene

*When our journey with Pearl here on earth was over, my doctor, who is also a personal friend, said to us, "Now I see why you did this the way you did." Also, a precious friend, who is a Labor and Delivery nurse, said to me, "I understand why you did this, and now I see why you love her so much. I will never tell anyone to terminate after a fatal diagnosis again."*

*Let me start at the beginning of our journey...*

It is March 22, 2006 when we go in for our routine 20-week ultrasound. We are informed that our precious unborn child, Pearl, has Alobar Holoprocencephaly with severe facial anomalies. We are devastated by the news. We have three beautiful children and were thrilled to be having our 4th. We do not know how we are going to navigate our way through these uncharted waters.

As I lay on the table in the perinatologist's office, he tells us her condition is fatal and asks us what we plan to do. "Do you think we should terminate?" He says, "Yes." No other options are presented to us.

I convey to the doctor my belief that this life is a gift. We will cherish each moment we have with her. We will not terminate. He informs me of the risks, then steps out of the room for a few minutes to let us "think about our decision."

There is no more decision to be made. We are going to honor Pearl's life by carrying her for as long as my body will allow. We trust that God is in control of a seemingly out of control situation. The perinatologist makes sure that we know time is not going to change the diagnosis. They can do nothing to make this better.

As a labor and delivery nurse, I am familiar with this diagnosis and know that we have a hard road ahead of us. Leaving that office I understand how people can get caught up in a vortex of emotions and choose to escape a hopeless, heartbreaking situation by terminating their pregnancy.

### Alone

A crushing sense of loneliness engulf us as we rehash our day. There is no comfort for our hearts and no encouragement to continue on the path we have chosen. I scour the Internet looking for information and support. There are some great sites for grieving parents who have lost children, but I find no place for parents who are carrying a baby to term in spite of a fatal diagnosis.

We find one good book, on the waiting process, but we are hungry for so much more. At the beginning, I throw myself into making arrangements for the end: a care plan for Pearl

at birth, and a method for handing her into the arms of Jesus.

### So much living to do

One day I realize that I'm focusing so much on the future, that I'm missing the present. Pearl is with us now. She is a part of our daily lives; part of our family. I choose to wear Pearl proudly.

And at the same time, we are profoundly sad. As we teach our 6-year-old son how to ride a bike, we cry because know we will never experience this with Pearl. She will miss so much of life, and we grieve that loss even though she is still with us in my womb, growing and moving. But through it all, we strive to treasure each moment we have with her.

We go to the doctor every two weeks and are thankful for each peek we are able to take into her world. The ultrasound is a gift for our aching hearts, allowing us to see her one more time. We are not wishing the days away. The day of her birth will come soon enough. We try to keep an eternal perspective on our current situation.

### Friends

Word spreads about our situation and, not surprisingly, we find that people do not know what to say to someone who is carrying a baby that is going to die. Our friends are now uncomfortable around us.



Courtesy of the NILMDTS Foundation

I want to break down the barriers and tell them to just ask me how I am doing. "Stop making excuses about why you haven't called me. Don't be afraid to cry with me. Pearl is not dead, she is very much alive right now. Don't treat me like I am walking around with a corpse in my womb. Celebrate her life with us. Honor her. Smile at my ever-expanding waistline, and don't run away from me. Don't ignore what is going on with us, and don't give me your spiritual platitudes. Just say you are thinking of me and ask what you can do for us." We long for emotional support for our hearts and minds.

### Family

This journey is also reshaping our family. Our hearts' cry is that this "new" family will be more refined than ever before. Our other three children are incredible. They seem to know when we need a hug and when we just need some downtime.

As I sit with our 6-year-old son and talk about Pearl, he wants to know what she will look like. I think about it for a moment and realize that only the truth will suffice for this curious mind. I tell him about her facial malformations and

# Sanctity of Human Life

about our fears for her. I ask him how he feels about the problem with her eyes and nose. He looks at me with those beautiful green eyes and says, "It's OK mom, I'm not afraid. She is my baby sister and I love her. I want to see her." I hold him as I weep. We should all have that same kind of unconditional love for those around us that appear to be different.

A few weeks later, he tells me that he wishes that there were two of him. He says, "I wish there could be one of me in heaven so I could be with my baby sister, and one of me here so I could be with my family." How is he able to articulate so well exactly what I am thinking?

Our other two are equally as loving. The four-year-old rubs my belly, talking to "Baby Pearl." He wants to know when she is moving and to make sure she knows he loves her. Our two-year-old daughter comes to me when I'm crying — which seems to be a lot lately — and says, "You want Daddy? You want Lovie?" — the two things that she knows always make her feel better.

"Daddy" makes me feel better, too. In fact, words cannot describe what a rock my husband is for me. He holds me when I need it and does not waver in our decision to take hold of the time we have been given with Pearl, even though he knows it is painful to walk this path. He assures me he is not afraid; that he knows that God walks with us. That is where his strength comes from and I am drawing from that when I am feeling weak.

I love the way he talks to his "princess" and so lovingly caresses my growing belly. He assures me I am beautiful even when I am feeling the opposite. Without this brave man at my side I would not be able to walk this journey. He loves me so well, and I can only hope I am loving him well too.

## Birth Plans

The time of Pearl's birth draws near. We know our time with her in our arms is going to be short, so we do everything we can to prepare. I create a very detailed birth plan so there can be no questions as to what we want during my labor and delivery. I think for a long time about the different keepsakes I want to have with me. Our bag for the hospital begins to look like an aisle in Hobby Lobby; however, each item is meaningful. We have plaster for hand molds, clay for hand and foot-prints, scissors for a lock of hair, cameras, and my favorite oil that I have used after each of my children's first bath. A professional photographer with the organization Now I Lay Me Down To Sleep will donate their time to take priceless bereavement photos. There is not a detail overlooked.

## Preparing to Meet Pearl

I am approaching 32 weeks gestation, and the amniotic fluid increases rapidly. My doctor becomes concerned for my health. We have one therapeutic amnio to release the

excessive amount of fluid in my uterus, and just five days later all the fluid is back, and more. It is time to meet Pearl.

On June 5th, after a long, emotional labor, Pearl Jean Huene is born at 7:12 am. She weighs 4 pounds, 1 ounce and is 17 ½ inches long. Our time with her is unforgettable. We are able to lovingly release her into the arms of Jesus.

We have a beautiful memorial service for Pearl and are surrounded by so many who love us. The outpouring of love and support from our community is incredible. We give those around us the opportunity to be a part of her life as well as her death.

## The Gift of Time

We are so thankful to have had that time with our daughter. We do not regret our decision. At the same time, we know we need professionals to help us navigate our way through the postpartum period, as well as the intense period of grieving that follows Pearl's death. Hopefully someday we will be able to help someone else as they walk the painful journey of saying goodbye to their child much too soon. In the past year our lives have been filled with a wide range of emotions. Grief is a process that never really comes to a close.

We recently began a new chapter in the life of our family. Lucy Jean Huene was born on June 28, 2007, and is a picture of hope and God's redemptive plan for our lives. The sweet breaths that tenderly brush my face in the wee hours of the morning serve as a gentle reminder of how majestic life is. There is no greater honor than witnessing God's awesome handiwork. All life -- whether a work of art declaring God's creative mastery here on earth or a divine creation whisked straight to heaven — is sacred.

*Laura Huene is married to Joshua Huene and they live with four of their children in Denver, CO. Pearl's legacy is that now Laura is reaching out to help other parents who are walking the same journey that she and her family have walked. You can visit her website for families facing a fatal perinatal diagnosis at [www.stringofpearlsonline.org](http://www.stringofpearlsonline.org).*



Photo by Audrey Imfeld,  
NILMDTS



# Sanctity of Human Life

## Adoption: a viable option

### Deciding between adoption and single motherhood

- LIE No. 1: Adoption equals abandonment
- LIE No. 2: Adoption equals deception
- LIE No. 3: Adoption equals an unbearable sacrifice

### “You’re pregnant!”

However, if you’re unmarried, a pregnancy may well be some of the worst news you’ve ever received. You may be feeling shock, fear, dismay, guilt or embarrassment. You probably feel alone, scared and overwhelmed about the decisions you need to make.

Deciding whether to raise a baby as a single mother or make an adoption plan with a loving two-parent family can be a difficult one, full of churning emotions. Other people may have strong opinions about what should be done, however, the mother is the one who should decide who can do the best job of raising her baby.

It is difficult to get an accurate picture of adoption with all the unbiblical trends and ideas in our society about single motherhood. In particular, when magazines and TV shows glamorize the growing numbers of actresses and other female entertainers having babies outside of marriage, it’s tempting to get the idea that single motherhood is just another acceptable “option” for life and parenthood.

Of course, the media fails to mention that raising a baby on a celebrity’s income is an entirely different situation from the poverty-level existence that most single mothers and their babies experience. Nor do you hear much of anything about how these “Hollywood babies” are turning out without fathers in the home . . . and the statistics about the effects of fatherlessness on children are anything but glamorous.

No—not at all. Simply make an appointment to talk to one or more agencies that interest you. When you meet with a staff member from the agency, ask them to explain what the different adoption “options” are, what the process is and how they screen prospective adoptive parents. Ask all the questions you need to. The truth is that the more information you get (no matter what you decide in the end), the more likely you are to make the right decision.

### When you’re considering adoption

Check to find out what the requirements for prospective adoptive parents are in your particular state, and work with a licensed adoption professional.

Almost without exception, birth mothers who choose an adoptive family for their baby later say it was the right decision. Yes, you will experience some grief temporarily, but you will be supported by caring counselors and the knowledge that you made the best decision for your baby.

### Here are some facts you should consider during this important decision-making process:

- Statistically, adopted children have stronger identities and self-esteem than children raised by single mothers.
- Adoption saves your child from the all-too-frequent damage that comes from being raised in a fatherless home.
- Dads *do* make a difference!
- Children in families without fathers are five times more likely to grow up in poverty
- Children in families without fathers are three to four times more likely to commit suicide.
- Children in families without fathers are two to three times more likely to abuse drugs.
- 70 percent of long-term inmates grew up fatherless.
- Girls without a father in the home are more likely to get pregnant before marriage.
- Adoption is truly a heroic act—an act of love.

In most cases, adoption is the most loving and unselfish decision an unmarried, expectant mother can make. *Love is taking action in the best interests of another person or persons, regardless of one’s emotional feelings.* As one birth mother said of her choice to make an adoption plan for her baby daughter, “I knew that my decision would be the hardest thing in the world for me. It was about her. It was about what I could give her: a family, stability, a chance for a future.”<sup>7</sup>

*“I knew that my decision would be the hardest thing in the world for me. It was about her. It was about what I could give her: a family, stability, a chance for a future.”*

# Sanctity of Human Life

## The Truth About Abortion – The Serpent's Whisper



by Carrie Gordon Earll  
Senior Director, Public Policy  
Focus on the Family

I know how tempting abortion can be when faced with an unexpected pregnancy. That was my situation in 1981 was a single, pregnant college student. Abortion was legal and it seemed like the logical response to my dilemma, so I aborted the pregnancy.

From God's perspective, human life is of inestimable worth because it represents His image. Abortion is not a "social issue," it's a violation of His design for the sacred human lives it kills, wounds and scars.

For many women who experience an undesired pregnancy, the concept of human life as "sacred" rings hollow, offering little tangible support for those considering their choices in an abortion-friendly culture. The value of that tiny life growing in her womb loses distinction amidst her own needs, fears and uncertainty.

God's universal message declaring His likeness in humanity is crowded out by other voices around her: family, boyfriend or husband, job or school. If she listens closely to these voices, she may recognize an ageless and familiar utterance articulated in the quietness of a whisper.

A biblical account of this "woman whisperer" is found in Genesis when another woman's ear was tickled by a message contrary to God's. Her name was Eve, and her encounter with a wily serpent and subsequent choice to disregard God's instruction altered the course of human history.

The opening verse in Genesis chapter 3 recounts the story: "Now the serpent was more crafty than any of the wild animals the Lord God had made. He said to the woman, 'Did God really say, "You must not eat from any

tree in the garden?"' You can almost hear the serpent whispering in an enticing tone: "Did God really say...?"

The whisper challenged what Eve knew to be true, as is often the case with pregnant women considering abortion. As women, we know intuitively that it's not natural for us to kill our children. The very act of abortion disconnects us from our instinct to protect — not destroy — our young. If we listen to our intuition and the truth that is written on our hearts, we know that abortion is not our first choice. Circumstances may appear to make it our only choice; however, to abort our children disregards who we are as women and mothers. Abortion is contrary to what we know to be true.

Like Eve before us, we consider the serpent's whisper and the unthinkable embracing of abortion that it promotes. The serpent offered Eve half-truths that paved the way to justify disobeying God. Once she realized the heartbreak that resulted from her choice, Eve confessed what she failed to see at the time of her decision: "The serpent deceived me, and I ate."

Me, too, Eve. He deceived me, too.

The bitter fruit of abortion leaves more than an unpleasant aftertaste for those who eat it. Complications with future pregnancies, substance abuse and deep emotional regret represent only a few of the unintended consequences awaiting us when we are deceived by the serpent's whisper. Women whose ears are open to this murmuring soft voice need tangible support to counter its appeal — support that is available through a network of pro-life pregnancy resource and medical centers across the nation.

Women have a choice. The voice of truth will always silence the lies, if only we will listen.



*If you regret an abortion in your past, you might find this short booklet to be a helpful first step toward healing and restoration. You can read it online at [www.BeAVoice.net](http://www.BeAVoice.net), in English or in Spanish*



# Sanctity of Human Life

## Emotional Complications of Abortion

A recent literature review concluded that abortion is a risk factor for “mood disorders substantial enough to provoke attempts of self-harm.”<sup>1</sup>

Women who ended their first pregnancy by abortion are five times more likely to report subsequent substance abuse than women who carried the pregnancy to term, and they were four times more likely to report substance abuse compared to those whose first pregnancy ended naturally.<sup>2</sup>

Research published in the prestigious Archives of General Psychiatry acknowledges that many women experience posttraumatic stress disorder (PTSD) after an abortion. In one of the longest-running studies conducted on women after abortion, researchers found that, over time, relief and positive emotions relating to the abortion declined and negative emotions increased. PTSD symptoms include dreams or flashbacks to the abortion, a general numbing of responsiveness not present before the abortion and difficulty falling asleep. In the same study, a survey of women two years after their abortions found that 28 percent of women were either indifferent about or dissatisfied with their abortion decision and 31 percent said they were uncertain or would not have an abortion again.<sup>3</sup>

The circumstances surrounding an abortion decision can impact a woman afterward. According to research published in the American Journal of Psychiatry, “Abortion for medical or genetic indications, a history of psychiatric contact before the abortion and mid-trimester abortions often result in more distress afterward. When women experience significant ambivalence about the decision or when the decision is not freely made, the results are also more likely to be negative.”<sup>4</sup>

After an abortion, women can experience psychological reactions ranging from guilt feelings and nervous symptoms to sleep disturbance and regrets. Also, as many as 10 percent of women “experience serious psychiatric problems following abortion.”<sup>5</sup>

As many as 60 percent of women having an abortion experience some level of emotional distress afterward. In 30 percent of women, the distress is classified as severe.<sup>6</sup>

A Finnish study of suicide after pregnancy found: “The suicide rate after an abortion was three times the general suicide rate and six times that associated with birth.” Suicides were more common after a miscarriage and especially after an induced abortion than in the general population. An increased risk of suicide after an abortion indicates either common risk factors for both (suicide and abortion) or harmful effects of induced abortion on mental health.<sup>7</sup>

Welsh researchers examined abortion and suicide and concluded, “Our data suggest that deterioration in mental health may be a consequential side-effect of induced abortion.”<sup>8</sup>

A study of couples involved in first-trimester abortions in Canada found that abortion can be highly distressing for both men and women. Researchers found that both before and after the abortion, “study couples were found to be much more distressed than control” couples. High levels of distress among women “correlated with fear of [the abortion’s] negative effects on the relationship, unsatisfying relationships and not having had a previous child.”<sup>9</sup>

### Sources

<sup>1</sup> John Thorp, et al., “Long-term physical and psychological health consequences of induced abortion: Review of the evidence,” *Obstetrical and Gynecological Survey*, January 2003, 58 (1): 67-79.

<sup>2</sup> David C. Reardon and Philip G. Ney, “[Abortion and subsequent substance abuse](#),” *American Journal of Drug and Alcohol Abuse*, 2000, 26 (1):61-75.

<sup>3</sup> Brenda Major, et al., “[Psychological responses of women after first-trimester abortions](#),” *Archives of General Psychology*, Aug. 2000, 57:777-784.

<sup>4</sup> Paul Dagg, “[The psychological sequelae of therapeutic abortion—denied and completed](#),” *American Journal of Psychiatry*, May 1991, 148 (5):583-584.

<sup>5</sup> J.R. Ashton, “[The psychosocial outcome of induced abortion](#),” *British Journal of Obstetrics and Gynaecology*, Dec. 1980, 87:1120-1122.

<sup>6</sup> Hanna Soderberg, “[Emotional distress following induced abortion: a study of its incidence and determinants among abortees in Malmo, Sweden](#),” *European Journal of Obstetrics & Gynecology and Reproductive Biology*, Aug. 1998, 79 (2):173-8.

<sup>7</sup> Mika Gissler, et al., “[Suicides after pregnancy in Finland, 1987-94: register linkage study](#),” *British Medical Journal*, Dec. 7, 1996, 313:1431-1434.

<sup>8</sup> Christopher Morgan, “[Mental health may deteriorate as a direct effect of induced abortion](#),” *British Medical Journal*, March 22, 1997, 314:902.

<sup>9</sup> Pierre Lauzon, et al., “[Emotional distress among couples involved in first-trimester induced abortions](#),” *Canadian Family Physician*, October, 2000, 46:2033-2040

# Sanctity of Human Life

## Physical Complications of Abortion

Women face a number of possible physical complications as a result of legal abortion including hemorrhage requiring transfusion, perforation of the uterus, cardiac arrest, endotoxic shock, infection resulting in hospitalization, convulsions, undiagnosed ectopic (tubal) pregnancy, cervical laceration, uterine rupture and death.<sup>1</sup>

### Studies have found that:

- Seventeen percent of women participating in a study on the effects of abortion reported that they “had experienced physical complications (e.g., abnormal bleeding or pelvic infection) since their abortion.” That percentage represents approximately 200,000 women annually experiencing physical complications after an abortion.<sup>2</sup>
- Abortion can adversely affect later pregnancies. A recent literature review concluded that abortion is a risk factor for placenta previa (where the placenta implants over the cervix, causing hemorrhaging) and preterm delivery with subsequent pregnancies.<sup>3</sup>
- Research has found that women having abortions are more likely to have a low birthweight baby in a later pregnancy.<sup>4</sup>
- Abortion can increase the chance of having a tubal (or ectopic) pregnancy in the future.<sup>5</sup>
- Research published in the Journal of the American Medical Association found that having multiple abortions increases a woman’s chance of having a miscarriage in a later pregnancy.<sup>6</sup>
- All women, especially young teenagers, are at risk for damage to their cervix during an abortion, which can lead to pregnancy complications later in life.<sup>7</sup>
- Abortion puts a woman at increased risk for complications in later pregnancies: Medical research states, “Complications such as bleeding in the first and third trimesters, abnormal presentations and premature rupture of the membranes, abruptio placentae, fetal distress, low birth-weight, short gestation and major malformations occurred more often among women with a history of two or more induced abortions.”<sup>8</sup>

## Sources

<sup>1</sup> Warren Hern, *Abortion Practice*, J.B. Lippincott Company, Philadelphia, 1990, pp. 175-193.

<sup>2</sup> Brenda Major, et al., “Psychological responses of women after first-trimester abortions,” *Archives of General Psychiatry*, Aug. 2000, 57:777-784.

<sup>3</sup> John Thorp, et al., “Long-term physical and psychological health consequences of induced abortion: review of the evidence,” *Obstetrical and Gynecological Survey*, Jan. 2003, 58 (1): 67-79.

<sup>4</sup> W. Zhou, “Induced abortion and low birth-weight in the following pregnancy,” *International Journal of Epidemiology*, Feb. 2000, 29 (1): 100-6; W. Zhou, “Induced abortion and subsequent pregnancy duration,” *Obstetrics and Gynecology*, Dec. 1999, 94 (6):948-53.

<sup>5</sup> A. Kalandidi, “Induced abortions, contraceptive practices and tobacco smoking as risk factors for ectopic pregnancy in Athens, Greece,” *British Journal of Obstetrics and Gynecology*, Feb. 1991, 98 (2): 207-13; A. Levin, “Ectopic pregnancy and prior induced abortion,” *American Journal of Public Health*, March 1982, 72:253-256.

<sup>6</sup> A. Levin, “Association of induced abortion with subsequent pregnancy loss,” *Journal of the American Medical Association*, June 27, 1980, 243 (24):2495-99.

<sup>7</sup> K. Schultz, “Measures to prevent cervical injury during suction curettage abortion,” *The Lancet*, May 28, 1983, pp. 1182- 1184.

<sup>8</sup> S. Linn, “The relationship between induced abortion and outcome of subsequent pregnancies,” *American Journal of Obstetrics and Gynecology*, May 15, 1983, 146:136-140.



Stockbyte



# Sanctity of Human Life

## Abortion Statistics

Based on accumulative data from the two primary sources of U.S. abortion statistics (Centers for Disease Control and Guttmacher Institute), **more than 1 million** abortions are performed each year in the United States. Since 1973, we estimate more than **51 million** abortions have been performed in the United States. According to research compiled by the Guttmacher Institute, approximately 42 million abortions occur **worldwide** annually.

### Who Has Abortions?

- Based on current abortion rates, about one in three women will have an abortion by age 45.<sup>1</sup>
- 44 percent of women who had abortions in the U.S. had at least one previous abortion.<sup>2</sup>
- Almost half (49%) of abortions are among women and teens 24 years old and younger.<sup>3</sup>
- Women aged 20-24 obtain 34 percent of all abortions, and teenagers obtain 16 percent.<sup>4</sup>
- 85 percent of women who had abortions in the U.S. were unmarried.<sup>5</sup>
- Nearly 60% of abortions are among women who have had one or more children.<sup>6</sup>

### Abortion in the Church

*The church has a responsibility to speak out on the Sanctity of Human Life and to offer healing and forgiveness to women who have had abortions. Post-abortive women and men (as well as women and families at-risk for abortion) are sitting in their services every Sunday.*

- Nearly two-thirds of women having abortions say they are Christians.<sup>7</sup>

### Abortion and Women of Color

*Historically, the abortion industry intentionally markets abortion as a solution to women of color, locating their clinics in ethnic neighborhoods:*

- About 13 percent of American women are black, yet they account for over 35 percent of all abortions.<sup>8</sup>
- Less than 1 in 7 Caucasian pregnancies end in abortion.<sup>9</sup>
- Almost 1 in 2 African-American pregnancies end in abortion.<sup>10</sup>
- Hispanic women account for 21 percent of abortions.<sup>11</sup>
- The abortion rate among African-American women is three times higher than among white women.<sup>12</sup>

### Reasons for Abortion

*Although many think that abortions are done mainly for the "hard cases" of rape, incest, or to save the life of the mother, statistics gathered by abortion providers themselves tell a different story. In fact, fewer than 1% of women obtaining an abortion say that they were victims of rape and fewer than*

*0.5 % of women say their pregnancy was a result of incest. Here are the most common reasons given for abortion:*

- Nearly 75% say a baby would interfere with work, school, or other responsibilities.<sup>13</sup>
- Nearly 75% say they cannot afford to have a child.<sup>14</sup>
- Nearly 50% say they do not want to be a single parent or they are having problems with their husband/partner.<sup>15</sup>

### Sources

*NOTE: The Guttmacher Institute is the research arm of Planned Parenthood, the nation's leading abortion seller. .*

<sup>1</sup> Guttmacher Institute, "[Facts on Induced Abortion in the United States](#)", August 2011,

<sup>2</sup> Centers for Disease Control and Prevention, "Abortion Surveillance – United States, 2010" , " November 29 , 2013 , Table 19, p. 38.

<http://www.cdc.gov/mmwr/pdf/ss/ss6208.pdf>

<sup>3</sup> Ibid, Table 4, p. 22

<sup>4</sup> Ibid Table 4, p. 22.

<sup>5</sup> Ibid, Table 17, p. 36.

<sup>6</sup> Ibid, Table 18, p. 37.

<sup>7</sup> Jones RK, Finer LB and Singh S, [Characteristics of U.S. Abortion Patients](#), 2008, New York: Guttmacher Institute, May, 2010

<sup>8</sup> [Census Brief: Women in the United States: A Profile](#),

<http://www.census.gov/prod/2000pubs/cenbr001.pdf> ; Centers for Disease Control and Prevention, " [Abortion Surveillance – United States, 2010](#) " Table 12, pg. 31 .

<http://www.cdc.gov/mmwr/pdf/ss/ss6208.pdf>

<sup>9</sup> [National Vital Statistics Report, Vol. 60, No. 7, June 20, 2012](#), Table 3, p. 16.

[http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60\\_07.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf)

<sup>10</sup> Ibid, Table 3, p. 16.

<sup>11</sup> [CDC 2010 Report](#) , Table 12, p. 31:

[CDC 2010 Report](#), Table 12, p. 31.

<sup>13</sup> Finer, Laurence B et al, "[Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives](#)," Perspectives on Sexual and Reproductive Health, 2005, Guttmacher Institute.

<sup>14</sup> Ibid

<sup>15</sup> Ibid

# Sanctity of Human Life

## Abortion Descriptions

According to the Centers for Disease Control and Prevention (CDC), the most common forms of surgical abortion are vacuum aspiration, sharp curettage, and dilation and evacuation. These abortion methods are used in nearly 90 percent of all U.S. abortions. The remaining 10 percent are drug-induced “medical” or chemical abortions.<sup>1</sup>

### How surgical abortions are done



9 week old embryo



Feet at the end of the first trimester

### First-trimester surgical abortions

#### Vacuum (or suction)

**aspiration** involves insertion of a cannula – a long plastic tube suction tube with a sharp cutting edge - to empty the uterus. This tube-like knife cuts apart the fetus and placenta as it is rotated around inside the uterus. The cannula is connected to a powerful aspiration machine that suctions amniotic fluid, placenta and fetal parts out of the uterus and into a container.

**Sharp curettage or dilation and Ccrettage (D&C)** involves dilating the mother's cervix—the entrance to the uterus—in order to insert a loop-shaped steel knife to scrape out the fetus and placenta. A cannula may also be inserted for suctioning the uterus.<sup>2</sup>

### Second and third-trimester surgical abortions

Second-trimester abortions (after 13 weeks) are more difficult because the fetus is larger and there is a greater blood supply to the uterus. In 2006, about 11 percent of reported abortions were performed thirteen weeks or later into the pregnancy.<sup>3</sup>

### When are abortions done?

According to 2006 abortion statistics published by the Centers for Disease Control and Prevention, the following percentage of abortions were reported at various stages of pregnancy:<sup>4</sup>

#### Percentage of total abortions

▪ 12 weeks or earlier	86.6%
▪ 13-15 weeks	6.3%
▪ 16-20 weeks	3.7%
▪ 21+ weeks	1.3%
▪ Unknown	2.1%

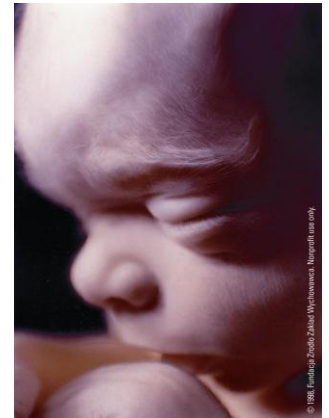
### Late-term surgical abortion methods include:

#### Dilation and evacuation

(D&E) is generally used in second trimester abortions. It also involves the dilation of the cervix and introduction of a sharp instrument into the uterus. In this instance, a loop-shaped steel knife is used to scrape out the fetus and placenta.<sup>5</sup>

#### Dilation and extraction

(D&X) also known as “partial-birth abortion”<sup>6</sup> describes a late term abortion procedure. This particular abortion method first came under public scrutiny after a 1992 presentation by abortionist Martin Haskell in which he graphically described the D&X abortion technique.<sup>7</sup>



Developing child at 5 months, in the second trimester

According to the presentation by Haskell, the initial step in performing a partial-birth abortion involves two days of dilating the mother's cervix. Afterward, the abortionist uses an ultrasound probe to locate the lower extremities of the preborn baby. He then works large grasping forceps through the mother's vagina and cervix and into her uterus.

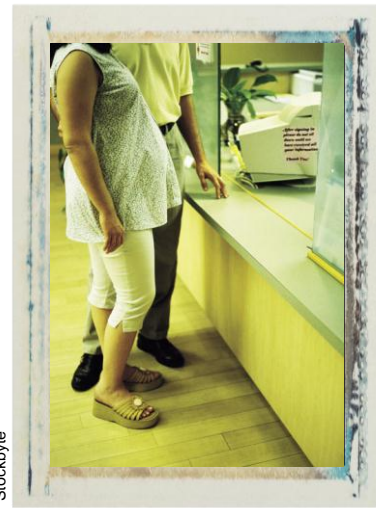
The abortionist grasps a leg of the baby with the forceps and pulls the leg into the mother's vagina. “With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities. The skull lodges at the internal cervical os,”<sup>8</sup> Haskell explained.



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While clutching the baby's upper body, the abortionist "takes a pair of blunt curved Metzenbaum scissors . . . He carefully advances the tip, curve down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger . . . The surgeon then forces the scissors into the base of the opening. The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient."<sup>9</sup>

## Two less-frequently used late-term abortion methods are:



**Intrauterine instillation** involves introducing a drug or substance (like saline) into the uterus to kill the preborn baby. This is followed by a drug to induce labor and the delivery of the fetus.

**Hysterotomy** is similar to a Caesarean section as incisions are made in the abdomen to enable the removal of the baby, placenta and amniotic sac.<sup>10</sup>

## How chemical abortions are done

Chemical abortions use drugs to abort the baby. The primary method used is a drug combination of mifepristone (RU-486) and misoprostol. A second drug, methotrexate, is sometimes also used along with misoprostol.

### Methotrexate

For years, doctors have used methotrexate to treat cancer and also to terminate potentially life-threatening pregnancies abnormally implanted in the fallopian tube. When given in pregnancy, methotrexate prevents the development of the preborn baby. It is not approved by the U.S. Food and Drug Administration (FDA) for use as a chemical abortion drug; however, some physicians prescribe it for that purpose anyway. Methotrexate is given as an injection, followed by the drug, misoprostol, which expels the dead embryo. The possible side effects of methotrexate in chemical abortion include nausea, heavy bleeding, vomiting, diarrhea and pain.<sup>11</sup> It must be given within seven weeks of pregnancy.<sup>12</sup>

### Mifepristone

Sometimes called the "abortion pill," mifepristone is the more common type of chemical abortion and here is how it is generally used.<sup>13</sup>

1. **At the first doctor visit:** A woman takes three mifepristone pills, also known by the brand name Mifeprex®. You may also hear it referred to as RU-486. These pills contain a drug that cuts off the supply of blood and nutrients to the developing embryo.
2. **Two days later:** The woman returns to the doctor to take another drug, misoprostol, also called Cytotec®. This causes the uterus to contract and expel the embryo. The FDA recommends that two tablets be taken by mouth, not vaginally which is tied to a number of deaths from *Colostridium sordellii*, a bacterium that causes rare genital infections in women. Currently, the FDA does not recommend preventative antibiotics.<sup>14</sup>
3. **Two weeks later:** a third visit to the doctor should confirm that the abortion is complete. However, 1 to 4 percent of women will still need a surgical abortion to terminate the pregnancy. This could mean a fourth and maybe fifth visit.

Women should expect to have vaginal bleeding or spotting for an average of 9 to 16 days. Up to 8 percent of all women may experience some bleeding for 30 days or more.<sup>15</sup>

### What are the side effects of the abortion pill?

As of April 2011, the FDA reports at least 14 women have died taking the mifepristone for a chemical abortion. The FDA also reports the abortion pill can have serious side effects and complications, such as hemorrhage (heavy bleeding) and serious infections.<sup>16</sup>

The FDA has updated the warnings associated with mifepristone several times to reflect the risk of fatal clostridial toxic shock from infection. In July 2005, the FDA announced the second change to the drug's "black box" warning label detailing the symptoms associated with the fatal bacterial infections, which can be "atypical...without fever, bacteria or significant findings on pelvic exam..." The "black box" is the FDA's most serious warning label.<sup>17</sup>

Despite its known risks, the abortion pill has been called a major medical breakthrough. In fact, some groups go so far as to say that it's a real step forward for the health of women, even that it "saves lives."

But what about the incredibly special and completely unique person is growing inside of every pregnant woman? Even if a woman has no major complications after taking the abortion pill, this method always leads to the death of a baby. At the Mayo Clinic's Web site on prenatal development, you can see that just six weeks after a woman's last period, the baby's heart has already begun beating, and he or she has the beginning of arms, legs, eyes, mouth and ears. See [www.mayoclinic.com/health/prenatal-care/PR00112](http://www.mayoclinic.com/health/prenatal-care/PR00112).

# Sanctity of Human Life

## Do you know the difference?

*Sometimes, these pills get confused*

The Abortion Pill:	The Morning After Pill:
An abortion method used to terminate an early pregnancy	A method used to prevent pregnancy. It may cause a very early abortion if fertilization has already occurred.
Medications are Mifeprex® (mifepristone) and Cytotec® (misoprostol).	Medication is Plan B® One-Step (levonorgestrel).
Must be taken within 49 days of when your last menstrual period began.	Must be taken within 72 hours after unprotected sex
Pills must be prescribed by a health-care provider. At least three visits to your provider are needed, possibly more.	The pill may be purchased over the counter without a prescription regardless of age..
Will not prevent sexually transmitted infections or diseases	Will not prevent sexually transmitted infections or diseases

## The Morning-After Pill

*(Also known as “emergency contraception” or “Plan B™” – this is not the same as the abortion pill)*

### What is the morning-after pill?

- It's a drug intended to be taken as soon as possible within the first 72 hours after unprotected sex to prevent pregnancy.
- It contains a high dose of levonorgestrel, which is found in many kinds of birth control pills.
- At the dosage found in the morning-after pill, this drug may work on rare occasion by preventing an embryo from implanting in the uterus.<sup>17</sup>
- It is often referred to by the brand name, Plan B®.
- Several products are on the market including single-dose tablet Plan B One-Step® and one- and two-dose generic products.<sup>18</sup>

### How does it work?

Depending on where a woman is in her menstrual cycle, the pill could affect her in one of three ways:

1. **It may prevent ovulation:** The egg will not be released to meet the sperm, so fertilization, sometimes known as conception, can't occur.
2. **It may affect the lining of the fallopian tubes** (where fertilization occurs) so that sperm cannot reach the egg. This also prevents fertilization.
3. **It may irritate the lining of the uterus.** If an egg has already been released and fertilized by the sperm, this irritation could make it harder for the embryo to implant in the uterus.<sup>19</sup>

### Are there side effects?

Some of the side effects that may be experienced when taking the morning-after pill include:<sup>20</sup>

- nausea and vomiting
- irregular and unpredictable menstrual periods
- cramping and abdominal pain — which might also be the sign of an “ectopic pregnancy” (see next question)
- fatigue
- headache
- dizziness
- breast tenderness

### What happens if emergency contraception is used after fertilization?

- The high dose of levonorgestrel found in the morning-after pill may irritate the lining of the uterus.
- That irritation may keep the embryo from implanting, ending its life.
- If this happens, an abortion will occur, because each human life begins as an embryo.<sup>21</sup>

### How can I know if an egg has been fertilized?

- That's the problem — you can't know.
- But we do know that sperm can reach the fallopian tubes mere minutes after intercourse,<sup>22</sup> and if an egg has already been released, fertilization could occur.
- So, there is a possibility that by the time you wake up on the “morning after,” a new human life may have already begun.
- If that's the case, using emergency contraception might cause a very early abortion.

This last point is one of major debate and one that pivots on the definition of pregnancy. Traditionally, fertilization—the joining of sperm and egg to form a zygote—is recognized as the beginning of pregnancy. Biologically, fertilization marks the creation of a genetically complete human being who only needs time, nourishment and a place to grow.<sup>23</sup>



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However, groups like the American College of Obstetricians and Gynecologists define pregnancy as “when the fertilized egg is implanted.”<sup>24</sup> Based on the fertilization definition of pregnancy, the morning-after pill may cause an early abortion. This is information women have a right to know before taking the pills.

## Sources

<sup>1</sup> Centers for Disease Control and Prevention, “Abortion Surveillance—United States, 2006” Nov. 27, 2009, Page 1 and Table 21, at <http://www.cdc.gov/mmwr/PDF/ss/ss5808.pdf>

<sup>2</sup> “Surgical Abortion Procedures,” American Pregnancy Organization, [www.americanpregnancy.org/unplannedpregnancy/surgicalabortions.html](http://www.americanpregnancy.org/unplannedpregnancy/surgicalabortions.html)

<sup>3</sup> CDC, Abortion Surveillance 2006, Table 7 - see footnote 1

<sup>4</sup> CDC, Abortion Surveillance 2006, Table 7 - see footnote 1

<sup>5</sup> “Surgical Abortion Procedures,” American Pregnancy Organization, [www.americanpregnancy.org/unplannedpregnancy/surgicalabortions.html](http://www.americanpregnancy.org/unplannedpregnancy/surgicalabortions.html)

<sup>6</sup> Christian Medical and Dental Association, “Standards 4 Life: Abortion,” [www.cmda.org/AM/Template.cfm?Section=Abortion&CONTENTID=7660&TEMPLATE=/CM/ContentDisplay.cfm](http://www.cmda.org/AM/Template.cfm?Section=Abortion&CONTENTID=7660&TEMPLATE=/CM/ContentDisplay.cfm);

<sup>7</sup> Martin Haskell, M.D., “Dilation and Extraction for Late Second-Trimester Abortion,” paper presented at the National Abortion Federation Risk Management Seminar, Sept. 13-14, 1992, Dallas, TX.

<sup>8</sup> Haskell, 1992: see footnote 7

<sup>9</sup> Haskell, 1992: see footnote 7

<sup>10</sup> Haskell, 1992: see footnote 7

<sup>11</sup> Richard U. Hausknecht, “Methotrexate and misoprostol to terminate early pregnancy,” *New England Journal of Medicine*, August 31, 1995, Vol. 333, No. 9, 537-540; <http://www.nejm.org/doi/full/10.1056/NEJM199508313330901>

<sup>12</sup> Medical Abortion, Mayo Clinic, May 31, 2012 <http://www.mayoclinic.com/health/medical-abortion/MY00819>

<sup>13</sup> WebMD, Mifepristone and Misoprostol for Abortion, September 22, 2010; <http://women.webmd.com/mifepristone-and-misoprostol-for-abortion> (new link is more accessible information)

<sup>14</sup> FDA Drug Safety: Mifeprex Questions and Answers, February 24, 2010; Q 21-23; <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111328.htm>

; (FDA changed this url to the new one above)

<sup>15</sup> FDA Drug Label Information: Mifeprex; <http://www.fda.gov/downloads/Drugs/DrugSafety/UCM088643.pdf>

<sup>16</sup> Mifepristone Adverse Events through April 2011; <http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf>; FDA Drug Safety: Mifeprex Questions and Answers; February 24, 2010, Q 10, 17-20; [www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111328](http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111328)

<sup>17</sup> . Testimony of Janet Woodcock, MD, May 17 2006; <http://www.fda.gov/newsevents/testimony/ucm112562.htm>

<sup>18</sup> FDA Prescribing and Label Information for Plan B® One-Step; Rev July 2009; pp. 13-14; [www.accessdata.fda.gov/drugsatfda\\_docs/label/2009/021998lbl.pdf](http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/021998lbl.pdf)

<sup>19</sup> This link is dead; Suggest this one instead: Emergency Contraception web site, November 12, 2013, <http://ec.princeton.edu/questions/dose.html#dose>

<sup>20</sup> FDA Prescribing and Label Information for Plan B® One-Step; Rev July 2009; p. 13; See footnote 18

<sup>21</sup> FDA Prescribing and Label Information for Plan B® One-Step; Rev July 2009; p. 3; See footnote 18

<sup>22</sup> Keith L. Moore and T.V.N Persaud, *The Developing Human: Clinically Oriented Embryology*, 6th Edition (Philadelphia, PA: Saunders, 1998), pp. 2-3.

<sup>23</sup> L. Speroff and M.A. Fritz, *Clinical Gynecological Endocrinology and Infertility*, 7th Edition (Baltimore, MD: Lippincott Williams & Wilkins, 2005), p. 235

<sup>24</sup> Merriam-Webster’s Medical Desk Dictionary (1996) defines fertilization as “an act or process of fecundation, insemination or impregnation” or to make pregnant

<sup>25</sup> “Contraception” Fact Sheet, American College of Obstetricians and Gynecologists, (dead link) <http://www.acog.org/~media/Departments/Adolescent%20Health%20Care/Teen%20Care%20Tool%20Kit/Contraception.pdf?dmc=1&ts=20131126T1617438976>

# Sanctity of Human Life

## Status of Abortion Law in the United States

In 1973, two U.S. Supreme Court decisions, *Roe v. Wade* and *Doe v. Bolton*, radically changed the legal landscape of American abortion law by striking down all then-existing state laws prohibiting abortion. The combined effect of the rulings required abortion to be:

- legal for any woman, regardless of her age
- legal for any reason through the first six months of pregnancy, and for virtually any reason thereafter

Reversal of the *Roe* and *Doe* court rulings would return the issue of abortion to state jurisdictions but would not automatically make abortion illegal in all states. In this event, the status of legal abortion would vary from state to state, depending on pre- and post-1973 laws and court rulings.

According to Americans United for Life, "First, even before the *Roe* decision in 1973, 14 states replaced their abortion prohibitions with regulations, some of which no longer exist. Second, since *Roe* many states have repealed their abortion prohibitions. Abortion prohibitions are still on the books in only 14 states, five of which would be blocked by existing pro-abortion state court decisions. Third, state courts in 16 states (some of which overlap with those states just mentioned) have created their own state versions of *Roe* (in effect creating a state constitutional right to abortion) which would block current or future legislation prohibiting and even regulating abortion." ([www.aul.org/Day\\_after\\_Roe](http://www.aul.org/Day_after_Roe))

This potential patchwork of laws in a post-*Roe* and *Doe* era prompts many in the cause for life to seek an amendment to the U.S. Constitution prohibiting abortion. Since 1973, the U.S. Supreme Court has issued more than 30 abortion-related rulings, including several that have upheld the constitutionality of state laws that regulate and limit abortion in the following ways:

- Parental Involvement Laws requiring a parent to be notified or give consent before their minor daughter has an abortion, subject to a judicial bypass option that allows a teenage girl to involve a judge rather than her parent(s); 43 states have passed such laws with 37 of those laws in effect.
- Informed Consent Laws requiring that women receive full medical disclosure of possible risks associated with and alternatives to abortion; 32 states have passed these laws with most in effect.
- Waiting or Reflection Period Laws requiring that after receiving such information, women wait a period of time (usually 24 to 48 hours) before having an abortion; 25 states have passed these laws.
- State legislatures are also considering and enacting laws in the following areas of abortion (and related) law:
  - Abortion and breast cancer legislation to inform women that abortion may increase their risk of breast cancer.
  - Ultrasound/fetal pain legislation giving women the opportunity to view an ultrasound or hear the heartbeat of their preborn child (or provide the information on to access such services), or information about the possibility of fetal pain during an abortion. Twenty-three states have passed laws along these lines.
  - Abortion clinic regulations to raise the level of safety and sanitation in clinics where abortions are performed.
  - Fetal homicide laws in 36 states recognize two victims (mother and preborn child) when a criminal act is committed against a pregnant woman (excluding abortion).

For more information on the status of abortion law in your state, see Americans United for Life's *Defending Life 2009: Proven Strategies for a Pro-Life America* available at [www.unitedforlife.org](http://www.unitedforlife.org)



# Sanctity of Human Life

## State Ultrasound Laws

It's been said that a picture is worth a thousand words.

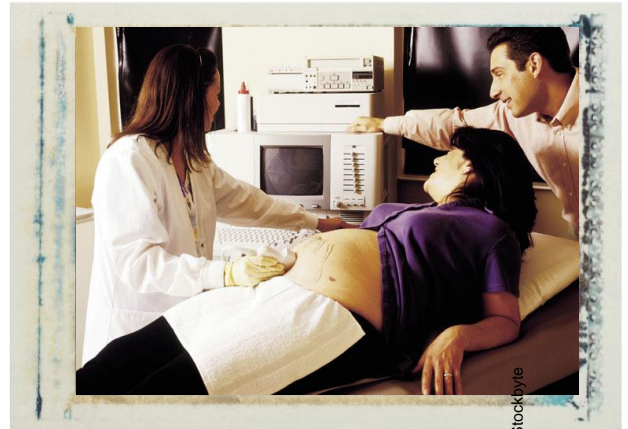
Ultrasound is an irreplaceable medical tool that allows a woman to see a real-time image of the child inside her womb – and many women would say that picture is priceless.

The first thing a woman needs when she thinks she's pregnant is an accurate diagnosis of pregnancy. There are many health issues a woman must consider at this time: pregnancy confirmation, the possibility of miscarriage or an ectopic pregnancy and how far along she may be. She needs accurate and truthful information on existing options from someone who will not benefit financially from her decision.

Ultrasound services help women understand their bodies, pregnancy and their babies' development. During the exam to confirm a viable, intrauterine pregnancy, a woman has the opportunity to see what the abortionist likely will not disclose – her preborn baby – which provides vital information and also gives her an important bonding opportunity.

Ultrasound helps reveal the truth of what, until recently has been hidden. The facts of her baby's existence become a reality to her and an important consideration in making an informed and future decision.

The vast majority of women have little information on the intricacy of their baby's development. Now, instead of the pregnancy being perceived as "a problem," a woman's heart and perspective changes – the majority of women, who initially came to a center considering abortion, have cried tears of joy upon seeing their baby for the very first time.



Below is a summary of the laws in different states regarding the rights of pregnant women to see an ultrasound of their baby: **24 states** have provisions giving women the opportunity to view ultrasounds before abortions are performed or offering information about how to obtain an ultrasound before an abortion.

As of 1-1-2014	AL	AZ	AR	FL	GA	ID	IN	KS	LA	MI	MS	MO	NE	NC	ND	OH	OK	SC	SD	TX	VA	UT	WV	WI
Ultrasound required and women must be offered the opportunity to view the image.	X	X		X				X	X		X			X			X			X	X			X
Ultrasound must be offered to women before an abortion.							X					X			X				X					
If ultrasound is performed as part of abortion preparation, women must be offered the opportunity to view the image.			X		X	X				X			X			X		X				X	X	
Women must be informed about ultrasound services and how to obtain these services.					X	X	X	X	X	X		X	X	X			X	X		X	X			
Women must be informed of the opportunity to hear the fetal heart beat.					X		X	X	X		X	X		X	X		X			X				X

Data includes information from state codes, American's United For Life's "Defending Life 2013" and National Right to Life's "Guide to State Laws on Ultrasound."

# Sanctity of Human Life

## Bio-Ethical Issues at the Beginning of Life . . .

### Birth Control Pills and Other Hormonal Contraception

The terms family planning, birth control, and contraception have been applied to a broad range of techniques and technologies that are intended to allow sexually active people to control when — or if — they will have children.

Focus on the Family acknowledges that there is a broad range of viewpoints within the Christian community regarding the moral and spiritual implications not only of many methods of family planning, but also of birth control in general. In this position statement, we will not attempt to address the breadth of those issues, but rather we will look at questions that have been raised specifically about the mechanism of birth control pills and other forms of hormonal contraception.

In so doing, we will seek to distinguish between issues on which Focus on the Family has taken clear positions, and others where it acknowledges honest differences of opinion among people who are committed to a biblical worldview.

#### Guiding Principles

Any discussion about family planning requires that we keep in mind three of Focus on the Family's guiding principles:

- We believe that the institution of marriage is a sacred covenant designed by God to model the love of Christ for His people and to serve both the public and private good as the basic building block of human civilization. Marriage is intended by God to be a thriving, lifelong relationship between a man and a woman, enduring through trials, sickness, financial crises and emotional stresses. Therefore, Christians are called to defend and protect God's marriage design and to minister in Christ's name to those who suffer the consequences of its brokenness.
- We believe that children are a heritage from God and a blessing from His hand. Parents are therefore accountable to Him for raising, shaping, and preparing them for a life of service to His Kingdom and to humanity.
- We believe that human life is created by God in His image. It is of inestimable worth and significance in all its dimensions, including the preborn, the aged, those deemed unattractive, the physically or mentally challenged, and every other

condition in which humanness is expressed, from the single cell stage of development to natural death. Christians are therefore called to defend, protect, and value all human life.

These guiding principles have a number of important implications as we consider any birth control method:

- Focus on the Family not only upholds marriage as a God-ordained permanent relationship between a man and a woman, but also maintains that marriage is intended to be the context for the expression of human sexuality.
- When discussing birth control, we must keep firmly in mind the fact that children are indeed a blessing from God.
- Because human life is of inestimable value from fertilization, we must be aware — and in some cases beware — of the mechanism(s) by which a particular birth control method works, or is thought to work.

In light of these guiding principles, Focus on the Family opposes the use of any form of birth control that acts after fertilization — and thus ends a new human life — whether by preventing its implantation in the womb or terminating its life at some point after implantation. (Such effects are referred to as abortifacient.)

For example, the intrauterine device (or IUD) is thought to work not only by preventing sperm from gaining access to eggs, but also by interfering with implantation of a fertilized egg. For this reason Focus on the Family does not support the use of the IUD as a method of family planning.

#### Hormonal contraceptives

Hormonal contraceptives — most commonly used in oral forms known as birth control pills or simply as “the pill” — have been a focus of controversy for a number of years because of concerns that they may occasionally contribute to the loss of human life after fertilization. This is a complex matter, not only because it involves multiple biological mechanisms, but also because there are many different formulations of hormonal contraceptives.

At present, it appears that birth control pills containing only progesterone do not reliably prevent ovulation. (This is also true of the contraceptive Implanon, a device implanted under the skin that slowly releases progesterone for three years. The implantable contraceptive Norplant, which is no longer available in the U.S. and Canada but is still used in other parts of the world, has a similar mechanism of action.)



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Furthermore, research indicates that pregnancies that might occur while a woman is using one of these medications have a greater chance of being ectopic — that is, located outside of the uterus. This suggests that progesterone-only contraceptives are more likely to disrupt the normal implantation of an early pregnancy, rather than merely preventing fertilization, and thus are problematic for those who believe that life begins at fertilization.

The most commonly prescribed birth control pills contain both estrogen and progesterone, and are thus known as “combined” oral contraceptives. These, as well as the NuvaRing and Depo-Provera, appear to work primarily by suppressing ovulation.

They also cause the mucus at the opening of the uterus to be thickened and, therefore, less likely to be penetrated by sperm. If combined oral contraceptives, NuvaRing and Depo-Provera work only through these mechanisms, they are functioning as true contraceptives, preventing the union of sperm and egg. However, there is controversy as to whether they also bring about changes (primarily within the uterus) that could increase the likelihood of losing a fertilized egg if ovulation and fertilization should occur.

(NuvaRing is a combination contraceptive in the form of a flexible ring that is inserted vaginally once monthly. Depo-Provera, an injection given every three months, actually contains only progesterone, but in a high dose that is highly effective at preventing ovulation.)

Pro-life physicians who have carefully and conscientiously studied this issue have come to different conclusions regarding the interpretation and implications of the relevant scientific data. Some have concluded that combined contraceptives and Depo-Provera may have an abortifacient effect at least some of the time, and have raised concerns about their use, even if this is a rare occurrence. Others are convinced that the available research supports a conclusion that these medications do not have an abortifacient effect.

Focus on the Family’s Physicians Resource Council (PRC), a panel of doctors representing a broad range of specialties that advises the ministry regarding medical concerns, reviewed this question at length in the late 1990s. After extended deliberation and prayer in multiple meetings over a two-year period, the PRC could not reach a consensus as to whether these medications might contribute to the loss of human life after fertilization. In 2011 the PRC revisited and reviewed this issue. Physicians who are familiar with the relevant studies, and who hold differing opinions regarding their interpretation, agreed that no new research has been carried out over the last decade that would decisively resolve this issue.

Focus on the Family respects the integrity and pro-life convictions of those who hold differing opinions regarding the mechanism and use of combined hormonal

contraceptives, and asks the pro-life community at large to do likewise. In addition, the ministry recognizes that scientific reasoning is not the only factor that may influence one’s viewpoint regarding the use of contraceptives. Couples who are considering whether or not to use any method of family planning would be wise to review relevant resources and to discuss their questions, concerns and — most importantly — their options with their physician.

Needless to say, couples with pro-life convictions would be wise to seek input from health care professionals who share their viewpoint. They should also prayerfully consider whether they are comfortable utilizing a particular contraceptive method when there are varying opinions in the pro-life medical community regarding its mechanism of action.

## When Pregnancy Threatens the Mother’s Life

The study of prenatal biology helps us to understand that when a woman is pregnant, there are two lives at stake. How do we respond when pregnancy threatens the mother’s life? Here is the position of the American Association of Pro-Life Obstetricians and Gynecologists ([www.aaplog.org](http://www.aaplog.org)):

*Abortion is the purposeful killing of the unborn in the termination of a pregnancy. American Association of Pro-Life Obstetricians and Gynecologists opposes abortion. When extreme medical emergencies that threaten the life of the mother arise (chorioamnionitis or HELLP syndrome could be examples), AAPLOG believes in “treatment to save the mother’s life,” including premature delivery if that is indicated — obviously with the patient’s informed consent. This is NOT “abortion to save the mother’s life.” We are treating two patients, the mother and the baby, and every reasonable attempt to save the baby’s life would also be a part of our medical intervention. We acknowledge that, in some such instances, the baby would be too premature to survive.*

## When Pregnancy Results from Rape

Abortion and rape are both deeply damaging perversions of the beauty and dignity of life. When a woman or girl has been raped, our first response should be to protect her from further assault, especially if she is a child living in an unsafe environment. We should help to provide comfort, support, and medical treatment and we should be the first to say, “Shame on anyone who would try to blame her for the rape, as though she were somehow responsible for it.” Our cry for justice and the focus of our anger should be on ensuring that the rapist is held legally accountable for his assault.

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The sad truth is that while an abortion does not take away the horror of the rape, it can actually add to the damage in one's life. Here's why: whereas the one who has been raped has been victimized and is innocent of any wrongdoing, when an abortion follows a pregnancy caused by the rape, the woman may feel that she has become the victimizer herself and she can have a hard time forgiving herself and dealing with the guilt of the abortion, on top of all of the trauma caused by the rape itself. Some women have also reported that the abortion was like a "mechanical rape" and that the invasion of the instruments into her body caused them to relive the rape experience all over again.

Anyone who has been raped needs to know that their inherent value to God is unchanged – they aren't sullied or worthless in His sight, though the rapist has treated them as such. God is a safe refuge who can bear the weight of their pain and grief and questions and He offers His comfort freely, for God says that He is near to the broken-hearted and the crushed in spirit.

There is likely also a need for counseling and restoration in the life of anyone who has experienced such trauma and our licensed counselors at Focus are available to talk with victims of sexual abuse, as well as with those who regret an abortion in their past, regardless of the circumstances. They can also advise as to the steps that can be taken to help victims of ongoing abuse, and this is the responsibility of any adult who knows that a girl is enduring sexual abuse. To arrange to speak confidentially, and at no charge, to a counselor at a time convenient for you, call 1-855-771-HELP (4357) Monday through Friday between 6:00 a.m. and 8:00 p.m. Mountain time.

## In Vitro Fertilization

The first successful birth resulting from *in vitro* fertilization was England's Louise Brown—born July 25, 1978. Since then, more than one million babies have been born worldwide using this assisted reproductive technology.<sup>1</sup>

*In vitro* fertilization (IVF) takes place in a laboratory setting for the purpose of fertilizing an egg with sperm outside of the human body. This process involves a number of general steps:

- Using drugs to stimulate the woman's ovaries in order to produce a number of eggs in a single cycle
- Collecting mature eggs from the woman's ovaries
- Collecting sperm from the man
- Fertilizing an egg with sperm in a laboratory environment
- Transferring the newly created human embryo(s) into the woman's uterus for implantation, gestation and a birth.

The average cost of an IVF cycle in the United States is \$12,000. Each cycle offers infertile couples a 25 to 30 percent chance of having a baby.<sup>2</sup> Due to the expense and effort involved in IVF, some couples may create more embryos than they transfer in a given IVF cycle. In 2000, 65 percent of IVF procedures transferred three or fewer embryos to reduce the likelihood of multiple births, which may put mother and children at risk.<sup>3</sup>

The creation of additional, non-transferred embryos raises moral concerns for many. If frozen and thawed for a subsequent IVF cycle, some of the embryos may not survive. If frozen embryos remain after the couple completes all intended IVF cycles, it is common for infertility clinics to offer the parents the following options for the remaining embryos:

- Donate the embryos to another infertile couple for transfer and adoption
- Donate the embryos for scientific research that results in the destruction of the embryo
- Authorize the destruction of the embryos.

One alternative to creating additional embryos that is gaining in both popularity and success is freezing retrieved eggs that were not fertilized during the IVF cycle. The frozen eggs are then thawed, fertilized and transferred at a later time. Many legal and moral questions surround IVF, including questions of ownership regarding non-implanted embryos when married couples divorce and the moral status of additional embryos—whether frozen or destroyed.

<sup>1</sup> Rosie Mestel, "Birth by test tube turns 25," *Los Angeles Times*, July 24, 2003.

<sup>2</sup> Emma Ross, "Strides made since first test-tube, but IVF still frustrating, costly for many," Associated Press, July 24, 2003; "2000 Assisted Reproductive Technology Success Rates," Centers for Disease Control, December 2002, p. 17, accessed online Nov 12, 2007 at [www.cdc.gov/ART](http://www.cdc.gov/ART).

<sup>3</sup> CDC report, December 2002, p. 34.

## Pre-implantation Genetic Diagnosis

One outgrowth of *in vitro* fertilization is the development of a genetic test called pre-implantation genetic diagnosis (PGD). PGD screens very young human embryos created through *in vitro* fertilization before they are implanted in the uterus. Embryos are subjected to biopsy—the removal of one or two sample cells for analysis.

Reasons for screening embryos range from testing for genetic diseases and chromosomal disorders to providing a tissue match to treat a sick sibling. Once testing is



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complete, only those embryos with the desired genetic components are transferred to the mother's uterus; the rest are discarded, frozen or donated for destructive scientific research.

Approximately 1,000 babies worldwide have been born using PGD since it was first developed in 1989.<sup>1</sup> The use of PGD is controversial and unregulated in the U.S. In July 2002, the President's Council on Bioethics recommended a federal review of PGD practices due to ethical concerns.<sup>2</sup>

Despite its popularity, PGD has no purpose other than to screen and choose embryos based on their desired genetic material:<sup>3</sup>

- PGD does not identify diseases without a clear and simple genetic component, nor does it recognize diseases that are known to have complex interactions between genes and the environment.
- PGD does not have any therapeutic benefits—it cannot create or change any of the genetic characteristics or abnormalities that an embryo has inherited from its parents.
- PGD does not allow parents to enhance their children's genetic code in order to "custom-make" them with specific mental or physical characteristics.

PGD raises many questions, including the moral status of the human embryo, the destruction of young human life and whether parents should be able to determine the genetic characteristics of their children.

For more information on this topic, see "Pre-implantation Genetic Diagnosis" at: [www.citizenlink.org/fosi/bioethics/genetics](http://www.citizenlink.org/fosi/bioethics/genetics)

<sup>1</sup> Mark Henderson, "Embryo checks found safe for designer babies," *The (London) Times*, August 18, 2004.

<sup>2</sup> "Human Cloning and Human Dignity," The Report of the President's Council on Bioethics, Public Affairs, New York, NY, 2002. See Executive Summary: page LVIII in book; page xxxvi in online PDF version, on Nov 12, 2007 at [www.bioethics.gov/reports/cloningreport/execsummary.html](http://www.bioethics.gov/reports/cloningreport/execsummary.html).

<sup>3</sup> Pre-implantation Genetic Diagnosis: A Discussion of Challenges, Concerns and Preliminary Policy Options Related to the Genetic Testing of Human Embryos, Genetics and Public Policy Center, Jan 2004 [www.dnapolicy.org/pub.reports.php?action=detail&report\\_id=8](http://www.dnapolicy.org/pub.reports.php?action=detail&report_id=8)

## Prenatal Gene Therapy

Expectant parents routinely undergo prenatal testing to assess the physical health of their preborn baby.

Parents who receive an adverse diagnosis are often subjected to significant pressures to end the life of their preborn child. Those who understand the inherent value and dignity of the life entrusted to their care will wish to seek out information about supportive services that will help them to prepare for the birth and care of a child with disabilities, or explore the option of perinatal hospice if their child will be stillborn or die soon after birth.

For more information about perinatal hospice, see the article, *Journey of a Lifetime*, in this SOHL Handbook. You can also find a sample family birth plan, at the website of the American Association of Pro Life Obstetricians and Gynecologists: [www.aaplog.org/perinatalhospice.htm](http://www.aaplog.org/perinatalhospice.htm)

Someday there may be a third option for an adverse diagnosis in pregnancy: repairing the preborn baby's genetic code before he or she is born. Prenatal gene therapy—also known as fetal gene therapy, gene transplant surgery and fetal gene transfer has the potential to correct the genetic defects in a preborn child before the mother gives birth. Although it may not be available for use in humans for years, studies being done in animals are promising.

Clinical trials using traditional gene therapy have focused on correcting genetic defects in children and adults. One of the biggest challenges of this type of gene therapy has been targeting the correct area of the body without generating a response by the immune system. Often, the agent transporting the new genes is recognized and attacked by the body's immune system as a foreign substance. Scientists are trying a variety of methods to minimize this reaction, but progress is slow.

Prenatal gene therapy has the potential to eliminate this problem by targeting the body before the immune system is fully developed. Current prenatal gene therapy studies by British scientists have successfully treated mice affected with the same genetic defect as humans with Hemophilia B. So far, the results have been encouraging. The fetus' genetic makeup was altered before the immune system was completely formed—thus avoiding the immune response.

Another advantage of prenatal gene therapy is the possibility of permanent cures. In humans, many diseases must be dealt with by providing treatment on an ongoing basis. For example, Hemophilia B can be treated by repeatedly injecting the missing protein into the patient throughout life. If prenatal gene therapy was used, frequent treatments could be eliminated by correcting the patient's genetic code at an early stage of life.

Lastly, many diseases begin to harm the patient physically and mentally before birth or shortly thereafter. Prenatal gene therapy has the ability to address genetic defects before there is any damage done by the disease.

The capability of the newly inserted genes to affect subsequent generations (germline gene transformation) is still unknown. Currently, scientists believe there is no transfer of genes to reproductive (egg and sperm) cells involved in prenatal gene therapy. However, if later generations are affected, there is concern about altering the human genetic code for generations to come.

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## Genetic Testing and Screening

As the number of genetic tests has increased, the use of genetic tests to predict or diagnose disease has become significantly more widespread. As of 2001, there were at least 300 tests available for genetic disorders. In 2004, the number was over 1,000.

Genetic testing is performed by examining chromosomes, DNA or gene products (proteins) for abnormalities in an individual's genetic code. Although there are some technical differences between genetic testing and genetic screening, the terms are often used interchangeably. Since this distinction is negligible for most people, we will use the broader term, genetic testing, to encompass both categories.

Genetic testing can either predict if a person will be susceptible to a disease later in life (based on their genetic code) or diagnose the presence of a genetic disease in an individual (sometimes before they show symptoms of the disease).

It is important to emphasize that the majority of genetic tests do not actually tell an individual if they have a disease—rather, the tests show the level of risk they have of developing a specific disease or passing a disease on to their children.

From pre-implantation testing in embryos to adult testing, there are a variety of genetic tests that encompass every period of life. We will examine six categories—beginning with reproductive tests and proceeding to tests for adults.

## Reproductive Testing

### Carrier testing

Carrier testing determines if an individual has a genetic abnormality that could be passed on to their children. It can be used by couples who know they have a family history of genetic disease. Normally, carrier testing is done before pregnancy in order to determine if an individual's children might be affected by a particular disease.

The knowledge gained from this test can help prospective parents determine their course of action in starting a family. The desire to give birth to a child may override the risk of bringing a baby into the world with the susceptibility to a genetic disease. Or, they may choose to look into other options such as traditional and/or embryo adoption.

## Prenatal testing

Prenatal testing falls under two broad categories: invasive and non-invasive procedures. Invasive procedures, such as amniocentesis and chorionic villus sampling (CVS), have a

higher risk of miscarriage than non-invasive procedures like maternal serum screening.

Pre-implantation genetic diagnosis (PGD) is a new type of genetic testing that parents are using to test their in vitro fertilization embryos for genetic defects. For a more in-depth look at PGD, see "Beginning-of-Life Issues: Pre-implantation Genetic Diagnosis."

Although parents can use prenatal testing to better prepare for the birth of an affected child, too often the result of an adverse prenatal diagnosis is abortion. For more information, see *Journey of a Lifetime*, in this SOHL handbook.

## Newborn testing

Available since the 1960s, this type of testing determines if a newborn's blood or tissue samples test positive for genetic disease. The effect of some diseases, like mental retardation caused by PKU (phenylketonuria), can be prevented or minimized by taking proactive steps to fight the disease.

Unlike prenatal testing, which may involve ending the life of a preborn baby, newborn screening focuses on detecting diseases that can be remedied or minimized early in the child's life.

## Adult Testing

### Predictive testing

Sometimes called pre-symptomatic testing, this test has traditionally been used to determine if a patient will develop rare genetic disorders. The information, in some cases, is helpful for individuals who can take preventative measures to reduce the likelihood that they will develop the disease. The nature of the disease, and the foreknowledge that an individual desires to have about potential health risks, will help determine if this test is right for them.

### Susceptibility testing

This test is often used to identify individuals with a genetic predisposition that increases susceptibility to certain toxic substances found in the workplace. The genetic susceptibility puts them at a higher risk for adverse reactions and future disabilities if they come in contact with these substances.

### Forensic testing

Forensic testing is used to ascertain a genetic link between criminal suspects and investigations. It can also be used to determine family relationships—such as paternity.



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## Human Cloning

Human cloning intentionally copies the genetic code of one human being in order to create another human with the same genetic material. It creates a new, individual human life based on the genetic blueprint of only one donor (or parent) rather than two.

### Somatic Cell Nuclear Transfer

Current attempts to clone humans utilize the same technique previously used to clone animals, such as Dolly the sheep. The method employed is called somatic cell nuclear transfer (SCNT), which results in the creation of a new organism by artificially fusing one cell with the DNA of another cell, as opposed to the natural process of fertilization.

In the process of SCNT, scientists remove the nucleus of an unfertilized egg, which contains 23 human chromosomes and replace it with the nucleus of a somatic cell (like a skin cell) from the donor to be cloned. The somatic cell contains the full set of 46 human chromosomes and contains the donor's DNA or genetic code. Then, instead of fertilization, a small electric pulse (or chemical bath) is applied to cause the cells to fuse and divide. If successful, the result is a newly cloned individual who has started the same process of human development that we all experienced.

### "Reproductive" vs. "Therapeutic" Cloning

The debate over human cloning often distinguishes between "reproductive" and "therapeutic" (also called "research") cloning. In reality, all human cloning is reproductive, because it duplicates the genetic material of the donor and creates a new human life.

The terms "reproductive" and "therapeutic" speak to what you intend to do with the cloned embryo: it can be implanted into a woman's womb with the goal of a live birth (reproductive) or destroyed in a research laboratory for its stem cells (therapeutic). It is important to understand that cloning is the method used to create the human embryo, regardless of why the embryo was created.

Supporters of reproductive cloning view cloning for the birth of a live infant as another method to help infertile couples have a family. Critics say there are other options for infertility and, among other reasons, oppose reproductive cloning because of the risk it poses to both mother and child.

Proponents of therapeutic cloning base their support on speculation that embryonic stem cells from cloned embryos may be a promising source of cures for a variety of human illnesses and ailments.

### Human cloning as a method of stem cell research

Human cloning is an important component in embryonic stem cell research. Embryonic research often involves stem cells extracted from embryos created through in vitro fertilization (IVF). But another way of gathering embryonic stem cells is through cloning: new embryos are created for stem cell research through somatic cell nuclear transfer. As research into embryonic stem cells continues, the need for additional embryos intensifies. Cloning is viewed by many scientists as the best way to obtain these embryos.

To date, scientists attempting to use embryonic stem cells (cloned or otherwise) have failed to develop a successful human model confirming their theory. Opponents of cloning argue that cloning for stem cell research is unnecessary. They point to the proven track record of adult stem cells—ranging from bone marrow to umbilical cord blood—which currently provide medical therapies for patients.

### Risks to women

The method currently used by scientists for cloning research requires the use of women's eggs. This method (somatic cell nuclear transfer) has two necessary components: a body cell (like a skin cell) and a woman's egg. Harvesting these eggs is an essential step in this research.

The indisputable connection between human cloning for stem cell research and harvesting women's eggs makes many people uncomfortable because of the health risks involved in egg harvesting. During this process—which is the same process women undergo during fertility treatments—a woman is injected with powerful hormones that cause her ovaries to produce more than the usual one or two eggs per month. Then, she is put under anesthesia so a doctor can surgically extract her eggs.

Studies report that anywhere from 5 to 14 percent of women who undergo ovarian hyperstimulation experience severe complications. These can include blood clots, kidney and liver damage, infertility and death.

The lack of existing frozen embryos (from IVF) available for use in research means scientists will likely turn to cloning to provide the embryos needed to create embryonic stem cell

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lines. Yet, the vast number of eggs that would be needed to create enough stem cell lines threatens to subject millions of women to the dangers of egg harvesting. Scientists, with cash in hand and desperate for eggs, may find young and low-income women as eager participants.<sup>1</sup>

## Status of Laws Banning Human Cloning

Currently, there is no federal law banning human cloning for either reproductive or therapeutic [research] purposes. Presidential executive orders signed by Presidents Clinton and George W. Bush prohibit the use of federal funds for human cloning.

There is a patchwork of laws that regulates human cloning in the states - several states have a complete ban on human cloning while some states allow human cloning for destructive embryonic stem cell research.

<sup>1</sup> For more information and citations, see [www.VoteNoCloning.com](http://www.VoteNoCloning.com) web site and click on "Booklet References."

*The following references provided background information for this article:*

Gina Kolata, "Cloning creates human embryos," *The New York Times*, February 12, 2004.

Lauren Neergaard, "Scientists speed creation of stem cells," *The Associated Press*, May 19, 2005.

## Stem Cell Research

All of our bodies contain stem cells. Stem cells are the basic building blocks of the human body with the potential to develop into different types of cells. As we develop as embryos, these master cells become the 200 or so distinct cell types in the body. As adults, stem cells replenish existing cells when they wear out or are destroyed.

There are primarily two different sources of stem cells: embryonic and adult. Embryonic stem cells come from embryos. In order to harvest these cells, a living human embryo must be destroyed. Adult stem cells come from a variety of sources, including bone marrow, placenta, umbilical cord blood, nasal tissue, and body fat. No human lives are destroyed when adult stem cells are collected.

The flexibility of human embryonic stem cells has led some scientists to speculate that the ability of these young cells to become any cell type holds great promise for healing the human body. To date, scientists attempting to use embryonic stem cells in such therapy have failed to develop a successful animal or human model confirming their theory. This means there has been no demonstrated benefit to patients from embryonic stem cell research.

Meanwhile, ongoing research using adult stem cell sources is very promising. Recent research demonstrates that some sources of adult stem cells are as flexible as embryonic ones and equally capable of converting into various cell

types for healing the body. Progress with adult stem cell research has increased dramatically because of success in treating patients with these cells.

Therapies using stem cells from sources such as bone marrow, cord blood and the pancreas have proven successful in treating patients with various conditions, including sickle cell anemia, Parkinson's disease, multiple sclerosis, cancer and heart damage, diabetes and spinal cord injury.

In addition to the proven success of adult stem cell research, scientists have discovered a process that reprograms ordinary body cells into embryonic-like stem cells. This new technique - called induced pluripotent stem (iPS) cell research - gives researchers the ability to create flexible, embryonic-like stem cells without destroying young human life. This type of innovative yet ethical research like this is a testament to pro-life voices who have persevered in their call for ethical research options.

These, and other success stories, demonstrate that advancements using adult stem cells in humans surpass any research currently underway using embryonic stem cells in animals.

The science is clear: adult stem cells are providing tangible therapies for patients while embryonic stem cells have yet to be successfully used in any human therapy.

Objections to embryonic stem cell research often center on the moral status of the human embryo. Biologically, an embryo represents one of the earliest stages of human life. Human development progresses in a continuum, from the single cell to the embryonic stage, then a fetus, newborn, toddler, adolescent and adult.

Embryos, regardless of how they are created, are fully human and deserve protection. It is never morally or ethically justified to destroy one human in order to possibly save another. Advances in ethical stem cell research provide tangible hope for patients and an ethical avenue for developing the therapies they need.

For more information on this topic, see [www.citizenlink.org/FOSI/bioethics/cloning](http://www.citizenlink.org/FOSI/bioethics/cloning)

*Jacki Rabon was an outstanding athlete who dreamed of playing college volleyball. That all changed when a tragic car accident fractured her spine and doctors told her that she would never walk again. Jacki is helping repair and regenerate tissues in her spine as a result of a ground-breaking new treatment using adult stem cells from her own nose!*







### *3. In the Midst of Life*



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## The Bible calls us to protect life at every stage



**Proverbs 31:8** “Speak up for those who cannot speak for themselves; ensure justice for those being crushed.”

**Proverbs 24: 11- 12**  
“Rescue those being led away to death; hold back

those staggering toward slaughter. If you say, “But we knew nothing about this,” does not he who weighs the heart perceive it? Does not he who guards your life know it?”

**James 1:27** “Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress and to keep oneself from being polluted by the world.”

**Isaiah 1:17** “Learn to do right; seek justice. Defend the oppressed. Take up the cause of the fatherless; plead the case of the widow.”

**Hosea 14:3** In you the orphan finds mercy.

**Deuteronomy 27:19** “Cursed is the man who withholds justice from the alien, the fatherless or the widow.”

**Psalms 41:1** “Blessed is he who has regard for the weak; the Lord delivers him in times of trouble.”

**Matthew 25: 34-40** “Then the King will say to those on his right, ‘Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.’

“Then the righteous will answer him, ‘Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit

you?’ “The King will reply, ‘I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.’ “

**Psalms 10: 12-15** “Arise, LORD! Lift up your hand, O God. Do not forget the helpless. Why does the wicked man revile God? Why does he say to himself, “He won’t call me to account”? But you, God, see the trouble of the afflicted; you consider their grief and take it in hand. The victims commit themselves to you; you are the helper of the fatherless. Break the arm of the wicked man; call the evildoer to account for his wickedness that would not otherwise be found out.”

**Isaiah 58: 6 -10** “Is not this the kind of fasting I have chosen: to loose the chains of injustice and untie the cords of the yoke, to set the oppressed free and break every yoke? Is it not to share your food with the hungry and to provide the poor wanderer with shelter— when you see the naked, to clothe them, and not to turn away from your own flesh and blood? Then your light will break forth like the dawn, and your healing will quickly appear; then your righteousness will go before you, and the glory of the LORD will be your rear guard. Then you will call, and the LORD will answer; you will cry for help, and he will say: Here am I. “If you do away with the yoke of oppression, with the pointing finger and malicious talk, and if you spend yourselves in behalf of the hungry and satisfy the needs of the oppressed, then your light will rise in the darkness, and your night will become like the noonday.”

**Luke 4: 18-19** “The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free, to proclaim the year of the Lord’s favor.”

**Deuteronomy 30:19** “I call heaven and earth to witness against you today, that I have set before you life and death, the blessing and the curse. So choose life in order that you may live, you and your descendants.”





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## *A Teen Pregnancy in the Family*

### She's pregnant.

### You're shocked.

Here are some guidelines to help you through this unexpected time of confusion and heartache.

"I'm pregnant."

When your daughter first breaks the news to you, you may feel shock, disappointment, despair, embarrassment. You may think, "Her life is shattered. Our lives are ruined. All of her (and our!) hopes, dreams and plans are threatened."

It's not good news. It's also not the end of the world. Remember to:

- Stay calm.
- Avoid assigning blame or condemning.
- Focus on the positive. (She could have chosen abortion.)
- Show grace and mercy as Jesus would (even when it's toughest!).

### Step into her shoes

Understand her fears. She is probably overwhelmed:

- Feeling like she has lost your love and confidence.
- Feeling alone and needing a support group.
- Wondering what her options are.
- Facing a future she hadn't planned.

### Step up

Be an asset to your daughter by:

- Reassuring her of your unconditional love and concern.
- Affirming your confidence in her.
- Trusting God whole-heartedly.

### Simply say it

She can't read your mind. You need to speak the words:

- "I still love you. No matter what."
- "I'm here for you and will help you in whatever way I can."
- "You do have options." (marriage, adoption, single-parenting, evening college courses, etc.)
- "Some people will look down on you. Many more will extend their compassion."

- "You are ultimately accountable to God, not other people."
- "You have a whole lifetime ahead of you. This one mistake doesn't need to destroy your bright future."

### A comfortable environment

Create a non-threatening atmosphere by:

- Being willing to listen as she talks about her feelings.
- Giving advice only when asked.
- Enabling her to make rational, thoughtful decisions.
- Respecting her privacy. (Allow her to ponder secret thoughts.)
- Respecting her feelings about the baby's father (whether the relationship continues or is terminated).
- Guiding the baby's father into responsible participation.

### Family matters

Lighten your daughter's burden by offering to tell close family members about her pregnancy. They need to know because:

- It gives family an opportunity to express their genuine concern.
- Siblings, because they are closer in age, may offer her unique sympathy.
- They may have suggestions you haven't thought of.
- You can unite as a family to be a support for her.

### After sharing the news, remember:

- To respect one another's opinions.
- You are not obligated to act on every suggestion made by others.
- Family members may strongly disagree on some decisions.
- Ultimately, it's your daughter and the life inside of her who are affected by the decisions made by your family.

### Don't deny it

You need support, too! You can best help your daughter when you are strengthened and healthy. Check out the people and places ready to help:

- Pregnancy resource centers (They have a wealth of information and can refer you to other parents who have "been there.")

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- Church (pastors, Sunday school and Bible study groups)
- Youth leaders (They are in-tune with what teens are dealing with.)
- Other parents who have gone through similar experiences
- An existing parent support group (or be willing to start your own!)
- Other agencies in your area working with unmarried pregnant women

## Higher ground

The spiritual lives of both you and your daughter have been catapulted into unknown territory. Regardless of spiritual maturity or how well you think you're handling things, don't ignore this critical part of each other's well-being. Take action by:

- Requesting that your pastor or other mature Christians help you and your daughter grow through this situation.
- Remembering that God is big enough to handle your doubts and questions.
- Resting in the fact that God's love is everlasting and unconditional.
- Realizing that sometimes God doesn't make sense, but pain can be necessary to pave the way for healthy growth.
- Receiving the help that others offer.

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## When Your Son is the Father

If your son has had a sexual relationship from which a pregnancy has resulted, remember that he will probably be experiencing many of the same emotions as his girlfriend, including fear, guilt and ambivalence. In addition, he will feel considerable conflict and confusion over the role he should play.

### What's His Level of Commitment?

Usually the relationship with the mother-to-be has not, until this point, involved any long-range plans. Now he must make a decision about the level of commitment he intends to assume, and the issues are significant. What does he owe this young woman? Can he walk away from this situation? Should he make a lifelong commitment to her because of this unplanned pregnancy? He does not bear the biological consequences, of course, and the mother of the baby has the legal right to have an abortion or carry the pregnancy to term with or without his input.

This may leave him with the impression that he has no control over the unplanned pregnancy and therefore no responsibility for it. As his parents, you are one step further removed from the situation and may have similar questions about the role you should play.

## Encourage Appropriate Responsibility

Above all, your son will need encouragement and guidance to assume the appropriate level of responsibility for his role in the pregnancy. He should not be allowed to abandon his girlfriend with a cavalier, hit-and-run attitude. "It's her problem now," "She should have protected herself" or even "She should just get an abortion" are shallow and disrespectful responses to a serious situation. Pushing for a quick marriage may seem honorable, but is probably unwise. Teenage matrimony carries with it very short odds of long-term success, and the combination of immaturity, lack of resources, and the intense demands of a newborn baby will usually strain an adolescent relationship to the breaking point.

## Family Issues

In a best-case scenario, the families of both participants will cooperate to find a productive balance among several tasks: facing the consequences of the sexual relationship, accountability of adolescents to the adults in both families, short- and long-term planning, and mature decision-making.

Your son will need encouragement to acknowledge his responsibility to the girl's family and to accept with humility their response, whether it is measured or angry. All of you may have to face the possibility that the other family will choose to deal with the pregnancy on their own, even if you are willing to participate in the process.

And if that decision includes forbidding your son to have further contact with someone about whom he cares very deeply, he will have to find the strength to abide by the other family's wishes. If he is allowed to continue their relationship and support her when the going gets tough, clear ground rules (including abstaining from sexual contact) will need to be established and respected.

Having a pregnant girlfriend is tough and painful. But it also can be an opportunity for your son to mature--to find out what he is made of. In the long run, the pregnant adolescent girl isn't the only one who has to make important choices.

*Excerpted from Let's Talk About Sex, published by Focus on the Family. Copyright © 1998 Focus on the Family.*



# Sanctity of Human Life

## Reflecting God's Image: What it means to truly value others

by Stephanie O. Hubach

I saw the rage in his eyes and heard myself thinking, *No...o...o...o...!* but it was too late. Five-year-old Freddy, protecting his younger brother, unleashed his fury on two taunting girls in the shallow end of the pool. Honestly, I think he meant to create the community pool version of a tidal wave. But his force behind the water turned into a full-fledged slap across their faces.

Freddy's brother, Timmy, who has Down syndrome, had been standing poolside, wonderfully excited about the prospect of going swimming. At age 3, he sometimes expressed emotional overload by flapping his arms, opening his mouth and blinking his eyes repeatedly. However, this time two little girls decided that Timmy's behavior was entertaining and began to laugh, point at and imitate him. Apparently, it was more than Freddy's justice-oriented personality could handle. He drew back his arm and swiftly administered the due penalty.

Within seconds, Freddy received his own share of compassionate justice for hitting two young ladies. Struggling with his first exposure to public, intentional disrespect toward Timmy, Freddy experienced a very teachable moment. While his response to the mocking girls was inappropriate, Freddy had rightly recognized disrespect when he saw it.

### An indelible image

What do you first envision when you think of respect? High regard for those in authority? Honor for the elderly? Maybe esteem for a person's noteworthy accomplishments or for his ability to persevere? The Bible indeed teaches that individuals in positions of authority, those who have seen many days and people who live their lives in an admirable fashion are worthy of our respect. But there is something much deeper and inherently more central to the concept of respect: the glory of God imprinted into the essence of man. In encountering *any* person, we ought to marvel at all of the things that are good and admirable and beautiful about them (Philippians 4:8).

Let's be honest. How many of us respond to our closest family and friends this way? When was the last time you

looked at your children and stood in awe of the glory of God within them? How about your spouse?

What's your view of strangers who have special needs? When you are in a hurry, and a cashier with obvious developmental disabilities slowly attempts to count your change, do you first and foremost see the glory of God? Or if you are at a restaurant and a man with cerebral palsy drools on his shirt at the table next to you, is your first realization one of wonder and honor?

It takes conscious effort to appreciate the most fundamental blessing of creation—that we are all created in the image of God—and to gaze speechlessly at His goodness, truth and beauty in others. We need to search for His glory in each individual until we find it, and then we need to celebrate it!

### Different standard

Unfortunately, our culture often measures personal value as a function of productivity. The degree to which we are able to contribute to society is the degree to which we are valued. In God's economy, however, human value is defined by the Creator himself through the imprint of His image in mankind. Others take notice, not merely when we say this is true, but when we live as though it is true.

When we look for the "good and admirable and beautiful," we focus on the positive, and we will impart encouragement to others in the process. Learning to see God's image helps us to keep our perspective by focusing on the potential in every person, rather than on limitations. It also emphasizes what matters most—a person's dignity—and not his abilities or disabilities.

The individual who provides support for a person with special needs is upholding the sanctity of human life—and so are the parents who promote the image of God in their "typical" children by lovingly raising them. We honor the image of God when we serve a neighbor who has AIDS, when we meet the needs of our spouse who has cancer, or when we care for a family member with dementia. The concept of the sanctity of human life is immense and broad, and it motivates us to respectfully engage others in God's name in whatever we do.

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# Sanctity of Human Life

## Adoption and Orphan Care



The needs of the world are staggering, especially relating to children. Current estimates show that more than 150 million children worldwide have been orphaned. With such an overwhelming need, Christians have an incredible opportunity and responsibility to respond with the love of Christ.

When considering what can be done to help these millions of children, the options are vast. Here are a few you can begin to think and pray about:

- Pray for these children on a consistent basis
- Be an advocate in your community for adoption and orphan care
- Mobilize your church to action
- Mentor a child/youth
- Support an adoptive family
- Take a short-term mission trip overseas
- Sponsor a child in another country
- Give financially to orphan care and adoption ministries
- Consider adoption – open your home and family to a child without either

Thankfully, many families are choosing adoption. But many more are needed. Pastor John Piper called adoption “the visible gospel” at it portrays a picture to the world of our own adoption into the family of our heavenly Father:

*In love, he predestined us to be adopted as his sons through Jesus Christ, in accordance with his pleasure and will. Ephesians 1:4-5*

But adoption isn’t something to be taken lightly – it is a covenant relationship between parents and a child. And while stories of adoption begin with brokenness, whether it is through birth parent death, abandonment, or inability to properly care for their children, there is great hope. Jesus said, “I have come that they might have life, and have it to the full” (John 10:10). Every child deserves to know the love of a forever family. Currently, the United States has approximately 127,000 legal orphans waiting in foster care for adoptive families to call their own. Most people simply don’t realize America has orphans because we don’t have orphanages. Yet these hidden and often forgotten orphan children need love and security as much as any of God’s children. Given the number of churches

throughout the U.S., every waiting child in foster care could have a family today if less than one family per church opened their home and hearts.

People have typically thought of adoption in the context of infertility. A growing number of families, however, are motivated by the understanding of the number of children in need of families and the realization that followers of Christ are God’s plan for orphan children:

*God sets the lonely in families. Psalm 68:6*

When considering if adoption is right for your family, it is important to know the distinctions between the three types.

- **Domestic** – This type of adoption usually means an infant adoption within the United States. It often has a bit of a waiting period and is usually accomplished by working with an agency who works directly with birthmothers. Often, the birthmother will choose the adoptive family for the baby. The adoptive family will also have input into the level of openness that is comfortable. A completely open adoption means the birth family is involved in the child’s life (often within some pre-set parameters). Semi-open means they do have some access but it is more restricted (for example, no direct contact with the child but do receive updates). In a closed adoption, the child has no contact with the birth family. This type of adoption is usually \$10,000-\$20,000.
- **International** – This type of adoption involves adopting a child from another country. Depending on the country, the wait can be anywhere between 1 and 4 years. This type of adoption is nearly always closed as many of the children overseas have been orphaned by death or abandonment. This kind of adoption can range between \$15,000 and \$35,000 depending on the country and agency you work with.
- **Adoption from foster care** – Adopting a child from the US foster care system is a frequently overlooked option. There are just over 100,000 children and youth in foster care waiting for adoptive families to call their own. These children are usually older and have had a difficult start in life. Their birth parents’ rights had to be terminated so they would have the opportunity to have a safe, healthy, and happy family. These kids wait in foster care to be adopted. Their only legal parent is the state or county with custody of them. There are generally little to no costs associated with adoption from foster care.

*Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress... James 1:27*

Christians have a clear command to care for orphans. And while not every family is called to adopt, everyone can play a role through prayer support, mentoring, giving, or mobilizing the church. For more information, visit [www.iCareAboutOrphans.org](http://www.iCareAboutOrphans.org).

\* [http://www.acf.hhs.gov/programs/cb/stats\\_research/afcars/waiting2010.pdf](http://www.acf.hhs.gov/programs/cb/stats_research/afcars/waiting2010.pdf)



# Sanctity of Human Life

## The Truth about Adoption

While more than one-third of Americans have considered adopting, no more than 2 percent have actually done it.<sup>1</sup> Misconceptions and fears often shape our actions. So let's take a look at the common myths and realities surrounding adoption.

### Myth 1: Adoption costs too much.

Not all adoptions are expensive. A private infant adoption or an international adoption can range between \$15,000 and \$40,000. However, adoption from the United States foster care system is usually less than \$500, including court costs, legal fees, and background checks on the adoptive family.

Families can also seek financial assistance from organizations such as Show Hope, LifeSong for Orphans, and The Abba Fund. In addition, in 2011 the government offered just over a \$13,000 tax credit per adopted child (visit [www.irs.gov/taxtopics/tc607.html](http://www.irs.gov/taxtopics/tc607.html) for more information), and many families adopting children with special needs are eligible for a monthly adoption subsidy.

### Myth 2: There isn't a need for adoption in the U.S.

The United Nations Children's Fund (UNICEF) estimates that there are more than 150 million orphans throughout the world. While the vast majority of those orphans live outside the U.S. in places like China or Africa, more than 100,000 children are waiting for adoptive families in the U.S. foster care system. This means that all parental rights have been terminated and the government is the only legal parent to these kids. They live in temporary foster care, often moving from home to home, waiting for an adoptive family.

### Myth 3: The birth parents might come back and take my child away.

We've all heard the heart wrenching stories of birth families who surface after a child has lived with a prospective adoptive family for years. In reality, those stories are the exceptions. Birth parents have no right to come back after their parental rights have been terminated and any legal appeals are exhausted.

Foster care is different. Foster parents are advised that the initial goal for most children is to reunite them with either their birth parents or another relative. Consequently, the children don't always live with foster parents for long periods of time.

In a foster-to-adopt situation, the potential adoptive family is made aware of the risk that nothing is permanent until the

adoption is finalized. The level of risk depends on which stage of the foster care process the child is in. The prospective adoptive parents reserve the right to determine what level of risk they feel comfortable with before any child is placed in their home.

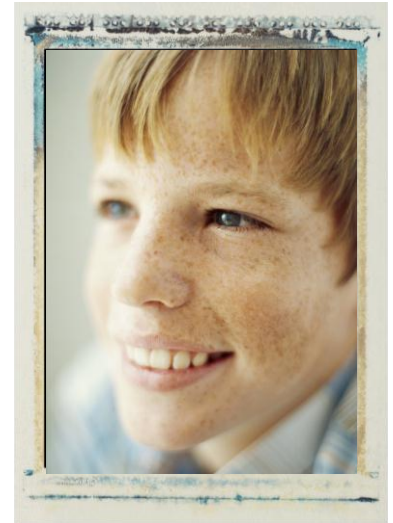
### Myth 4: I don't think I could love an adopted child like a birth child.

Many adoptive families have the same fear as they start thinking about adoption. Most all of them will tell you that once they met their child, no one could deny they were meant to be part of their family.

### Myth 5: The government will be in my home for life.

In order to adopt, families must successfully complete a background check and a home study. While at times the process may seem a bit invasive, it is important to remember that the government's role is to ensure that children are placed in families that are a good match for both the child and the parents. Once the adoption is finalized, the government is no longer involved and adoptive parents possess the same legal rights as birth parents.

While deciding to adopt is a big decision, it makes it easier when you have the right information. Take time to examine your motives for wanting to adopt and be sure to look into all the facts. Who knows, maybe the Lord is asking you to open your home and family to a child without either.



For more information, visit [www.iCareAboutOrphans.org](http://www.iCareAboutOrphans.org).

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<sup>1</sup> Child Welfare Information Gateway, *Persons Seeking to Adopt: Numbers and Trends*, 2005.  
[http://www.childwelfare.gov/pubs/s\\_seek.cfm](http://www.childwelfare.gov/pubs/s_seek.cfm)

# Sanctity of Human Life

## Quick Facts: Adoption from Foster Care

By Kelly Rosati

Senior Director, Sanctity of Human Life

Focus on the Family



- On any given day, more than 450,000 children are in the U.S. foster care system.
- More than 100,000 children in the U.S. are waiting to be adopted - just waiting for the right family to find them.
- The average age of the child waiting to be adopted from foster care is eight years old. Many are older, in sibling groups, are minority children and/or have special needs.
- Each year, 20% of children (26,517 in 2006) exit foster care at age 18 without an adoptive family – of those,
  - 2% earn a bachelor's degree or higher;
  - 51% are unemployed;
  - 25% have been homeless at some point;
  - 30% receive public assistance;
  - Many end up in prison and many have children of their own who also end up in foster care.
- In a recent survey of public opinion, 45% of those surveyed believed children were in foster care because of juvenile delinquency when the reality is that these kids have been abused, neglected or abandoned.
- More children in foster care wait for adoption each year than are adopted.
- In 2010, more than 64,000 children had parental rights terminated by the courts, yet:
  - Less than 53,000 were adopted from the foster care system;
  - In 2010, the average length of stay in foster care was nearly 22 months;
  - A child in foster care can wait *five years or more* to be adopted.



*Christians have a clear command to care for orphans. And while not every family is called to adopt, we believe everyone can play a role through prayer support, mentoring, giving, or mobilizing the church. Focus on the Family believes our efforts will inspire and equip families and churches to meet the needs of orphan children in their communities. For more information, visit [www.iCareAboutOrphans.org](http://www.iCareAboutOrphans.org).*



# Sanctity of Human Life

## Identifying and Overcoming The Impact of Abortion

"In him we have redemption through his blood, the forgiveness of sins, in accordance with the riches of God's grace"

—Ephesians 1:7, NASB

### The Importance of Healing

Many women who have abortions are very uncertain about their decision. On the one hand, their feelings say, "This is my baby . . . I will do what I need to in order to protect and nurture this child." But too often, their circumstances say, "This is not a good time to have a baby . . . abortion is legal and easy; it'll be as if it never happened . . . it's the only solution to this mess." One writer said that a woman chooses an abortion like an animal, caught in a trap, chooses to gnaw off its own leg in order to escape.

Simply put, most women who choose abortion are going against their own moral codes, and this explains why they feel guilt afterward. And the guilt is what stops them from talking about it or getting the emotional help they deserve. A number of counselors who have explored this issue in some depth have identified a common reaction to abortion as an ongoing inability to:

- Process the painful thoughts and emotions—especially guilt, anger and grief—which arise from one or more unplanned pregnancies and subsequent abortions.
- Identify (much less grieve) the loss that has been experienced.
- Come to peace with God, herself and others involved in the pregnancy and abortion decision.

If a woman chooses to have an abortion in order to bring a personal crisis to an end, why on earth should she be upset afterward about losing her baby? Needless to say, the post-abortive woman faces a number of monumental barriers to moving through the process of grieving her loss, or even recognizing that she has experienced a loss at all.

### The grieving process

A post-abortive woman may not have her grief validated as a normal and predictable grieving process; and as a result, she may repress her feelings of sadness and anger. Without an opportunity to work through it, the grieving process is interrupted and may not be resumed until years later, when another significant loss occurs or she becomes pregnant again. This may trigger, to her dismay, a response whose

magnitude and intensity seem out of proportion; and she may think, "Why am I having such a horrible reaction to this? Am I losing my grip?" She may begin experiencing a number of the following symptoms at this point.

- Guilt
- Anxiety
- Avoidance behaviors
- Psychological "numbing"
- Depression
- Re-experiencing events related to the abortion
- Preoccupation with becoming pregnant again
- Anxiety over fertility and childbearing issues
- Interruption or disruption of the bonding with present and/or future children
- Self-abuse/self-destructive behaviors
- Anniversary reactions
- Brief psychotic disorder

### The tasks of healing

When a woman comes to a point in her life where she recognizes the need to finally deal with a past abortion, there are several tasks to be accomplished.

#### 1. Remembering the pain

The first step in the healing journey is peeling away the callus formed by months or years of denying and repressing the painful emotions connected with the abortion experience. Why is it necessary to dredge up that which the mind has worked so hard to forget? Because the grief, anger and guilt a woman felt about the events surrounding her abortion were never processed. They were bundled up and hidden away since they were too painful to deal with; but they continue to fester like a smoldering infection, affecting current choices and behavior.

#### 2. Spiritual issues: guilt and forgiveness

Many post-abortive women, as we have already described, are secretly convinced that their transgressions are literally in a class by themselves, beyond the reach of God's forgiveness. Then the more important task is to accept on an emotional level, what they may already know on an intellectual level: that God's forgiveness is already available, and that they must decide to reach out and grasp it firmly.

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There are three important aspects to this “firm grasp” on forgiveness:

- (1) knowing Who ultimately has paid the debt,
- (2) allowing intimacy with God to be restored and
- (3) understanding the difference between punishment and consequences.

## 3. Identifying and releasing the anger

Many post-abortive women have a serious resistance to verbalizing their anger. They think, “If I go to that bleak, unlit place inside me, I may get in touch with a rage that will lead to a total loss of control.” And control is everything to a person who is barely hanging on to normal functioning in the wake of unresolved trauma.

Many people are raised in homes where it is not only considered wrong to express anger, but any display of negative emotions is off limits. The woman who has been raised in a religious home may be particularly hampered in this task area, because she has heard countless sermons exhorting her not to be angry or to express anger toward another human being. Rather, she is to swallow it and forgive others, as she has been forgiven by God.

Unfortunately, until the anger is identified and disposed of, it lies beneath the surface like a pool of toxic waste, always threatening to boil up and interfere with any efforts to reach wholeness. The paradox is this: until the post-abortive woman is willing to stop denying the pain and anger she felt (and still feels) about her abortion, she will never get rid of it.

## 4. Grieving the loss

The need to grieve a pregnancy loss fully is well documented, and for good reason. When a woman becomes pregnant, she instinctively knows her life has changed forever. The bonding process between mother and child begins very soon after an initial period of dazed and conflicting emotions. When that bond is broken—yes, even when it is the mother’s choice to break it—something is ripped out of the woman’s very soul. Needless to say, awareness of the need to grieve the loss of an aborted child is almost nonexistent in our culture. It is thus very common for the post-abortive woman to approach this task with confusion: “How do I grieve the death of a child when I was the executioner?” Learning how to think of the baby as a real individual, naming the baby, writing out her feelings for her child, and even having a quiet, private memorial service are ways to work through the grief.

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## Taboo Grief: Men and Abortion

Many men suffer from the after-effects of abortion as much as women. Here are two stories.

by Elaine Minamide

Michael “Chico” Goff was an honor student and a talented athlete headed for the pros in baseball when a knock on his door the summer after high school graduation changed his life. It was his girlfriend. She was pregnant.

Chico did what many in his situation have done — he convinced her to get an abortion. “Neither of us wanted to hassle with parenting,” he explains. “But I was the one who felt stronger about it. So I did what I thought was the responsible thing to do: I took her down to the clinic, and she had the abortion.”

It wasn’t until the following fall that the impact of what he had done crashed down on Chico. “I would walk into a grocery store and hear a baby crying, and it would totally spook me.” Ultimately, guilt and shame led Chico to seek counsel from a local pastor, where he learned about God’s forgiveness and became a Christian.

Another man, “Don,” was faced with the same situation when someone knocked on his door. “I was about 24 years old when I began a relationship with a woman at work,” he said. “The relationship fell apart, but a few weeks after it ended, she informed me she was pregnant.”

When Don, who had backslidden from his faith, learned she was considering abortion, he protested. “I was in sales at the time, and I used every sales tactic I had ever learned to persuade her not to go through with it.” Don lost the battle. Though he refused to pay for the procedure or even accompany her to the clinic, he agreed to pick her up afterwards. When he was driving her home, they were both traumatized by the sight of a mother at a bus stop, holding a newborn.

In both cases, the men initially felt a sense of relief, followed quickly by regret, sorrow and conviction. Both are permanently scarred. They’ve been called forgotten fathers, men stripped of their fundamental right to protect their unborn children. Their grief is not validated by a society that paradoxically demands accountability from the deadbeat dad but scorns the one who wants his child to live.



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"Abortion rewrites the rules of masculinity," says Dr. Vincent Rue, one of the nation's leading psychologists in post-abortion issues. "Whether or not the male was involved in the abortion decision, his inability to function in a socially prescribed manner leaves him wounded and confused." Society is not sympathetic to abortion survivors in general, and men are virtually ignored when it comes to abortion.

Men are bypassed legally as well. "Most men do not realize until they face a problem pregnancy that they have been stripped of all legal recourse to protect their unborn child," says Wayne Brauning, founder of Men's Abortion Recovery Ministries in Coatesville, Pa.

"There's a sense that this is not your issue," says Chico. "You've donated something to the process, but the process really happens outside of you."

Abortion rights come neatly packaged with two lies: Abortion is a woman's issue only, and the death of the unborn is not a real death. By accepting both lies, men who have lost children to abortion already have two strikes against them when they are confronted with their loss. Strike three is called when men neglect their own healing to console the woman, rather than express their own feelings of anger, hurt or betrayal.

## Post-abortion Men and the Church

The church is not immune to the ravages of abortion. Warren Williams, founder of Fathers and Brothers in Boulder, Colo., says the incidence of abortion inside the church and outside is virtually identical. And the impact is substantial. "Proverbs 28:17 says that a man tormented by the guilt of murder will be a fugitive until death," Williams says. "When you're involved in an abortion, you exhibit fugitive behavior — running, hiding, ignoring, covering up. A church populated by people with a fugitive mind-set is an emasculated church."

What prevents men from dealing with past abortions? First, men often don't know they are suffering. Symptoms of post-abortion stress seem unrelated to the abortion itself: inability to form trusting relationships, difficulty bonding with children, anger, risk-taking, depression, suicidal feelings, panic attacks, addictions. Psychotherapist Jim Benefield says it can take up to 10 years before men make the connection between their unhealthy behavior and an abortion.

Second, talking about abortion isn't easy. "It was very tough for me to go back and revisit the abortion," Chico said. Williams of Fathers and Brothers says that men need to know that they can talk about their emotions freely in a safe environment before they'll come forward.

Third, pastors are often unwilling to confront the issue directly. Yvonne Wagner, a pregnancy center volunteer, discovered this when she began calling area churches to offer her services as a post-abortion counselor. Out of 100 pastors she contacted, only two felt her services were necessary.

Williams suggests that church leaders work together with organizations such as crisis pregnancy centers or Promise Keepers. In this way, pastors can point hurting men in the right direction and raise the level of awareness in the church.

## Stepping Out of Denial

For a man to heal from an abortion he must:

- *Be motivated.* Psychotherapist Benefield says this is the first step toward healing.
- *Grieve.* "Men are conditioned not to show their feelings," says Pete Palmer, who after 25 years still recalls the pain of his girlfriend's abortion. "But even though we're males, we have to cry. We won't make any progress beyond that until we can say, 'Yes, I've lost somebody who's dear to me.'"
- *Forgive.* It took two years before Chico fully grasped what he had done and accepted God's forgiveness. Finding forgiveness from God, then learning to forgive those involved in the abortion is vital.
- *Reconcile.* Though most relationships end following abortion, many men seek some sort of reconciliation with those involved. Chico and Don each contacted his former girlfriend and apologized for his role.
- *Seek closure.* Many men acknowledge their aborted child for the first time by naming or writing letters to him. One father purchased a gravestone and had it placed in a cemetery.

Acceptance doesn't come easily. Last year at Father's Day, for example, when fathers at his church were asked to stand and be recognized, Chico remained seated. "I thought about standing," he said. "I am a father — my child would be about 13 by now. But I didn't. I don't know why. Maybe people wouldn't understand." Maybe they won't understand. But until men begin to acknowledge that abortion has damaged their lives and do something about it, families, the church, and society will continue to suffer.

This article appeared in the January, 2000 issue of Focus on the Family magazine. Copyright © 1999 Elaine Minamide. All rights reserved.

# Sanctity of Human Life

## Slavery Today

The injustice of human bondage has never been greater.

by Penny Hunter

"Today I learned about a couple in Asia who were selling their two little boys as prostitutes," our friend Bob said over dinner. I wanted to plug my ears and begin humming loudly. Everything in me screamed, *I don't want to know!* I've forgotten the rest of the evening except the thought in my mind as we said good night: *Let's not have Bob over again.*

I quite enjoyed my life: two sons, 20 years of marriage, self-employment as a marketing consultant. Safe. Predictable. But God was about to open my eyes to an adventure I would never have invited—but now can't imagine leaving.

## Misplaced fears

Most of my life I struggled with fear. I had a rough childhood with two alcoholic parents. Many years later, when my husband and I had our first son, Zach, I worried about his health and well-being. Son No. 2, Nate, was one more reason to worry over what could happen.

I had begun trusting God and being free from worry when we first heard Bob's story. Ironically, a few days after our dinner, Bob asked if I would help him establish promotional material for International Justice Mission (IJM), where he worked. I don't know what possessed me to say yes, but I agreed. Soon I was unloading boxes of photographs from countries where IJM was working to rescue slaves.

I spent hours looking for images to tell the stories that represented the work of IJM. I shuffled through the photographs and found notes on the backs about little girls being sold into brothels, men working as slaves in rice mills, whole families being held in slavery, intimidated and beaten.

I wept. I wept over the evil I was uncovering. I wept over the lost innocence of children. I wept over the freedom that's been stolen from fellow human beings. I wept over my own lack of courage simply to know more.

"Blessed are they who maintain justice, who constantly do what is right" (Psalm 106:3).

## Justice for all

As the days went by, God revealed to me the truth taught by the men and women who work as abolitionists for IJM: He is on the side of the oppressed, and those who engage in the plight of the hurting and suffering are drawn closer to His heart.

I discovered joy in the stories of former victims of slavery. The more I learned, the more I appreciated my own liberties—and the opportunity to make a difference. I began to realize that even a mom with two kids, a husband, a dog and a safe little life could be used, no matter how small, to bring about justice.

My newfound courage proved contagious. In junior high, my son Zach studied some of the activists of history: Harriet Tubman, Frederick Douglass, Sojourner Truth and William Wilberforce. He already knew a little about modern-day slavery because of my consultations with IJM; Zach became angry over the evil that people inflict on others for selfish gain.

He wanted to be a part of the abolitionist movement, to carry on in the spirit of the great abolitionists. He wanted to use his voice to help free others. So he launched the Loose Change to Loosen Chains campaign to help mobilize students and raise money toward ending slavery.

Now in high school, Zach travels the country carrying shackles that were used on child slaves. He conveys the stories of children like Rakesh, who was held as a rug loom slave, beaten with an iron claw and forced to work long hours in appalling conditions. Rakesh is now free.

## Free

The safe little world I'd created was sheltering me from the realities of the world. As long as people are in slavery and injustice runs rampant, if I remain silent, then my world is a self-absorbed existence. As Martin Luther King Jr. wrote, "Injustice anywhere is a threat to justice everywhere."

Through the courage of IJM, emancipated slaves and my own son, I gained the courage to face the world's atrocities. I discovered the joy of working for a God who loves justice.

For more information about the work of International Justice Mission, go to [www.ijm.org](http://www.ijm.org)

*Penny Hunter is the director of the Amazing Change campaign, a global effort inspired by the film Amazing Grace to abolish modern-day slavery.*

This article first appeared in the November, 2007 issue of *Focus on the Family* magazine. Copyright © 2007 Penny Hunter. All rights reserved.



# Sanctity of Human Life

## Genocide & Sanctity of Human Life

The genocide of human beings made in the image and likeness of Almighty God is a direct assault on the dignity and sanctity of human life.

by Kelly M. Rosati, J.D.



Photo from Make Way Partners.

What comes to mind when you hear the word *genocide*? According to the dictionary, it is the deliberate and systematic extermination of a national, racial, political or cultural group. Most people are familiar with the horrific genocides during the Holocaust and in Rwanda. After these tragedies, the world said, "NEVER AGAIN."

But what many people don't know is that "NEVER AGAIN" is happening now in Darfur, Sudan.

The genocide of human beings made in the image and likeness of Almighty God is a direct assault on the dignity and sanctity of human life. Genocide pierces the heart of God and grieves our hearts as well.

At Focus on the Family, we believe that human life is of inestimable worth and significance in all its dimensions, including the preborn, the aged, the mentally disabled, those deemed unattractive, the physically challenged and every other condition in which humanness is expressed from the single stage of development to natural death.

We believe Christians are therefore called to defend, protect and value all human life. In Darfur, Sudan, hundreds of thousands of men, women and children have been killed in the genocide and millions have been displaced. Unspeakable crimes of rape and torture are routine tools of war. Women and children are taken and forcibly placed in the sex-slave trade.

These circumstances seem so overwhelming and hopeless. It is natural to therefore feel helpless to do anything about it.

Are there things, however, that we can do to be a pro-life voice in the face of genocide? Absolutely. We can pray fervently for an end to the genocide. We can also educate ourselves, and then raise our voices on behalf of the victims and survivors. Proverbs says to speak up for those who cannot speak for themselves (Proverbs 31:8) and rescue those being led away to death (Proverbs 24:11).

Isn't it amazing that we can heed the ancient words of Proverbs in 2009? We can speak out for those who cannot speak for themselves: preborn children, vulnerable elderly people, orphans worldwide, and victims and survivors of genocide in Darfur.

One practical way to be a voice for life is by partnering with Christian ministries working on the ground to bring the love of Jesus Christ in tangible ways to the people of Darfur. One Christian ministry doing precisely that is Make Way Partners in Birmingham, Alabama.

Make Way Partners is a Christian mission agency committed to prevent and combat human trafficking and all forms of modern-day slavery by educating and mobilizing The Body of Christ. They build partnerships within The Body of Christ to call forth those willing to answer the Biblical call to seek justice on behalf of the oppressed through:

- Prayerful Intercession
- Financial Support
- Ministry and Mission Service

To those who are oppressed and at high risk of trafficking, they offer indigenous ministries of counseling, discipleship, education, employment, food, medical, shelter, and transportation which offer hope and practical assistance in the fight for freedom! Visit their Web site at [www.makewaypartners.org](http://www.makewaypartners.org) to see how you can be a voice for life!

*(Referrals to Web sites not produced by Focus on the Family are for informational purposes only, and do not constitute an endorsement of the sites' content.)*

Kelly Rosati is the Vice President of Community Outreach at Focus on the Family®.



# Sanctity of Human Life

## Five Ways to Care for the Aging in Your Church Family

by Kenneth Gosnell

A developing trend in recent years has been the aging of our society. In 2007 the first of the baby boomers began to retire. This shift in the landscape of America will change the face of the congregation of the 21st Century. We must become more aware of the needs of the aging population and how to better care for the aging in our church families.

In fact, the U.S. Census Bureau, in a March 13, 2001 press release, projected the doubling of the nation's population by 2100. In the release, it stated that in 1900 there were 3.1 million older Americans living. In 1999 that number grew to 34.6 million and by 2050 the number is estimated to reach 85 million people.

These numbers are quite alarming and remind all us to reach out to those who are aging in our congregations. James 1:27 says that, "Pure and undefiled religion before our God and Father is this: to look after orphans and widows in their distress and to keep oneself unstained by the world." (HCSB).

How can we care for the aging in our church families?

### 1. Develop programs that address the needs of the aging.

Create programs targeted for retirees and the older population of your congregation. Most programs today in churches are targeted towards the young. Consider the aging trends in society by focusing more on connecting older people and their friends. Events such as lunches and special trips appeal to this age group and allow them the opportunity to share in the fellowship of the local church.

### 2. Get younger members involved.

You may find that older congregants need help driving to the doctor or to the grocery store. Arrange partnerships with other members of the church who are willing to help the seniors with these weekly tasks. You will help solve a major problem for the aged, but in so doing will help create lasting friendships, while bridging the gap between varying age groups.

### 3. Encourage sermons on topics that are important to the older members.

A sermon that I gave on the topic of worry received more comments from the aged in my church than any other. The older members in your church have specific spiritual challenges as they face the sunset of their life. Ask your pastor to help them to navigate these challenges by preaching some sermons that speak directly to them.

### 4. Pay attention to their life's story.

Those who care about the aged will spend time visiting and listening to them. Specifically, those who care about the aging will need to carve out time each week to visit members and just listen and learn from their lives' wisdom. The truths and wisdom that can be learned from the lives that these older Christians have lived can provide wonderful stories to guide the younger members in your church from making the same mistakes that have caused grief and guilt in the aged lives. Learn to listen to their story and make use of what you learn.

### 5. Plan for specific events in their life.

While this may sound morbid or morose, there are many issues that you can expect and plan for which happen to the aged in your congregation. Issues such as sickness and death, grief over a lost loved one or rejection from children are events that can be planned for ahead of time. Help your pastor to be aware of these issues and offer your help to plan ahead for how your church body might minister to a family during those times.

I keep a folder of some of my oldest members and I ask specific questions to them while they are living that I know I can use in a funeral sermon or in a conversation with the family. I ask about family members, or their favorite passage of Scripture or even a favorite song. I have found that these conversations bring joy to the aged while they are living and comfort to the family in a time of sorrow.

Many times the aged in our congregations feel neglected and forgotten. Taking the initiative to move forward on focusing on the aged in our congregation will make a difference not only in their life, but also the life of your church.

*Ken Gosnell is the lead pastor for a new church work in the DC Metro area and the senior director of national programming for the National Fatherhood Initiative: [www.fatherhood.org](http://www.fatherhood.org). Contact Ken at [kgosnell@fatherhood.org](mailto:kgosnell@fatherhood.org)*





# Sanctity of Human Life

## Caring for Loved Ones

by Kenneth L. Connor

### Living With Alzheimer's

As people live longer, and as more progress is made in preventing the leading causes of death — such as cancer and heart disease — the chronic conditions of older adulthood make a more profound impact on families and society. Of these, Alzheimer's Disease may be one of the most devastating because of its progressive nature and associated disability.

The typical progression of Alzheimer's is familiar: a person, usually an older, begins to forget details. Errors in thinking become more frequent and serious until they interfere with the patient's and their family's activities of daily life. Eventually, the victim may fail to recognize familiar people and places, and lose the ability to care for themselves. Death usually occurs due to other illnesses or as a result of complications of the disability.

Although the underlying cause is not fully known, the changes in brain tissue that bring on the symptoms of Alzheimer's are readily recognized. The support structures between neurons progressively become more and more damaged. At least two proteins that are most likely responsible for this damage have been identified. Then, the neurons themselves die. Although a definitive diagnosis can be made only by examining brain tissue under a microscope — usually at autopsy — Alzheimer's can be identified with reasonable certainty from a computerized tomography (CT) scan and laboratory tests, provided other common causes of dementia have been excluded.

In the early to middle stages of Alzheimer's, family members are usually responsible for most of the care. A familiar, quiet and well-structured environment with a simple, regular routine works best for most people with Alzheimer's. Family caregivers need support from friends, neighbors and employers in maintaining this kind of environment; they also need support and encouragement for themselves. For example, respite care that enables caregivers to get away for a break can be helpful.

Formal support groups across the nation exist for patients and families coping with Alzheimer's. Many organizations have published literature about every aspect of Alzheimer's, available both in hard copy and online. Also, a national bracelet-identification program has now been established to reunite caregivers with Alzheimer's patients who may have wandered away.

Search by location for Alzheimer's support at <http://www.alz.org/findchapter.asp>\*

In the later stages needs are often too intense for family members to handle in their homes. Placement in a residential facility may become necessary. When choosing an environment for a loved one, make sure the facility is clean, has a positive track record with the state licensing agency and specializes in the care of persons with Alzheimer's. When making your choice, it may be helpful to talk with several families of other residents to hear their opinions on the service and level of care. It's important for you and your loved one that you continue to be active in their circle of care.

### Is Assisted Living the Best Option?

*Are you considering moving an aging loved one into a care facility? Here are four tips if you're considering assisted living*

Pray about every move, take as much time as you can and pour out your fears, hurts and frustrations to the Lord (Phil. 4:6-7). Your own strength cannot sustain you when emotionally charged issues overtake you, But God's can.

Ask God to make correct moves obvious and to close doors tightly to any wrong moves.

Ask God to bring a trustworthy friend to help you and to listen to you (Heb. 10:24-25).

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Seek godly counsel from people and agencies with experience who can help you in concrete ways. Talk with people in your church who have gone through this with their parents or aging loved ones. Maybe you can start a support group at church for other caregivers.

To determine if your elder is a good match for assisted living, consider your loved one's personality and health needs. If your aging loved one is losing some function but is a sociable person, it may be the ideal choice. If your elder is not fond of congregate living, a better option may be to arrange for help through adult day-care programs and/or home care. Following a hospital stay, extended care/sub-care hospital rooms are offered by some hospitals on a temporary basis for those who cannot go home but do not want to move into an assisted-living or continuing-care facility.

Consider your elder's financial stability, too. Will your elder's income and assets be enough to cover assisted-living expenses for the next few years, including possible increases in monthly charges and additional fees if more services are needed?

A continuing problem with assisted-living facilities is what happens to the elder when she needs care beyond the levels provided by assisted living. She may end up transferring to a nursing home if the assisted-living facility is not licensed or equipped to handle her increasing medical needs. After spending much of her savings on the assisted-living facility, the elder may be asked to leave with no guarantee of where to go. Many seniors have been left "high and dry" by the assisted-living industry when they needed more care. That is why the continuum of care offered by continuing care retirement communities appeals to many.

If assisted living seems to be the most appropriate and welcomed kind of care for your aging loved one, the best time to talk about it is before it is needed. Try to anticipate the day when in-home care combined with community services and family help is no longer viable.

*This article first appeared in December 2004 on the Focus Over Fifty Website from "Caring for Aging Loved Ones," Focus on the Family Publishing.*

## Caring for Ill or Aging Parents

*by Carol Heffernan*

Caring for an aging parent is a responsibility few people ever expect or envision. We avoid thinking about our parents falling ill or growing weak. We don't feel equipped to handle the welfare of those who raised us. Confusion, sadness, helplessness jar us during this unsettling transition.

As baby boomers live longer, healthier lives, any assistance that is required typically becomes the children's responsibility. For many families, the discussion about who will take care of Mom and Dad comes on the heels of a crisis. As a result, most families find themselves unprepared to handle their parents' increased dependency.

Still, with the increase in number of older adults comes the increase of adult children caring for their parents. More than 20 million in the U.S. alone provide care for an aging parent or in-law. What's more, families rather than institutions provide 80 percent of long-term care.

So how can adult children, siblings and parents deal with the inevitable challenges that accompany this life transition?

Begin by openly discussing each person's role and responsibilities within the family structure. While caregiving can be extremely stressful, sharing duties is a guaranteed way to ease the tension. Whatever distance family members live from one another, devise a care plan so everyone can be involved.

Addressing the sensitive topic of finances is also a must, as is compiling important personal and financial documents. Finally, take the time to evaluate how to build unity among siblings—in spite of the high potential for tension.



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There's no question that many caregivers only find frustration and exhaustion. But with solid support and communication, caring for an aging parent can bring a renewed sense of love, compassion and tenderness into any family.

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## Managing Stress When Caregiving

*Consider these suggestions to help ease the emotional and physical strain when you've become the caregiver.*

*by Carol Heffernan*

Joan Johnson remembers when her parents started becoming dependent on their children. She remembers her brothers and sisters talking at length about their care options. A nursing home, an assisted-living facility, hiring in-home care.

Ultimately, family members chose to care for their parents themselves.

"We thought it would be easier than it was," says Joan. "My mother and father ended up needing 24-hour assistance, and while we were happy to do this, we should have been taking better care of ourselves. It was difficult, emotionally, to see them deteriorate, and the mounting responsibilities really took a toll."

Providing day-to-day and even minute-to-minute care for an aging parent can be tremendously stressful. Caregivers suffer symptoms so severe that they themselves become known as "hidden patients;" they fail to notice the signs of stress in their own lives.

When the attention is so focused on their parent, numerous and potentially harmful symptoms go unnoticed in the lives of the adult children. What's more, the warning signs of stress can attack so

subtly that they're difficult to detect—and this can create a real danger.

Studies show that more than half of all caregivers suffer from depression, while the majority experience what's commonly referred to as "caregiver stress."

It's no wonder, considering many who care for a parent also juggle a multitude of responsibilities. Full-time jobs, parenting their own children and household duties all add to already high levels of stress. In the process, it's common for caregivers to put their own health, feelings and well-being aside. The results can be damaging: anxiety, sadness, guilt, and a whole host of physical ailments.

If you are in a caring for aging parents, recognize the warning signs, then deal with the stress immediately.

- Unusual sadness, moodiness or anger
- Social withdrawal from activities and friends
- Fatigue, exhaustion and difficulty sleeping, either too much or too little
- Change in eating habits, and weight loss or weight gain
- Recurrent headaches, stomachaches and colds
- Difficult concentrating on other areas of your life, possibly resulting in a decline in work performance
- Unexplained irritability
- Feelings of dread, hopelessness and depression

If you care for others, it is also imperative to make your own health a priority. Consider these suggestions:

- **Create lists and establish a daily routine.** Keep track of tasks, then balance, prioritize and delegate responsibilities. Most importantly, modify your schedule to avoid anxiety and exhaustion.
- **Ask for help when you need it.** Enlisting the support of friends and loved ones does

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not make you appear weak. It is of utmost important that you care for yourself in order to provide good care for your parent. Looking beyond immediate loved ones, many cities provide adult care and other services for the elderly, and many churches offer programs for seniors. With safe, friendly environments and plenty of activities, use outside care to give yourself and your parent a break.

- **Take care of your body and mind.** Besides fitting exercise into your schedule and maintaining a balanced diet, it's crucial to find time to relax, pursue a hobby and connect with friends. While leaving a parent in someone else's hands is difficult, getting away at least a few hours a week is critical. Neglecting your own physical and emotional health leaves you vulnerable to disease and exhaustion.
- **If you feel depressed, get help.** Caregivers are at tremendous risk for depression, yet many do not realize that they are depressed. These feelings can develop over time and will become progressively worse if not treated. Instead of hoping this condition will just go away, seek medical help; it'll make all the difference.
- **Regularly talk with a counselor, support group or close friend.** Even though you may not want to discuss your feelings and frustrations, it's beneficial to find an outlet. A parent may have behavioral issues—yelling, hitting, wandering from home—that stir up unfamiliar and very painful emotions. A sympathetic listener could provide the support, comfort and perspective you need to get through the day.

It's worth noting that caring for an aging parent—while challenging—can have many positive effects on the whole family. There's an added sense of purpose, the ability to nurture an intergenerational bond and the knowledge that you're making a difference in the life of your parent.

Giving proper care and attention to yourself and your loved ones will create a healthier, happier environment sure to improve everybody's quality of life.

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## One Family's Story:

### The challenges and rewards of providing day-to-day care for an elderly parent.

by Carol Heffernan

Much that is written about aging parents describes the stresses, the challenges and the headaches that come with providing care. My story shows a different side—a more positive side—of sharing those last years together.

My husband Norman and I were both raised with the model of bringing elderly family into the home. My mother cared for her parents, and Norman's grandmother lived with his family for ten years. Naturally, I figured, our parents would some day move in with us.

After my father died, my mother lived on her own for a decade, keeping up her house and yard, and trying to stay on top of her burgeoning health problems. Her decline was a slow one, but I could see subtle changes.

She would call one of us in a panic, saying she was having trouble eating, when she was really having trouble remembering directions to the grocery store. She couldn't remember which medication to take. Her vision also deteriorated, and her back problems worsened.

We lived several hours away from one another at that point and kept in touch through daily phone calls and frequent visits. During one stay, my mother noticed that the home behind ours was for sale. Her decision to purchase it was a good one; she lived there for five years. Nearly every night,



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Norman would bring her over for dinner, and we regularly helped with her household chores. But as her daily care became more and more difficult, she knew it was time for a change.

## When Mom moved in

While we were remodeling our kitchen, my mother asked if she could come live with us. So we added to the remodel, enlarging a bedroom and bathroom to fit her needs. Since her parents had lived into their 90s, we expected the same—and we wanted her comfortable.

What a blessing it was to have her with us! That's not to say there wasn't work. She needed help with everything from bathing to dressing to going to the bathroom. For some reason, instead of helping herself to food, my mother preferred that Norman or I did this for her, quickly earning her the adoring nickname "The Queen."

Looking back, I know Norman and I could have gotten short with her, succumbed to anger or worried about the future. But we made an effort to laugh as much as possible, see the humor in things and always communicate openly.

I certainly wasn't raised with this kind of honest communication, but I knew it was necessary to sustain a healthy environment. I used to say, "Everybody do the best they can, and we'll forgive the rest." Together, we learned about setting boundaries, not holding grudges and being up front with one another.

Yes, it was difficult to watch her health decline. And yes, it was sometimes a trying experience. My mother, for example, would often ask the same questions over and over again. But I quickly learned that getting irritated and scolding her didn't do any good. When she complimented me on the "new" dress I wore every Sunday to church, I would simply respond, "I'm so glad you like it!"

I knew she wasn't choosing to forget, and I knew aging was a part of life. So I accepted her

absentmindedness and made every effort to treat her gently—even when I didn't feel like it.

Living without regrets

My mother's insurance enabled us to get help with her routine care on weekdays. This allowed my husband and me to carve out time for each other. We realized that our relationship had to be the priority.

Speaking of Norman, he was the biggest help, and I couldn't have done it without him. When we married, we agreed we would love each other's parents as our own—and that agreement stuck.

We both knew that the time with my mother was finite—just like the time we spent raising our children. Neither of us wanted those lingering "if only" thoughts when our parents passed away: If only we would've given our parents more time, more love, more attention. Caring for my mother certainly made our lives busier and more complicated. But we wouldn't have done it any other way.

After living with us for two years, mom caught a cold and her body started to wear out. The last day of her life, our family was singing to her from a hymnal, and we could see her mouth moving along with the words. She died surrounded by her loved ones, and we have all the confidence that she continued her song in heaven.

Caring for my mother wasn't always easy. But when she died, I had no regrets. Helping her was a privilege, and I'm so thankful that she was happy while she lived and at peace when she died.

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#### *4. End of Life*



# Sanctity of Human Life

## What the Bible Says About the End of Life

### Is there an example of assisted suicide in the Bible?

There is an account of reported voluntary euthanasia (in which one person asks another to kill them, ostensibly in order to alleviate the first person's suffering) involving King Saul and an Amalekite (2 Samuel 1:1-16). The unnamed Amalekite tells King David that he killed Saul at Saul's request, as Saul was wounded in battle. David's response is to kill the Amalekite for touching God's anointed. If euthanasia were a beneficial practice, David would have rewarded the Amalekite, not sentenced him to death.

### How should Christians respond to the fear (or reality) of pain and suffering?

"Be strong and courageous, do not be afraid or tremble . . . for the Lord your God is the one who goes with you. He will not fail you or forsake you . . . And the Lord is the one who goes ahead of you . . . Do not fear, or be dismayed."

—Deuteronomy 31:6, 8, NASB

"He who did not spare His own son, but delivered Him up for us all, how will He not also with Him freely give us all things? . . . Who shall separate us from the love of Christ? Shall tribulation, or distress, or persecution, or famine, or nakedness, or peril, or sword? . . . But in all these things we overwhelmingly conquer through Him who loved us."

—Romans 8:32,35,37, NASB

"Even though I walk through the valley of the shadow of death, I fear no evil; for you are with me"

—Psalm 23:4, NASB

### How should Christians respond to personal challenges, disabilities and infirmities?

". . . Behold the bondsman of the Lord; be it done to me according to your word."

—Luke 1:38, NASB

"And He said to me, 'My grace is sufficient for you, for my power is perfected in weakness.'"

—2 Corinthians 12:9, NASB

"For I have learned to be content in whatever circumstances I am . . . I can do all things through Him who strengthens me . . . And my God shall supply all your needs according to His riches in glory in Christ Jesus."

—Philippians 4:11, 13, 19, NASB

### In the midst of Job's physical, spiritual and psychological suffering, how did he respond?

"Then Job arose and tore his robe and shaved his head, and he fell to the ground and worshipped. And he said, 'Naked I came from my mother's womb, and naked I shall return there. The LORD gave, the LORD has taken away. Blessed be the name of the LORD.' Through all this Job did not sin nor did he blame God . . . [And Job said] 'Shall we indeed accept good from God and not accept adversity?'"

—Job 1:20-21, 2:10, NASB

### Does suffering have spiritual value? Can God be glorified in how we respond to suffering?

"That I may know Him, and the power of His resurrection and the fellowship of His sufferings, being conformed to His death; in order that I may attain to the resurrection from the dead."

—Philippians 3:10, NASB

"But we have this treasure in earthen vessels, that the surpassing greatness of the power may be of God and not from ourselves."

—2 Corinthians 4:7, NASB

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“Therefore we do not lose heart, but though our outer man is decaying, yet our inner man is being renewed day by day. For momentary, light affliction is producing for us an eternal weight of glory far beyond all comparison, while we look not at the things which are seen, but at the things which are not seen; for the things which are seen are temporal, but the things which are not seen are eternal.”

—2 Corinthians 4:16-18, NASB

**But it's my body. Don't I have a right to choose when I die?**

“Do you not know that you are a temple of God, and that the Spirit of God dwells in you? If any man destroys the temple of God, God will destroy him, for the temple of God is holy and that is what you are.”

—1 Corinthians 3:16-17, NASB

“Or do you not know that your body is a temple of the Holy Spirit who is in you, whom you have from God and that you are not your own? For you have been bought with a price: therefore glorify God in your body.”

—1 Corinthians 6:19-20, NASB

**Is it acceptable for a Christian who is terminally ill to refuse available technology in order to let nature take its course and bring about a natural death?**

Yes.

“There is an appointed time for everything. And there is a time for every event under heaven—a time to give birth, and a time to die.”

—Ecclesiastes 3:1-2, NASB

“Precious in the sight of the LORD is the death of His godly ones.”

—Psalm 116:15, NASB

“And in your book were all written the days that were ordained for me.”

—Psalm 139:16, NASB

**Do the acts of assisted suicide and euthanasia deny God the opportunity to demonstrate His healing power?**

Yes.

“And when evening had come, they brought to Him (Jesus) many who were demon-possessed; and he cast out the spirits with a word, and healed all who were ill.”

—Matthew 8:16, NKJV

“Therefore, confess your sins to one another, and pray for one another, so that you may be healed. The effective prayer of a righteous man can accomplish much.”

—James 5:16, NASB



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## Aborting the Elderly

Other than the unborn, no single age group suffers more from a diminished view of the value to human life than the elderly.

by Kenneth L. Connor

For 20 years I have represented elders who have been victims of abuse and neglect in long-term care institutions. Despite having seen many sad cases, I continue to be amazed at man's inhumanity to his fellow man.

I have represented clients with avoidable pressure sores as large as dinner plates — sores so putrid and infected that when you walked down the hallway of the nursing home you could smell the person's sores before you could see them.

I have seen residents, hollow-eyed and emaciated from hunger and thirst, who would eat and drink ravenously if only someone would take the time to assist them by putting a fork to their mouth and a cup to their lips.

I have seen residents who were victims of violent abuse tremble with fear at the approach of those who were supposed to be their caregivers.

Other than the unborn, no single age group in our country suffers more from a diminished view of the value to human life than the elderly. The utilitarian ethic that was established in law in *Roe v. Wade* has implications as negative and profound for the end of human life as it has had for the beginning.

Human life is an unbroken continuum that extends from conception to natural death. Devalue life at any point on that continuum, and life at every other point is put at risk.

Once the principle of the sanctity of life is compromised, the lives of those who cost more to maintain than they produce or whose quality of life has become diminished become difficult to defend.

Having stripped human life of its intrinsic worth from the moment of conception until the moment of birth, on what moral or ethical basis can we defend life in its closing stages? *Roe* set into motion a barbaric cost-benefit/quality-of-life calculus with consequences that are all but impossible to restrain. Once one's net worth is calculated in such terms, the door is opened to unspeakable abuses.

If being "wanted" is the operative ethic for the beginning of life, what is to prevent it from becoming the prevailing ethic towards the end of life? Already it is common to hear discussions concerning so-called "quality of life" issues with

regard to the elderly. Stripped of their gloss, these discussions really boil down to little more than the question: "Who would want to live in that condition?"

Let's face it: The terminally ill, the chronically afflicted, the permanently bedridden have, in the eyes of many, lost any meaningful quality of life. Why not dispose of them for their own and society's good? Isn't this humane?

It is precisely this perverse logic that caused former Colorado Governor Richard Lamm ("Governor Gloom" as he was known to many) to declare that the elderly had a "duty to die" and get out of the way.

The key question here, of course, is who gets to define "quality of life?" Who decides whether someone else's life is worth living? Phrased differently, the question is who gets to decide if someone else is "wanted?"

How we treat our fellow human beings depends on certain basic moral attitudes and habits of thought. The attitude that life is basically a negotiable commodity leads easily to abuse and neglect and, in the end, to disposable people. Once we have consciously devalued life, it is but a short step to throwing it away like a worn-out old shoe.

It is doubtful that a generation nurtured on the *Roe* ethic will be willing to make the economic commitment — let alone sacrifice — needed to protect or sustain the lives of those elderly whose "quality of life" is suspect. Walk through any nursing home and you will find an ample number of candidates for inclusion in the class of "throwaway" people.

Many elderly individuals require round-the-clock care. Many require expensive medication and costly medical procedures. Those afflicted with dementia often have little or no consciousness of their surroundings, family, or even of life itself. Others live out long, lonely, solitary days, without surviving relatives, abandoned by family and friends. These people do not score well when a cost-benefit ratio or quality-of-life calculus is applied to them.

American society is increasingly treating certain classes of human beings at the beginning and at the end of life as though they were property, subject to use, abuse and disposal at the hands of other human beings. Such actions fly in the face of the sanctity of life ethic that arose from the Judeo-Christian view that life is inherently valuable, because it is the gift of God.

*Roe* undercut 4,000 years of Judeo-Christian teaching on the sanctity of life. More than 42 million unborn children have already paid the price for such arrogance. The elderly will be the next to pay.

*Ken Connor is an attorney and the Chairman of the Center for a Just Society: [www.centerforajustsociety.org](http://www.centerforajustsociety.org).*

# Sanctity of Human Life

## The Forgotten Generation

Eighty-five percent of the residents of skilled-care centers never have visitors, not from family, friends, clergy or anyone from a church.

by Kay Owen

I'd like to tell you about one of the largest forgotten people groups in America. You might be surprised and even shocked to learn that this group includes the precious people who reside in our communities' care centers. Research of 16,000 care facilities shows that approximately 85 percent of the residents of skilled-care centers never have visitors, not from family, friends, clergy or anyone from a church.

This generation was known as "The Greatest Generation," but now they are termed the "Forgotten Generation." The primary reasons are because of the breakdown of the family and the geographical relocation of family members throughout the country.

### Loneliness and Depression

Most of the residents are lonely. Many are depressed and discouraged. Some are angry. Most feel they are of no value to their families or to society. Many, in an effort to make sense of why they have been forgotten, excuse their family members' absence by saying they are "just too busy to visit," that "they have their own lives and careers" or that it is "just too depressing" to visit the care center where their elder mother or father resides.

The residents rarely get to share their personal stories with anyone. A gentleman who is 100 recently told me that he has many stories he would like to tell but that no one takes time to listen. Someone has said, "When we lose an elderly person, we lose a library." How true! It is very important for us to record their legacy before they're gone.

Let me backtrack for a moment and tell you how and why I became a missionary to these "precious jewels."

My parents lived in an acute-care facility in Jacksonville, Florida. My father had cancer, and my mother had a massive stroke that left her unable to talk, walk or eat. My two brothers and I spent many hours, sometimes entire days, in the facility with our parents. I began to see how lonely the residents were – day in and day out.

### No Visitors

The residents rarely had regular visits from anyone. And when one of them passed away, they were quietly taken out of the care facility and no mention was made of them again.

For the most part, I observed that the staff members of the care facilities were taking care of the physical needs of the residents, but their spiritual and emotional needs were not being met.

The Lord began to work in my heart, but for several reasons, I was very resistant to start this ministry. I was working a full-time job, my husband had many health issues and I felt I was just too old! After my dad and mom passed away, I began having terrible dreams about my mom. I was very close to her and in the dreams I saw her in disturbing situations that I would not have allowed her to be in. I would wake up crying and very upset.

One day, out of frustration, I said to the Lord, "My mom is not here, she is not involved in these situations, so I can't help her." His reply to me was, "Yes, but what about all those you can help?"

After struggling for several months, I finally said yes to the Lord. I began doing research for the purpose of founding a ministry to serve the elderly residents in care centers. What I found was astounding and heartbreaking. Very little was being done to meet the spiritual and emotional needs of elders anywhere in the country.

My husband, Jerry, and I began to ask the Lord what He wanted us to do to meet these needs, and He said: "Our care facilities must be filled with chaplains, counselors, pastors and lay people to meet the spiritual and emotional needs of this forgotten generation."



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## Determined

My research included reading many books, hours spent on the Internet and interviews with chaplains, faculty members of several universities and organizations that work with the elderly. The facts I discovered were astounding and I was even more determined to do something to reach these residents.

In addition to the approximately 85 percent of the residents who have been “abandoned” by their families mentioned earlier, only about five percent of those same facilities had chaplains. Another survey revealed that, per capita, those over age 65 have the largest suicide rate of any other age group in America.

My heart was broken for their plight. I decided to become a missionary to this “special” group of people and get as many others as possible to help me reach out to them with the love of Christ. You, too, can use your gifts and talents to reach out to those who reside in our communities’ care centers. The Lord is looking for people who will share His love and to give of themselves without reservation.

There are many ways you can get involved. Pastors, you can get your people involved in regular visitation to the residents of a nearby care center. They are worth the time it takes to spend with them! Anything that touches the Lord’s heart should touch ours. The elderly are very close to His heart. He has given us very specific commands in His word to take care of them.

During a visit to a nursing home in the United States, Mother Theresa said the following, “There is a pain, far worse than hunger or poverty; it is the pain of being rejected.”

Families, Sunday school classes, home churches, cell groups and individuals as well as local churches can get involved. Together, we can reach this generation for the Lord. The fields are indeed “white unto harvest.” Crossroads Ministries USA is available to bring training to local churches and other groups who are interested.



Kay said to God, “My mom is not here, so I can’t help her”

God’s reply to Kay was, “Yes, but what about all those you can help?”

Pictured are Randolph and Dolly Moody, Kay Owen’s parents.

## Make a Difference

The residents of our care centers are at a Crossroads in their life, and many of them are ready to make a decision for the Lord. We can make an eternal difference in their lives as well as the lives of their families and the staff of the care centers.

Bill Daniels, founder of the Daniels Fund, a philanthropic organization, said:

*“Imagine a world where people give of themselves simply because they want to. Not out of a sense of debt or because they want something in return. No ulterior motives. No guilt feelings. Just the desire to give for the sake of giving. Now, instead of imagining this kind of world, do your part in making it happen. Make a charitable donation. Volunteer your time to improve your community. Give back to the world that gives so much to you. And if it happens to make you feel good to give, that’s all right. Feeling good is the one ulterior motive that’s acceptable.”*

Yes, God has given us much, spiritually, physically and financially. Let us in return give back to those who have given us so very much.

Kay Owen is the president of Crossroads Ministries USA, Inc. Find out more at [www.crossroadsusa.org](http://www.crossroadsusa.org)

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# Sanctity of Human Life

## A Patient's Guide: Discussing Your Medical Wishes

*Talking with a loved one about your medical preferences in the event that you cannot decide for yourself is an important but rarely easy task. High profile situations such as the one involving Terri Schiavo remind us that an accident or illness could render any one of us unable to communicate our medical wishes. Planning ahead for such a situation will prove helpful to you, your family and loved ones.*

**"Advance medical directive"** is an umbrella term that refers to written and/or oral directives you make about future medical care if you are unable to make your own decisions. This term includes a variety of documents; the two most frequently discussed are a "Living Will" declaration and a Durable Power of Attorney for Health Care.

The "Living Will" declaration is discouraged as it is a signed statement that attempts to predict your preferences in often-complex future medical situations that you cannot foresee. The statement offers a narrow list of options that may be used to prohibit treatment you may want in certain circumstances - even for a short period of time.

A Durable Power of Attorney for Health Care is encouraged as it allows you to name a trusted family member or friend to make medical decisions for you if you are unable to do so. It also permits you to name a secondary health care agent if your primary agent is unable to serve.

Signing a Durable Power of Attorney for Health Care is only part of the equation. You also need to discuss your general views, preferences and overall philosophy of medical decision-making with your health care agent.

The following "discussion categories" may be useful to help you formulate a personal medical decision-making philosophy. It may also be used to facilitate conversation with the individual(s) named as your health care agent(s). Remember that your health care agent can only make decisions for you if you are incapacitated and unable to do so for yourself.

*Note: This information sheet is not intended as a legal document such as a "living will" or to be legally attached to a Durable Power of Attorney for Health Care. Your health care agent may want to write notes on this page or a separate piece of paper during and after your conversation(s) for his or her personal reference.*

## Discussion Categories

This document includes the following discussion categories:

- I: A Life-Affirming Perspective
- II: Patient's Prognosis
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### I: A Life-Affirming Perspective

The writer of Ecclesiastes reminds us that there is a time for everything, including "a time to die" (Eccl. 3:1-2). Today's life-sustaining interventions may appear to create a fine line between postponing death and sustaining life. When uncertainty exists, God invites us to ask Him for wisdom when we are in need of understanding and discernment in decision-making, including medical ones (James 1:5).

A pro-life philosophy on medical decision making presumes intervention will be attempted to preserve a patient's life as long as the intervention is determined to:

- Be physiologically possible for the patient;
- Offer an expected benefit without excessive risk or burden to the patient; or
- Provide reasonable hope of sustaining or improving the patient's life.

### II: Patient's Prognosis

Your preferences regarding medical interventions and the use of technologies may vary depending on your age, physical condition and the diagnosis and prognosis of your condition. Therefore, it may help to distinguish between the following categories when discussing your wishes with your health care agent:

- **Acute**—short-term, reversible medical condition with expected patient recovery.
- **Disability**—physical and/or mental loss or impairment, including neurological (brain) injury.
- **Chronic**—slow, progressive illness, disease or condition over an extended period of time.
- **Terminal**—irreversible and fatal illness, disease or condition.
- **Actively Dying**—imminently, in the process of dying due to a terminal illness, disease or condition.

### III: Possible Interventions

You may have different views and preferences regarding possible life-sustaining medical interventions. Here are a few to consider:



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- **Antibiotic**—a drug given to treat infection
- **Cardiopulmonary Resuscitation (CPR)**—an emergency procedure to restore normal breathing and circulation after cardiac or respiratory arrest using mouth-to-mouth or mechanical assistance for breathing and external heart massage. Other medical methods commonly utilized during CPR include giving IV fluids and oxygen, infusions of antiarrhythmic or other cardiac drugs, electric shock delivered through a defibrillator (paddles placed on the chest), and intubation (placing tubes down the throat into the patient's airway).
- **Dialysis**—the process of using a machine to cleanse the body of impurities and waste when the patient's kidneys fail to do so. It can be a short-term or long-term intervention.
- **Medically Assisted Nutrition and Hydration**—the provision of nutrition (food) and hydration (water) to patients who are unable to swallow or digest normally. This can be provided by a flexible rubber or plastic gastric tube inserted into the stomach under local anesthetic at the bedside; it can also be provided intravenously or through a tube inserted through the nose. It can be a short-term or long-term intervention.
- **Surgery**—an invasive operation or procedure to correct disease or injury.
- **Ventilation**—the process of using a handheld device for a short period of time or a machine called a ventilator or respirator for a longer period of time to help the patient to breathe.

## IV: Considering Various Scenarios

Section II offers a list of possible prognoses and Section III provides a list of possible interventions. Cross-referencing these two lists may be helpful in considering and discussing your personal views and preferences with your health care agent:

**How do you generally view the following possible interventions if you are in an acute medical situation where recovery is expected?**

- Antibiotic
- Cardiopulmonary Resuscitation (CPR)
- Dialysis
- Medically Assisted Nutrition and Hydration
- Surgery
- Ventilation

**How do you generally view the following possible interventions if you are physically and/or mentally disabled, including neurological (brain) injury?**

- Antibiotic
- Cardiopulmonary Resuscitation (CPR)
- Dialysis

- Medically Assisted Nutrition and Hydration
- Surgery
- Ventilation

**How do you generally view the following possible interventions if you are chronically ill?**

- Antibiotic
- Cardiopulmonary Resuscitation (CPR)
- Dialysis
- Medically Assisted Nutrition and Hydration
- Surgery
- Ventilation

**How do you generally view the following possible interventions if you are terminally ill?**

- Antibiotic
- Cardiopulmonary Resuscitation (CPR)
- Dialysis
- Medically Assisted Nutrition and Hydration
- Surgery
- Ventilation

**How do you generally view the following possible interventions if you are actively dying?**

- Antibiotic
- Cardiopulmonary Resuscitation (CPR)
- Dialysis
- Medically Assisted Nutrition and Hydration
- Surgery
- Ventilation

Bear in mind that patients' preferences for intervention can change over time and with life experience. For instance, many disabled patients convey that an initial desire to refuse treatment disappeared after interactions with family and friends confirmed the value of their lives, even in light of disability.

## V: Additional Topics

Related topics you may want to discuss include:

- Being cared for at home, if possible, rather than in a hospital or long-term care facility.
- Your views on the use of pain- and symptom-control measures including narcotics and sedatives.
- Your views on the inclusion of palliative and comfort care offered through a hospice program.
- Whether you want your age, physical condition, finances or other circumstances to play a role in medical decision-making.

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## A Caregiver's Guide: Making Medical Decisions for a Loved One

Today's advances in medical technology can sustain the lives of patients in otherwise dire circumstances. Some people want every possible treatment medical science can offer in every situation; others do not. Competent adults have a legal right to refuse or have withdrawn any medical treatment. But, what do you do if a loved one cannot make his or her own medical decisions due to an injury or terminal illness? How can you make the right choices for them?

The following may be helpful in making medical decisions for a family member or loved one:

### Questions to Consider

- Did your loved one sign an advance medical directive (a "Living Will" declaration and/or a Durable Power of Attorney for Health Care) in which the patient indicates treatment preferences and/or names a health care agent to make decisions?
- What is the patient's prognosis? What is the likelihood of recovery or improvement? Is the condition irreversible? Can the patient be stabilized and regain lost capacity? What is the likelihood of death within six months, even if intervention is continued?
- What is the likely effect of the intervention? Will the intervention be a benefit to the patient, even in an irreversible condition? Or will it be burdensome, causing distress?
- Based on what you know of the patient's preferences, would he or she want this intervention utilized? If the likely effect of the intervention will be burdensome to the patient and/or the patient would not want the intervention, have you considered alternatives such as palliative comfort care rather than more aggressive treatment?
- Is the decision to withhold or withdraw the intervention intended to cause the patient's death or to allow a natural death when the dying process cannot be reversed? Will the intervention increase patient suffering while only providing a minimal improvement in an irreversible condition?
- What is the faith/religious tradition of the patient and what would he or she want in light of these beliefs?

- Is the decision to withhold or withdraw treatment from the patient influenced by someone's view that the patient's life is burdensome and not worth living?
- What are the attending physicians' ethical views regarding these types of medical decisions? What are the policies and procedures of the health care facility regarding the intervention that is being considered?
- What are the financial constraints that may have an impact on medical decisions (e.g., limited HMO or Medicare/Medicaid coverage)? Is the decision based upon or influenced by someone who does not want to spend money on the patient's treatment and care?

### Relevant Terms

In any discussions with family members or medical professionals, it is important to define the terms used to insure that all parties interpret the words in the same way.

- **Acute Care:** short-term medical care for reversible disease or trauma with the expectation of cure and patient recovery.
- **Intensive Care:** the care and treatment of critically ill patients, often in an intensive care unit. This involves the use of life-sustaining interventions to stabilize the patient, hopefully leading to recovery.
- **Palliative Comfort Care:** the care (including pain and symptom control) of patients who are in the dying process due to an irreversible and fatal illness, disease or condition. The goal of palliative comfort care is to make the patient comfortable and meet his or her physical, spiritual and psychological needs during the final days of life.
- **Terminal:** an irreversible and fatal disease, illness or condition. Although a patient may be diagnosed with a terminal condition and live for some time, this term generally refers to cases where the underlying cause of death cannot be reversed by medical technology and death is likely within six months, regardless of treatment or intervention.
- **Health Care Agent (also referred to as Surrogate Decision Maker):** an individual designated by a patient to make medical decisions on the patient's behalf if he or she is unable to do so. Ideally, the health care agent named by the patient should discuss general medical decision-making philosophy with the patient in advance of any medical situation resulting in the patient's incapacitation.
- **Benefit:** when an intervention has (or is expected to have) a positive effect to sustain or improve the patient's health or life.
- **Burden:** when an intervention has (or is expected to have) a negative effect on the patient's health or life.



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- **Cardiopulmonary Resuscitation (CPR):** an emergency procedure to restore normal breathing and circulation after cardiac or respiratory arrest using mouth-to-mouth or mechanical assistance for breathing and external heart massage. Other medical methods commonly utilized during CPR include giving IV fluids and oxygen, infusions of antiarrhythmic or other cardiac drugs, electric shock delivered through a defibrillator (paddles placed on the chest) and intubation (placing tubes down the throat into the patient's airway).
- **Do Not Resuscitate (DNR) Order:** a patient or a health care agent may request a DNR order. It prevents cardiopulmonary resuscitation (CPR) should the patient stop breathing or suffer a cardiac arrest. Patients who are in compromised conditions may be less likely to recover after CPR. The intense physical nature of CPR can cause broken bones or collapsed lungs, especially among frail or elderly patients. DNR orders can vary in interpretation, so you should define the term with the health care facility before considering one for your loved one.
- **Medically Assisted Nutrition and Hydration:** the provision of nutrition (food) and hydration (water) to patients who are unable to swallow or digest normally. This can be provided by a flexible rubber or plastic gastric tube inserted into the stomach under local anesthetic at the bedside; it can also be provided intravenously or through a tube inserted through the nose. It can be a short-term or long-term intervention.
- **Ventilation:** the process of using a handheld device for a short period of time or a machine called a ventilator or respirator for a longer period of time to help the patient to breathe.
- **"Pulling the Plug":** a term used to include everything from turning off a ventilator to withdrawing medically assisted nutrition and hydration. It is better to avoid this term and specifically state what treatment and procedures you do or do not want.
- **"Quality of Life":** a subjective, non-medical assessment made by others regarding the patient's satisfaction with his or her present circumstances. Too often this phrase is used with the conclusion that a patient's life is not worth living or preserving.
- **Passive Euthanasia:** an act or the absence of an act that by intent or result causes the death of a patient.
- **Physician-Assisted Suicide:** when a medical doctor provides patients with the means to kill themselves.
- **Euthanasia:** the intentional killing of a patient (usually by lethal injection) by the direct intervention of a physician or another party, ostensibly for the good of the patient or others.

## Preventative Measures

- **Talk to your family members** about your medical decision-making philosophy before a medical crisis puts loved ones in a position to make decisions for you if you are incapacitated.
- **Consider signing a Durable Power of Attorney for Health Care,** a specific advance medical directive document that names a health care agent to make your medical decisions if you are unable to do so. This document is recommended over a "Living Will" declaration.

## What Is God's Will?

When making decisions about the appropriateness of initiating or withdrawing life support or other medical interventions, the Christian caregiver asks, *What is God's will regarding the treatment of my loved one?* No two situations are identical. There are always circumstances to weigh and consider in every person's illness and death. But we can also consider the Creator's point of view. Imagine how God would treat your aging loved one in a given situation. The way we treat ourselves and our elders actually reflects the way we treat God.

In our Maker's eyes, human life is sacred, created in His image, and of inestimable value—at every stage, from conception/fertilization to natural death. He knew the number of our days before one of them had come to be (Psalm 139:16), and He has appointed the time to die (Hebrews 9:27). He has not given Christians a spirit of fear, but of power and of love and of a sound mind (2 Tim 1:7).

Medical technology can be a marvelous tool God uses to bring healing. But it is not a cure-all. When a treatment is invasive but ineffective, causes extended suffering, and creates an excessive burden in terms of physical function and pain, it may be time to allow treatment to be stopped and/or withheld. There is no requirement to continue treatment that has no benefit or which may cause a burden to a terminally ill patient. Ultimately, whatever questions you face, such as when to use or withdraw life-prolonging procedures, should be answered in light of God's perspective and with the wisdom He supplies (James 1:5). It is also vital to seek wise counsel and support from others—family members, friends, pastors with experience in these matters, hospital chaplains, and support groups.

*This "quick fact" information sheet does not constitute legal or medical advice. For professional counsel, please contact an attorney or physician.*

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## End-of-Life Issues: Advance Medical Directives

Advance medical directives are documents intended to provide guidance to medical professionals and your loved ones if you are incapacitated and cannot make your own medical decisions. The two most frequently discussed documents are a “Living Will” declaration and a Durable Power of Attorney for Health Care (sometimes offered as a combination document).

The “Living Will” Declaration is **discouraged** and the Durable Power of Attorney for Health Care is **encouraged** for the following reasons:

### “Living Will” Declaration

- A vague statement generally stating that a physician may withhold or withdraw treatment if you are terminally ill or unconscious.
- A piece of paper that medical professionals may ignore or misinterpret.
- Gives blanket authority to a doctor you may or may not know, a serious concern in these days of managed care.
- Attempts to predict your preferences in often complex medical situations that you cannot foresee by offering a narrow list of options that may be used to prohibit treatment you would want in a certain circumstance.
- Allows “treatment” to be defined by state law; in many states, medically assisted nutrition and hydration is considered medical treatment.
- May be used to justify the removal of life-sustaining interventions (ventilators, feeding tubes, etc.) for patients who are disabled but not dying.
- Generally supersedes the directions of a health care agent named by the patient through a Durable Power of Attorney for Health Care.

## Durable Power of Attorney for Health Care

- Names a person who will be your health care agent to make your medical decisions in any crisis, regardless of prognosis.
- Gives decision-making authority to a loved one who knows your wishes and has discussed such decisions with you.
- Legally clarifies your health care agent (as well as secondary agent if primary is unable to serve) instead of leaving such determination up to state law.
- Generally exempts doctors from liability if following directions from your health care agent.
- Defers all decisions to your health care agent.

## Other Information to Consider

The first “living will” was devised in 1967 by members of the Euthanasia Society of America, now known as Choice in Dying. The Patient Self-Determination Act of 1990 requires health care facilities receiving federal funds to ask patients upon admission if they have or want to sign an advance medical directive. However, the best time to consider and sign such a document is before you are ill, injured or hospitalized.

The existence of a medical treatment or technology does not obligate you to utilize it in every circumstance. There is a “time to die” and let nature take its course when medicine and medical technology cannot reverse the dying process.

## Making the Most of a Durable Power of Attorney for Health Care

A Durable Power of Attorney for Health Care document allows you to name a trusted health care agent to make decisions for your medical treatment and care if you are unable to do so. So, how does your health care agent know your wishes and preferences? For the reasons stated above, a traditional “living will” declaration is not the best vehicle for communicating with your health care agent. It is better to discuss your views with your agent outside of a formal, legal document.



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## How to Obtain a Durable Power of Attorney for Health Care

All states have statutes allowing advance medical directives, including a Durable Power of Attorney for Health Care (or equivalent). Copies of the document approved in your state may be obtained through an attorney, your state legislature or Probate Court. You do not have to hire an attorney in order to sign this legal document.

However, not everyone is comfortable with the standard language provided in a state statute. For individuals who want to ensure their advance directive reflects a pro-life/anti-euthanasia position, we recommend a document created by the International Task Force on Euthanasia and Assisted Suicide.

This document, titled the **Protective Medical Decisions Document** (PMDD), defines and prohibits euthanasia, as well as directs that "ordinary nursing and medical care and pain relief appropriate to your condition be provided." The PMDD is a general Durable Power of Attorney for Health Care that allows the signer to name a trusted family member or friend to make medical decisions in the event the signer is incapacitated for any reason, not just terminal illness. The PMDD may be used in any state and may be attached to the advance directive form(s) approved by your state legislature.

After signing an advance medical directive, you may want to print and laminate a brief reference to it and carry it in your wallet or billfold.

### **Suggested language:**

I, \_\_\_\_\_, have signed an advance medical directive. In the event of an emergency, please contact

You can order copies of the **Protective Medical Decisions Document** from:

International Task Force on Euthanasia and Assisted Suicide  
P.O. Box 760  
Steubenville, OH 43952  
Phone: 740-282-3810

Note: This "quick fact" information sheet is intended as general information and does not constitute legal or medical advice. For professional counsel, please contact an attorney or physician. State laws vary regarding the legality and particular details of advance medical directives.

## One Family's Story:

When Vince's 69-year-old wife, Annie, had a heart attack and went into a coma, it was just the beginning of a tug-of-war to save her life. She came out of the coma but had to have kidney dialysis, a feeding tube, and a tracheotomy. After being in intensive care for nearly a month, her heart stopped but was revived.

Vince knew Annie needed a pacemaker and requested it in a meeting with about 25 people who were involved in her care—doctors, cardiologists, pulmonologists, as well as her pastor and deacons. Considering her medical condition, the professionals recommended withdrawing Annie's life support, but Vince wanted to give her more time. When he remained firm about wanting the pacemaker put in, the chairman of the deacons stood up and said, "Are you trying to force God?"

Vince replied, "What are doctors and hospitals for?"

Annie got the pacemaker and began to improve, but some of the doctors and nurses were reluctant to do more to promote her recovery. When two nurses suggested hastening her death by no longer feeding her, Vince refused. "I told them that if she just lies in bed and smiles at me until we're both gone, that's enough for me."

Soon, Annie was transferred to a long-term-care hospital where she was weaned off the dialysis within a month and also started breathing on her own again. She had to learn to swallow and talk again, but after eight months she returned home and received therapy from there. After a several months, she also got off the feeding tube. Two years later, she hardly uses her walker and has the doctors mystified.

Vince concludes that in today's health-care environment, it is important to be your loved one's advocate. He's grateful for the support he received from a few of the doctors as well as many people in his church—including meals delivered to the hospital waiting room and countless prayers. "There was a chapel in the hospital, and I was in it every day, praying," Vince says. "My wife had so many visitors from our church. The waiting room was often full of friends and family members who cared for her." Today their church calls Annie their "miracle girl."

**Please note:** *Annie's story is unusual. Each case is individual—what is best in one situation may not be best in another. Utilizing all available life-sustaining interventions is not always appropriate or loving. As your loved one's advocate, your role is to make the best decision you can with the information you have been given. Also, this anecdote is not meant to disparage all medical professionals. It is simply meant to point out that they are not always correct; there are times when we must speak up in defense of our relatives and friends.*

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## Hospice Care: Help in the Final Stages of Life

In 1967 in London, Dr. Cicely Saunders founded St. Christopher's Hospice, a special treatment center for the dying. She emphasized pain control and provided the dying with sympathetic support staff. She recognized the dying person and his family as the unit of care so the patient did not feel that he was dying alone. The patient's pain was controlled, but he was not too sedated to relate to family members and friends. This center became the model for the present-day hospice.

The goal of the hospice movement is to maximize the quality of life for the dying patient and his family and to make the most of the time remaining. There is an emphasis on the comfort of the patient, including appropriate use of medication for control of pain and other symptoms. Hospice uses a team approach, incorporating professionals and volunteers. It also seeks to serve the patient's family, helping them cope with the illness and death of their loved one.

While the nation's hospice programs are filled with professionals dedicated to helping terminally ill patients die a comfortable, natural death, this is not to say that all hospice programs or employees necessarily embrace a life-affirming philosophy. Also, the very nature of hospice (providing an environment in which to die) can lend itself to the restriction of medical treatments and procedures, which may make some families uncomfortable. Try to find out if the ethical views of a hospice you are considering align with yours; if not, ask if they would be willing to work with you with respect to your ethical views.

### What Hospices Can Offer

Most hospices offer home care supported by a team of doctors, nurses, physical and occupational therapists, health aides, dietitians, pastoral-care professionals, social workers, and volunteers. Some hospice programs have their own on-site facilities where dying people can spend the final days or months of life. Other times hospice workers will go into a nursing home to supplement the care received there. Many hospice workers talk with family members about death and dying and spend time at the patient's bedside. Hospice is a comforting choice and can be a good option when you do not live near your dying loved one. Consider these examples:

#### **One family turned to hospice care because none of the children lived near their parents.**

*My father had hospice care when he was dying of cancer," one of the daughters related. "He had been hospitalized, and finally the doctor said there was nothing more they could do. So Dad decided he wanted to go home with Mom. The hospital assigned a hospice worker to him. She was wonderful. She really came to love them. She was also a great resource. She knew how to get Dad in touch with someone who would bring him oxygen. When he died, she came out to the house and sat with my mom. They had already made all the funeral arrangements but she was available for whatever they wanted her to do. So it was really nice for me to know that this person was loving him and holding his hand and kind of taking our place.*

#### **One woman told how a hospice volunteer supported her parents with "non-medical" care as her father endured the end stages of cancer.**

*A lot of times she would just come and sit with them. Once when I was there she came over just to see how they were doing. She asked about them and told them about her life. Her father had died of cancer and that was what got her involved. She was someone who cared, someone they could talk to. My parents didn't have to treat her like company; mom didn't clean house before she came. They talked openly about death and dying. She talked to people at the church about coordinating meals. She walked with Dad in the garden. She was like a companion for both of them.*

Hospices can also offer "tune-up" services to make patients more comfortable. A patient may be admitted to a hospice to get her pain and other symptoms under control, to get help finding a hospital bed for her home, or to get nutritional help or home help in order to get her back into her own home again.

### How and When to Qualify for Hospice Care

To receive hospice services, the patient, family, and doctors must agree that the patient probably has six months or less to live. Families often feel it is "too soon" to begin hospice care and wait until death is very near. A better approach is to begin some level of professional care before a crisis exists. Arrange introductory home meetings or hospice visits before you need services so that a support network is in place.



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## Paying for Hospice Care

Medicare coverage of hospice care is available under Medicare Part A hospital insurance. (States may also offer hospice services under Medicaid for eligible seniors.) Medicare helps pay for:

- physicians' services
- nursing care
- medical appliances and supplies related to the terminal illness (such as wheelchairs, bandages, and catheters)
- drugs for symptom control and pain relief
- short-term acute inpatient care, including respite care
- home health aide and homemaker services
- physical and occupational therapy
- speech therapy
- social-worker services
- counseling, including dietary and spiritual counseling

To receive Medicare payment, the agency must be approved by Medicare to provide hospice services. Be sure to ask your doctor or the organization if they are approved by Medicare for hospice services.

The patient will be responsible for paying a copayment for outpatient drugs and part of the Medicare-approved payment for inpatient respite care.

A Medicare beneficiary may elect to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods. These may be used consecutively or at intervals. In some cases, a terminally ill patient's health improves or his illness goes into remission, and hospice care is no longer needed. Either way, the patient must be certified as terminally ill at the beginning of each period.

For more information, contact Medicare (request the booklet *Medicare Hospice Benefits*), or contact the National Hospice & Palliative Care Organization (see appendix).

## Hospice Checklist

When checking out hospice programs, competency in making patients comfortable should be the top priority. A hospice's values and beliefs regarding life, death, and the afterlife are also important. To help determine if you are comfortable with the hospice's principles, you might ask them to send you their "mission statement" or "statement of faith" for consideration. In *The Aging Parent Handbook* (HarperCollins, 1997), Virginia Schomp recommends you ask the following questions when looking for an agency:

1. What area does the hospice serve? Many programs accept only patients from within a specific geographic area.
2. Does the hospice specialize in dealing with certain types of illness? Some hospices, for example, provide care only for people with AIDS.
3. Will the hospice develop a professional plan of care? You and your loved one are entitled to a written copy of the care plan, which should spell out the hospice's duties and work schedule.
4. Who will be on the hospice-care team? Will the team include your elder's current physician? If not, who will provide medical direction?
5. What are the qualifications of the staff and volunteers? Ask if nurses, social workers, clergy, and volunteers have any special training in working with the dying.
6. What are the responsibilities of the family caregiver? What duties will you be expected to perform?
7. What resources are available to assist you?
8. Does the hospice provide bereavement counseling and support for the family?
9. What happens if there is an emergency in the middle of the night? You will want to know if after-hours calls are answered by a hospice staff member or an answering service, and how quickly help is available.
10. Is the hospice Medicare-certified? Medicare covers only care provided by an approved hospice program. Find out what out-of-pocket expenses Medicare patients are expected to pay.
11. What are the fees and how are they applied—per day, per visit, or some other rate? If your aging loved one has private insurance, ask whether the hospice will accept whatever the insurance company pays as payment in full.
12. Will the hospice handle the billing with Medicare or private insurance carriers? If not, find out if someone from the hospice can help you with insurance forms.
13. Does the hospice meet state licensing requirements? Your state department of health will provide information on applicable regulations. Also ask if the program has any kind of outside review or accreditation.
14. Will the hospice provide references from professionals such as hospital staff or a social worker with a community agency? Also check with the local Better Business Bureau for the hospice's complaint record.

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## Family Stories . . .

### Paying Attention

My mom had hospice care for the last seven weeks of her life. She had a hospital bed set up in her bedroom. The hospice workers were wonderful, not only to my mother but also to me. In fact, they paid as much attention to me as they did to my mom! That's not typical. Most people pay attention to the patient, which is good, but the caregiver also needs support.

My siblings would come over to the house occasionally and say, "How's Mom?" I'd answer, "Well, go in and see." In contrast, the hospice personnel would sit down with me and genuinely ask how I was doing. They assumed I would be tired and overloaded. And they followed up. "How are you now?" They even helped me cope with my sister, who differed with me on my care-giving decisions. She was suspicious of hospice care and wanted my mom fed even when she didn't want to eat anymore. My sister would bring over nourishing food to help Mom put on weight, but who cared about that when Mom was dying?

One morning I walked into the bedroom and saw my mother lying on the bed after she'd just been bathed. The workers were talking in whispers, and everything seemed so light and bright. I knew Mom was going to die soon and she was so ready to go to heaven. It was such a tender, special moment. The hospice workers were right there with me. They held me and let me cry.

*Diana F.*

### We Can Do It Together

When Mom had lymphoma 25 years ago and a bowel obstruction 20 years ago, I saw her suffer so much from being jabbed, stabbed, and poked. Tiny veins that roll and break make I.V.s sheer torture for her. It didn't make sense to put her through that again after she'd suffered a major stroke at age 92, so I called in a hospice group connected to a local Catholic hospital.

The hospice staff put to rest all the fears I had. They told me they would keep Mom comfortable, providing liquid medication or suppositories for pain and anxiety. They would not give I.V.s; doing so would simply force fluids into her tissues as her kidneys began to shut down. They would give me sponge swabs to keep Mom's mouth moist. I would continue to pay Josephine, our live-in Polish caregiver, but all other expenses would be taken care of by hospice. A nurse would visit three times every week, then

every day as Mom's pilgrimage on this earth began leading her to her permanent home in heaven.

Within a few days a chaplain came out to read Scripture to Mom. Then a social worker came to see how she could help meet my emotional needs, advise me regarding finances, and arrange for volunteer relief for Josephine and me. Every person I've met from hospice, whether paid staff or volunteer worker, has a vibrant, joyful, we-can-do-it-together attitude. They help me have the confidence and peace I need to know that Mom is getting the best care on her final journey.

*Betty F.*

### Dying Naturally

About six months after Mom, who had cancer, moved in with me, she started talking about her death, saying she didn't want any heroic measures, but she wanted to make sure her needs were met. She was concerned about euthanasia and didn't want someone to say, "Well, it's your time," and come and finish her off.

After looking for information at the library, I said, "Why don't we call a lawyer?" So I called someone who had been recommended to me, and he came to our house and sat down and talked to Mom. He said, "Well, tell me what you're thinking." She said, "I want to die a natural death. But I don't want anyone hastening my death." He seemed a little surprised by her forthrightness and candor.

He talked about who should have power of attorney, and she said, "I trust all my kids, but since Linda's here, I'd like to give her that authority." So we arranged an Advance Medical Directive and Durable Power of Attorney.

Mom did die at home with minimal intervention. The day after her death, I went to see her lawyer to settle her estate. I said, "I don't know if you remember me, but you came to our house one day to talk to me and my mom." The lawyer said, "I sure do remember you and your mom. I have never spoken to an elderly woman so clear on her wishes and so well informed and able to articulate her ideas about death and dying. I always tell others about your mom."

Death isn't an easy passage, but I'm glad my mom got her wish to die at home.

*Linda H.*



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## Physician - Assisted Suicide and Euthanasia

Should physicians be granted the power to intentionally end the lives of their patients? Recent proposals to legalize physician-assisted suicide have raised this question and triggered intense legal, medical and social debate.

For some individuals, the debate is fueled by their fear that medical technology may someday keep them alive past the time of natural death. However, this concern is unfounded for mentally competent adults who have a legal right to refuse or stop any medical treatment. It is also important to recognize that today's health care climate lends itself more to under-treatment than over-treatment.

However, the present debate is not about refusing treatment or taking extraordinary measures. The issue is whether physicians should be allowed to intentionally kill their patients, either by providing the means of death or ending the patient's life by the doctor's hands. There is a tremendous distinction between allowing someone to die naturally when medical technology cannot stop the dying process and causing someone to die through assisted suicide or euthanasia. The question is one of intent: Is the intention to cause the death of the patient?

The terms "physician-assisted suicide" and "euthanasia" are often used interchangeably. However, the distinctions are significant. The act of physician-assisted suicide involves a medical doctor who provides a patient the means to kill him or herself, usually by an overdose of prescription medication.

Meanwhile, euthanasia involves the intention to kill a patient by the direct intervention of a physician or another party, ostensibly for the good of the patient or others. The most common form of euthanasia is lethal injection. Euthanasia can be voluntary (at the patient's request), nonvoluntary (without the knowledge or consent of the patient) or involuntary (against his or her wishes).

## Legal Status

Euthanasia is illegal in the United States. Physician-assisted suicide is illegal by statute or common law in most states. Oregon is the only state where physician-assisted suicide is legal.

In 1997, the U.S. Supreme Court ruled in *Washington v. Glucksberg* that there is no federal constitutional right to physician-assisted suicide. However, the decision does

not address individual state constitutions, which could be interpreted by other courts to include a state right to physician-assisted suicide.

Many state legislatures have tackled this issue in recent years, with more than 25 states rejecting bills to legalize physician-assisted suicide and nearly a dozen adopting new laws to ban it. No state legislature has voted to legalize physician-assisted suicide.

Oregon approved a ballot initiative to legalize physician-assisted suicide in 1994 and reaffirmed the vote in 1997. Washington State approved a similar measure in 2008. Five other attempts to legalize physician-assisted suicide (or euthanasia) through ballot initiative (California in 1988 and 1992, Washington state in 1991, Michigan in 1998 and Maine in 2000) all failed.

## Stories Behind the Issue

Supporters often use emotional stories of terminally ill patients who suffer in the final days of life to justify legalization of physician-assisted suicide. These stories communicate that an early, premeditated death is the best, and perhaps the only, option for the patient. However, a growing number of medical professionals who work with dying patients are speaking out to dispute this perception. Consider the following statements:

*"If we treat their depression and we treat their pain, I've never had a patient who wanted to die."*<sup>1</sup>

William Wood, M.D., Clinical Director  
Winship Cancer Center

*"I simply have never seen a case nor heard of a colleague's case where it (physician-assisted suicide) was necessary. If there is such a request, it is always dropped when quality care is rendered."*<sup>2</sup>

Linda Emanuel, M.D., Ph.D., Director  
The American Medical Association's Institute on Ethics

*"In my clinical practice, I have been asked by suffering patients to aid them in death because of severe pain. I have had the opportunity to see these requests for aid in death fade with adequate pain control, psychological support, provision of family support and with the promise that their symptoms would be controlled throughout the dying process."*<sup>3</sup>

Kathleen Foley, M.D., Chief of Pain Service  
Memorial Sloan-Kettering Cancer Center  
New York City

# Sanctity of Human Life

## Reasons to Oppose

### Physician-Assisted Suicide

There are many reasons to oppose attempts to legalize such actions. Here are a few:

- **Acceptance of physician-assisted suicide sends the message that some lives are not worth living.** Social acceptance of physician-assisted suicide tells elderly, disabled and dependent citizens that their lives are not valuable. Doctors who list death by assisted suicide among the medical options for a terminally or chronically ill patient communicate hopelessness, not compassion.
- **The practice of physician-assisted suicide creates a duty to die.** Escalating health care costs, coupled with a growing elderly population, set the stage for an American culture eager to embrace alternatives to expensive, long-term medical care.
- **The so-called “right to die” may soon become the “duty to die”** as our senior, disabled and depressed family members are pressured or coerced into ending their lives. Death may become a reasonable substitute to treatment and care as medical costs continue to rise.
- **There are better medical alternatives.** Terminally ill patients do not need to suffer a painful death. Today’s pain-management techniques can provide relief for up to 95 percent of patients, thus offering true death with dignity.<sup>4</sup> In addition, these same techniques can lessen pain and other symptoms for all patients. Another alternative is palliative care through hospice, which addresses the physical, emotional and spiritual needs of dying patients and their families.
- **Physician-assisted suicide ignores what may be a legitimate cry for help.** Suicidal thoughts often indicate the presence of severe depression. A study of terminally ill hospice patients found only those diagnosed with depression considered suicide or wished death would come early. Patients who were not depressed did not want to die.<sup>5</sup> Depression can and should be treated.
- **Physician-assisted suicide gives too much power to doctors.** Assisted suicide does not give the patient autonomy; it gives power to the doctor. As in the case of physician-assisted suicide in Oregon, the doctor decides if a patient qualifies for assisted suicide.
- **Doctors can make mistakes.** Consider a survey of Oregon physicians published in the February 1, 1996, issue of the *New England Journal of Medicine*. Researchers found one-half of the physicians responding were not confident they could predict that a patient had less than six months to live. One-third were not certain they could recognize depression in a patient asking for a lethal dose of medication. Yet, these are the same doctors who, under Oregon’s law legalizing physician-assisted suicide, are allowed to assist in a patient’s death if they can recognize depression and predict patient death within six months.
- **The practice of physician-assisted suicide threatens to destroy the delicate trust relationship between doctor and patient.** Every day, patients demonstrate their faith in the medical profession by taking medications and agreeing to treatment on the advice of their physicians. Patients trust that the physicians’ actions are in their best interest with the goal of protecting life. Physician-assisted suicide endangers this trust relationship.
- **Physician-assisted suicide opens the door to euthanasia abuses.** Physicians who cross the line from curing to killing do not necessarily stop with willing patients who request it. A case in point is in the Netherlands, where doctors have practiced physician-assisted suicide and euthanasia for more than a decade. Two Dutch government studies conducted in 1990 and 1995 found that, on average, 26 percent of euthanasia deaths in Holland were “without the explicit consent of the patient.” In the second study, 21 percent of the patients who were killed without consent were competent.<sup>6</sup>



# Sanctity of Human Life

## More on the Dutch Experience

Dutch physicians have also extended the practice of euthanasia to include comatose patients, handicapped infants and healthy but depressed adults.

- In 1996, a Dutch court found a physician guilty of euthanizing a comatose patient at the request of the patient's family. Although the court determined the patient was not suffering and did not ask to die, the doctor was not punished.<sup>7</sup>
- In 1995, Dutch physician Henk Prins was convicted of giving a lethal injection to a baby born with a partly formed brain and spina bifida. The court refused to punish Prins.<sup>8</sup>
- Likewise, though psychiatrist Boudewijn Chabot was found guilty in 1994 of prescribing a fatal dose of sleeping pills for a woman who was suffering from depression, Chabot was not penalized.<sup>9</sup>
- That same year, the Dutch Supreme Court ruled that physician-assisted suicide might be acceptable for patients with unbearable suffering but no physical illness. A 1996 survey of Dutch psychiatrists found 64 percent of those responding "thought physician-assisted suicide for psychiatric patients could be acceptable."<sup>10</sup>

As the Dutch experience demonstrates, the acceptance of physician-assisted suicide and voluntary euthanasia cannot be controlled by safeguards and can lead to involuntary euthanasia.

## Sources

<sup>1</sup> Michael D. Lemonick, "Defining the right to die," *Time*, April 15, 1996, p. 82.

<sup>2</sup> Paul Wilkes, "The new pro-lifers," *The New York Times Magazine*, July 21, 1996, p. 22.

<sup>3</sup> Testimony of Kathleen Foley, M.D., before the House Judiciary Subcommittee on the Constitution, Washington, D.C., April 29, 1996.

<sup>4</sup> Kathleen Foley, "The treatment of cancer pain," *New England Journal of Medicine* 313 (1985): 84-95; Ira Byock, "Kevorkian: Right problem, wrong solution" [Letter to the editor], *The Washington Post*, January 17, 1994, p. A23; Don Colburn, "Assisted suicide: Doctors, ethicists examine the issues of pain control, comfort care and ending life," *The Washington Post*, September 14, 1993, p. Z7.

<sup>5</sup> S. Barakat, J.H. Brown, P. Henteleff, C.J. Rowe, "Is it normal for terminally ill patients to desire death?" *American Journal of Psychiatry* 143:2 (1986): 208-211.

<sup>6</sup> J.H. Groenewoud, P.J. van der Maas, G. van der Wal, "Physician-assisted death in psychiatric practice in the Netherlands," *New England Journal of Medicine* 336 (1997): 1796.

<sup>7</sup> P.J. van der Maas, J.J.M. van Delden, L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life*, (Amsterdam: Elsevier Science Publishers, 1992), pp. 73-75, 181-182.

<sup>8</sup> Susan Sachs, "The Dutch Guidelines," *Newsday*, January 6, 1997, p. A6.

<sup>9</sup> "Doctor freed in 'justified' mercy killing," *Chicago Tribune*, April 27, 1995, p. N21; "Murder charge proved against euthanasia doctor, but case dismissed," Associated Press, April 27, 1995.

<sup>10</sup> "Doctor unpunished for Dutch suicide," *The New York Times*, June 22, 1994, p. 10A.

# Sanctity of Human Life

## Physician - Assisted Suicide Laws in the United States

“Our Constitution isn’t a suicide pact. It wasn’t written to protect doctors who play executioner.”  
Attorney James Bopp Jr.<sup>1</sup>

In the spring of 1996, two federal appeals court rulings launched the debate about physician-assisted suicide into judicial overdrive. On March 6, 1996, the Ninth Circuit Court of Appeals declared unconstitutional a Washington state law banning physician-assisted suicide. The justices found “there is a constitutionally protected liberty interest in determining the time and manner of one’s own death.”<sup>2</sup>

This ruling created a constitutional right to physician-assisted suicide in the territory of Guam and the nine western states under the jurisdiction of the Ninth Circuit: Washington state, Oregon, California, Arizona, Nevada, Idaho, Montana, Hawaii and Alaska.

The court opinion relied heavily on U.S. Supreme Court rulings in previous abortion cases, including *Roe v. Wade*<sup>3</sup> and *Planned Parenthood v. Casey*.<sup>4</sup>

Just as Supreme Court justices discovered a right to abortion in *Roe* and its companion case, *Doe v. Bolton*,<sup>5</sup> the federal appeals court discovered the right to physician-assisted suicide.

In the days following the ruling, Justice Stephen Reinhardt, author of the opinion, said, “I think this may be my best ever.”<sup>6</sup>

This ruling was echoed on April 2, 1996, when another federal appeals court, the Second Circuit Court of Appeals, struck down New York state’s law banning physician-assisted suicide.<sup>7</sup> This decision affected the three northeastern states in the Second Circuit: New York, Vermont and Connecticut.

The U.S. Supreme Court entered the fray on June 26, 1997, issuing two decisions on the subject of physician-assisted suicide: *Washington v. Glucksberg*<sup>8</sup> and *Vacco v. Quill*.<sup>9</sup> The high court upheld both Washington and New York laws and unanimously declared there is no right in the Constitution to physician-assisted suicide.

However, while the unanimous judgment upheld existing laws banning physician-assisted suicide, justices did not put an end to the debate. Concurring opinions by justices John Paul Stevens and David Souter encouraged individual states to pass laws that allow physician-assisted suicide in some circumstances. These comments bolstered the ongoing debate over physician-assisted suicide at the state level, where proponents have

attempted to legalize it through state legislation, ballot initiatives and court challenges.

## State Legislatures

### Rejecting Physician-Assisted Suicide

While proponents of physician-assisted suicide have worked for years to lay the groundwork for public acceptance, so far their efforts to legalize the practice have netted few victories. Euthanasia is illegal throughout the United States. Physician-assisted suicide is illegal by specific law or legal precedent in most states.

Many state legislatures have tackled this issue in recent years, with more than 25 rejecting bills to legalize physician-assisted suicide and nearly a dozen states adopting new laws to ban it. No state legislature has voted to legalize this practice.

Oregon voters approved a ballot initiative to legalize physician-assisted suicide in 1994 and reaffirmed the vote in 1997, making Oregon the first government in the world to make the practice legal. Washington State approved a similar measure in 2008. Five other attempts to legalize physician-assisted suicide (or euthanasia) through ballot initiative (California in 1988 and 1992, Washington state in 1991, Michigan in 1998 and Maine in 2000) all failed.

The 1997 U.S. Supreme Court rulings in *Washington* and *Vacco* did not address the possibility of a state right to physician-assisted suicide in state constitutions. This question has reached state Supreme Courts in two states: Florida and Alaska.

In Florida, a man in the final stages of AIDS challenged the state’s ban on physician-assisted suicide, arguing that privacy rights guaranteed in the state Constitution included physician-assisted suicide. In 1997, the Florida Supreme Court upheld the state’s ban on assisted suicide, ruling that the state constitution privacy provision did not extend to physicians assisting in suicides.<sup>10</sup>

Likewise, the Alaska Supreme Court ruled in 2001 that physician-assisted suicide goes too far and is not protected under the state’s constitution.<sup>11</sup>

<sup>1</sup> Kevin Johnson, “High court to hear right to die,” *USA Today*, October 2, 1996, p. 1A.

<sup>2</sup> *Compassion in Dying v. Washington*, 79 F.3d 790 (9th. Cir. 1996).

<sup>3</sup> *Roe v. Wade*, 410 U.S. (1973).

<sup>4</sup> *Planned Parenthood v. Casey*, 112 S. Ct. (1992).

<sup>5</sup> *Doe v. Bolton*, 410 U.S. (1973).

<sup>6</sup> Paul Barrett, “Federal appeals judge embraces liberalism in conservative times,” *The Wall Street Journal*, March 15, 1996, p. 1A.

<sup>7</sup> *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

<sup>8</sup> *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

<sup>9</sup> *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

<sup>10</sup> “Court upholds law barring aided suicide,” *The New York Times*, July 18, 1997, p. A12.

<sup>11</sup> Mike Chambers, “High court rules against assisted-suicide case,” *The Associated Press*, September 21, 2001.



# Sanctity of Human Life

## Who are we?

Kelly Rosati, Vice President, Community Outreach

For more than 30 years, Focus on the Family® has upheld the sanctity of human life, in word and in deed. This core principle is foundational in all we do:

*"We believe that human life is created by God in His image. It is of inestimable worth and significance in all its dimensions, including the preborn, the aged, those deemed unattractive, the physically or mentally challenged, and every other condition in which humanness is expressed from the single-cell stage of development to natural death. Christians are therefore called to defend, protect, and value all human life."*

The sanctity of human life perspective impacts our marriages, how we parent our children, and how we relate to our fellow human beings – and it's at the very core of justice and compassion. It applies to preborn life, at the end of life and all points in between. This handbook is just one example of how we seek to help people apply this core principle to their everyday lives.

Focus on the Family is dedicated to nurturing and defending human life. We do so by increasing awareness of life issues through events, radio programs, publications, resources, media campaigns, web sites, community efforts and national initiatives. It's our hope that by planting seeds of change, we can elevate respect for life and motivate Christians to be a voice for life right where they are.

Each life matters because each one is created in the image of God, and there are several ways in which we act on this belief:

## Option Ultrasound™ Program

Focus on the Family regularly hears from women who, years later, still regret and grieve their abortions. In order to better serve abortion-minded women, and the babies they carry, we initiated the Option Ultrasound Program in 2004.

This innovative program provides grants for ultrasound machines and professional sonography training to life-affirming Pregnancy Medical Clinics (PMCs) in high abortion communities across the nation. These clinics provide compassionate counseling, ultrasound services and community referrals that help women take the first steps toward a healthy pregnancy and a healthy baby.

As of January 2014, PMCs in all 50 states will have received grants for ultrasound machines or sonography training—more than 626 grants in all—as well as one PMC in Romania.

The results confirm that when a woman considering abortion can see her baby and hear its tiny heartbeat, the majority choose life for their babies. As of January 2014, PMCs in the Option Ultrasound Program reported that **more than 230,000 women** have changed their minds about having an abortion! When these women were empowered with critical information that they would not have been given at the abortion clinic, along with non-judgmental support, they freely chose life for their babies.



## The Benefits for Women

Option Ultrasound's life impact is both pro-woman and pro-child:

### Promotes Educated and Informed Decisions:

Ultrasound services help a woman understand her body, her pregnancy and her baby's development, supporting an informed decision consistent with her values and priorities.

### Supports Health:

Ultrasound gives a woman an important bonding opportunity with her baby that encourages her to seek early prenatal care, protecting her own health and the health of her baby.

### Gives Hope:

Many women initially come to a PMC considering abortion because they see no other option. When a woman is given the opportunity to see for herself the baby developing in her womb and is provided with compassionate counseling and support, it gives her hope and perspective that she did not have before.

## What are the standards for participating in the program?

In order to participate in Option Ultrasound, a clinic must be a medical facility operating under the supervision and direction of a licensed physician, who serves as their medical director. They must use only trained nurse sonographers, operate according to the laws of its state, city and county, and comply with the national standards defined by the **American Institute of Ultrasound Medicine**. Patient referrals are made to local physicians for follow-up diagnosis and care as needed. Focus on the Family does not endorse the use of ultrasound outside of a medical clinic setting and does not endorse the use of ultrasound for non-medical reasons.

## Where can I find stories and photos of moms and babies who've been served by Option Ultrasound?

Go to [www.heartlink.org](http://www.heartlink.org) to read stories and see photos of women from around the nation who have been served through Option Ultrasound. Learn how the provision of ultrasound services helps make babies in the womb real to their moms.

# Sanctity of Human Life

## Educational Resources

Focus on the Family has developed an excellent line of educational resources for women, used by pregnancy resource centers and pregnancy medical clinics around the world. This helps to deliver medically accurate, life-affirming information to at-risk clients. Pregnancy centers around the world receive \$500 each year in benevolent resources, at no cost to them. In addition, a monthly e-newsletter called BoardLink helps to equip pregnancy center board members and executives to fulfill their unique roles.



## Adoption & Orphan Care Initiative™

Currently, in the United States there are more than **100,000 legal orphans** waiting in foster care for adoptive families to call their own. Most people simply do not realize America has orphans because we don't have orphanages. These children live in temporary foster homes, move frequently from home to home, and have no permanency in their lives. Unless they are adopted, they will exit

or "age-out" of the system at age 18 and become adults who belong nowhere and have no personal connection with anyone.

## Recruiting Adoptive Families

Believing that all children deserve to grow up in a family, Focus on the Family launched the Adoption & Orphan Care Initiative in the fall of 2006, in order to raise awareness of and recruit adoptive families for waiting children and youth in foster care.

We know that there are more than **300,000** churches throughout the United States of America, filled with believers who are called by Scripture to care for orphans. That means that **every waiting child could have a family if less than one family per church opened their home and hearts.**

We are working collaboratively with state, county, church, ministry and adoption agency leaders to help find adoptive families for waiting children and youth in foster care. We also participate in two larger campaigns each year in order to raise awareness of needs of orphans globally and help connect families to appropriate agencies and ministries.

## Providing Support

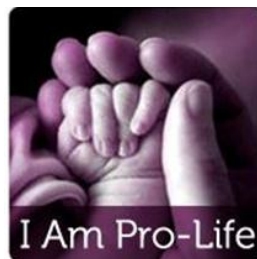
When a child joins a new family through adoption, he or she often brings traumatic experiences that make it difficult to develop healthy attachments, relationships and behaviors – despite the most secure and loving environment. Without specialized help, many children will continue to struggle at home, at school and in their communities.

As a result, our awareness and recruiting efforts are complemented by desperately needed post-placement resources for adoptive families – resources that are both biblically-based and relevant to their unique struggles. Our, *Handbook on Thriving as an Adoptive Family*, offers real life solutions for the common challenges faced by adoptive families and the booklet, *Wrapping Around Adoptive Families*, suggests practical ways for churches and individuals to support adoptive families in their communities.

In addition, our world-class respond team at Focus on the Family has been trained to provide Bible-based, adoption-competent support to assist adoptive families with their specific needs. Families are invited to call in for immediate help, as well as receive one hour of over-the-phone counseling from one of our licensed staff members.

Christians have a clear command to care for orphans. And while not every family is called to adopt, we believe everyone can play a role through prayer support, mentoring, giving, or mobilizing the church.

Focus on the Family believes our efforts will inspire and equip families and churches to meet the needs of orphan children in their communities and around the world. Visit [www.iCareAboutOrphans.org](http://www.iCareAboutOrphans.org) for more info.



## I Am Pro-Life Facebook Page

We believe there is an untapped reservoir of powerful personal stories in the pro-life community that fuels our commitment to speak up for those who cannot speak for themselves. With more than one MILLION fans, we welcome people from different perspectives and belief systems, Christian or non-Christian, to join in respectful dialog about life issues. Won't you tell us why you're pro-life? What's YOUR story?

Find us [www.facebook.com/FocusOnLife](http://www.facebook.com/FocusOnLife)

We hope you'll visit our website to find resources to equip you to be a voice for life at every stage and condition:

[www.BeAVoice.net](http://www.BeAVoice.net). Be sure to download the Life and Justice Resource Guide for Churches, to help equip your church to be a voice for life at every stage.

