# Table of Contents

## I. Introduction
- The Sanctity of Human Life 1
- What’s the Debate About? 2
- How to be a 21st Century Pro-Lifer 4

## II. At the Beginning of Life
- What the Bible Says: Life’s Beginning 8
- The Child in Womb: Fetal Development 10
- Help at the Point of Crisis 13
- Journey of a Lifetime: Perinatal Hospice 14
- One Family’s Story: Pearl 16
- Adoption: A Viable Option 18

## The Truth About Abortion
- Exposing the Lies 19
- Emotional Complications of Abortion 20
- Physical Complications of Abortion 21
- Abortion Statistics 22
- Abortion Descriptions 23
- Women Do Die from Legal Abortion 27
- Abortion Law in the United States 30
- State Ultrasound Laws 31

## Bio-Ethics at the Beginning of Life
- In Vitro Fertilization 32
- Pre-Implantation Genetic Diagnosis 32
- Prenatal Gene Therapy 33
- Genetic Testing and Screening 33
- Human Cloning 34
- Stem Cell Research and Therapies 36

## III. In the Midst of Life
- A Teen Pregnancy in the Family 38
  - She’s Pregnant. You’re Shocked
  - When Your Son is the Father
- Reflecting God’s Image 40
- Adoption and Orphan Care 41
- Exposing the Myths About Adoption 42
- Quick Facts: Adoption from Foster Care 43
- Post-Abortion Syndrome 44
  - The Importance of Healing
  - Taboo Grief: Men and Abortion
- Slavery Today 47
- Five Ways to Care for the Aging at Your Church 48

## Point to Ponder: Caring for Loved Ones 49
  - Living With Alzheimer’s
  - Is Assisted Living the Best Option?
  - Caring for Ill or Aging Parents
  - Managing Stress When Caregiving
  - One Family’s Story

## IV. At the End of Life
- What the Bible Says About the End of Life 55
- Aborting the Elderly 57
- The Forgotten Generation 58
- A Patient’s Guide: Medical Wishes 60
- A Caregiver’s Guide: Medical Decisions 62
- Advance Medical Directives 64
- Hospice: Help in the Final Stages of Life 66
- Physician Assisted Suicide & Euthanasia 69
- Physician Assisted Suicide Laws 72

## Endnote: Who Are We? 73

---

Permission is granted to make one copy of this handbook, or articles in this handbook, for personal use. Unless otherwise noted, for permission to reprint more than one copy, please contact Focus on the Family for permission: lifematters@family.org
I. Introduction
The Sanctity of Human Life

The sanctity of human life. Is it still a sacred concept or just another adage that doesn’t work in today’s society? Focus on the Family believes that human life is of inestimable worth and significance in all its dimensions, including the preborn, the aged, the widowed, the mentally handicapped, the unattractive, the physically challenged and every other condition in which humanness is expressed from conception to the grave.

Without a doubt, human life is sacred. At some point in your life you may have even expressed these words in one form or another trying to explain your pro-life views. Respect for the sanctity of human life is at the center of all we do as Christians. So what does that look like and how can we incorporate it into our daily lives?

Our Judeo-Christian tradition teaches us the sanctity of human life. The Bible says 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.” Having been made in the image of God means so much more than receiving certain abilities and attributes. It means we actually are the images of God. What a privilege! No other “creation” of God can say that!

Each of us carries the image of the creator. We are not merely flesh and blood. Since we are image-bearers of the Living God, our lives are sacred, based on something beyond our unique characteristics and abilities. This image or likeness of God is not tangible: you can’t see, touch or smell it. It’s part of the mystery of life.

Being made in the image of God provides us as humans with direction and guidance regarding how we treat one another. Men, women and children should be respected, regardless of their mental capacity, physical ability, faith (or absence of faith) or social position. These people may or may not exhibit attributes of God, but that doesn’t determine their worth. Their value is established on the basis of the nature of God, who is the perfect example of dignity and holiness.

The sacredness of human life is not based on accepting Jesus Christ as Savior. Every human life, Christian or not, has inestimable value because each life is created in the image of God. Each human spirit is a mirror image of the likeness of Yahweh. This is not just reserved for Christians, but extends to all members of the human family.

How do we define human dignity? Human dignity is innate, bestowed upon us by God. It’s not based on our ability to care for ourselves or even the 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 culture’s failure to honor human dignity is evidenced in words like “quality of life”. People would rather die than continue living with a disability. Dependency is looked upon as the ultimate weakness. From that attitude comes the press for cultural acceptance of solutions such as euthanasia, instead of giving compassionate care to those who cannot care for themselves. A common fear among the disabled or terminally ill is that of becoming a burden. No one is immune to this fear. We can restore human dignity through our witness of caring for each other, even in our times of dependence and need.

The challenge is before us. We need to reestablish the Sanctity of Human Life ethic in our generation and we must begin with the church. Even as Christians, we fail to comprehend the value of every human life because we cease to look at each other in awe. Our view of one another should be as breathtaking creatures, embodying a touch of the Creator Himself. Churches must lead the way by teaching the truth about the value of life from a biblical worldview.

So how can you help restore the Sanctity of Human Life ethic? Begin the restoration in your own heart! Routinely examine your heart for attitudes that violate the spirit of the Sanctity of Human Life ethic. It can take on many forms including disdain for someone we don’t know based on his or her appearance, a negative comment made under our breath or impatience with a slow driver. The sins of superiority, contempt and slander are far more frequent and easier to hide than the physical crimes of assault, rape or murder.

We need to teach the next generation a respect for all human life. Parents should teach their children through word and deed. Together we can restore the beauty and reverence our Creator intended by restoring dignity to humankind.

Excerpted from the article “The Sanctity of Human Life” by Carrie Gordon Earll.
Copyright © 2003, Focus on the Family. All rights reserved. International copyright secured. Used by permission.
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 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.

Francis J. Beckwith

is Professor of Philosophy & Church-Studies at Baylor University, teaching in the departments of philosophy and political science as well as the J. M. Institute of Church-State Studies. He is the author many books and essays on pro-life issues, including Defending Life: A Moral and Legal Case Against Abortion Choice, Cambridge University Press; 2007.

Copyright © 2005 Francis J. Beckwith. All rights reserved. International copyright secured.
How to be a 21st 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.

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. 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 unspeaking 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 or www.caseforlife.com.
II. Beginning of Life
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?

"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

Is God concerned with the preborn?

"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 the preborn 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
Who is responsible for life and death?

“Then God spoke all these words, saying, ‘You shall not murder.’”

—Exodus 20:13, 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

How should a woman view her body and the preborn life 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

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

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

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
Fetal Development

People have marveled at and tried to understand the miracle of life for centuries. The mystery of how two microscopic cells can unite and develop into a human being 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 unique 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.

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

**Gestational age** is the reference traditionally used by medical providers 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 booklet) 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 the sperm fertilizes the egg, a new life begins and this becomes the first fertilization day. 

We believe the dates shown, though approximate, to be fully accurate.

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

**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.

**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 / Day 6–10** 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. Around day 8 the baby is about the size of the “period” used in this sentence.

**4 Weeks / Week 2** 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. An ultrasound can provide further medical confirmation of pregnancy. By now, the embryo is completely attached to the lining of the uterus, and draws nourishment from its mother.

**5 Weeks** The heart, about the size of a poppy seed, is the first organ to function—it begins beating 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 heart is beating about 80 times a minute.

**7 Weeks** The baby is now 1/3 of an inch long and his or her beating heart can be seen on a Doppler ultrasound. The embryo makes its own blood. The arm buds now look like tiny paddles, and the leg buds look like little flippers. Depending on the baby’s gender, the testicles or ovaries are beginning to form.

**8 Weeks** The baby is now about 1/2 of an inch long. The elbows and fingers can be seen. Some reports show that the embryo can move its trunk and limbs and can respond to touch by reflex. Lungs begin to develop. Taste buds are forming on the tongue, tooth buds for “baby teeth” are taking shape in the jaw, and eyelids begin to form.
9 Weeks The baby measures 3/4 of an inch long and weighs almost 1/8 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 vocal cords form and can make sound. The limbs and fingers are growing rapidly, and the bones in the arms begin to calcify and harden. The intestines are developing and the kidneys begin to produce urine.

10 Weeks The baby’s brain is growing rapidly. Each minute it produces almost 250,000 new neurons, and for the first time in development, the brain can make the muscles move on purpose. The upper and lower portions of the arms and legs are clearly seen, and the bony tissues of the legs begin to calcify. The fingers and toes are lengthening and are separate digits. 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 in the next 2 months!

14 Weeks Now 1 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 and the baby is able to urinate and swallow.

16 Weeks The heart beats between 110 and 180 times per minute and pumps about 25 quarts of blood each day. You can see the gender of the baby 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 6 inches long and weighs almost 9 ounces. Fetal movement, commonly known as “quickening,” can usually be felt by the mother. 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 7 1/2 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 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 about 15 inches long and weighs about 2 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.

34 Weeks The baby is now about 16 inches long, weighs 4 1/2 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.

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!

Facts about fetal development were taken from the following sources:

Publications:
- Campbell, Stuart M.D. Watch Me Grow! St. Martin’s Press, 2004

Internet:

Other:

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

Photos owned by the Zrodlo foundation, Krakow, Poland were used with permission. Nonprofit use only.
Help at the Point of Crisis

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. Clinics report that when abortion-risk women receive this combination of compassionate counseling and ultrasound services, 90 percent of women state their intention to carry their baby to term. 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 optionline.org.
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.

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 Rabeca 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.carolinaperinatal.com.
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.

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 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 were two of him. He says, "I wish there could be one of

same kind of unconditional love for those around us that

seem to know when we need a hug and when we just

walk with us. That is where his strength comes from and

assures me he is not afraid; that he knows that God

though he knows it is painful to walk this path. He

hold of the time we have been given with Pearl, even

when I need it and does not waver in our decision to take

hold of the time we have been given with Pearl, even

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.

"Daddy" makes me feel better, too. In fact, words cannot describe what a rock my husband is for me. He holds me 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 whissted 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.
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.”

“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.”
The Truth About Abortion - Exposing the Lies

By Carrie Gordon Earll
Issue Analysis Senior Director, Focus on the Family

“I’ll have an abortion, of course.”

Those were my words about 20 years ago when the pregnancy test came back positive, threatening to put my plans for graduate school and career development on hold. I was a woman of the 1980s: empowered and liberated by the "right" to abortion.

Abortion was legal, advertised in the telephone book by physicians with the government’s implied stamp of approval. Abortion empowered me to face an unexpected pregnancy with clarity, decisiveness and self-respect. Or so I thought.

At the time, I viewed abortion as a reasonable solution for an unmarried woman, even for me—a pastor’s daughter attending a Christian university. My pregnancy and subsequent abortion were indisputable evidence that a Christian worldview was absent from my life. I was deceived by lies that appealed to my desires and seemed to alleviate my fears.

The abortion of my baby was a decision I would later deeply regret. And eventually taking responsibility for my past decision included examining the lies that had influenced me.

LIE No. 1: Abortion is the cure-all for an unwanted pregnancy.

I believed that my abortion would erase my pregnancy and make my life as it was before. That wasn’t true for me or for anyone; pregnancy changes a woman. Whether it results in abortion, miscarriage or childbirth, she is forever changed.

For many women, abortion can lead to physical, psychological or emotional harm. Whether this manifests as complications with future pregnancies or struggles with substance abuse, abortion is not without consequences—a fact that women have a right to know before an abortion.

LIE No. 2: Abortion is about choice.

Ironically, the word choice is closely identified with abortion, yet many women report that a perceived absence of choice pushed them toward abortion. The most common reasons women give for abortion include a lack of resources to give birth and fear of losing their place at school or in the workforce. Too often abortion is the decision a woman makes when her back is against the wall. I felt that way too. Abortion is no choice if you think it’s your only choice.

LIE No. 3: Abortion empowers women.

This equally powerful lie emerged during the 1960s. In the campaign to legalize abortion, radical feminists claimed that readily available abortion would enable women to control their lives. Under the banner of choice, we were assured that abortion would empower women with new opportunities in business, education and society.

Many women like me believed this would be true. Yet that’s not what happened. Legalized abortion didn’t promote cultural change to better serve women. Instead, abortion became society’s contingency plan, creating the expectation that a woman would take advantage of legal abortion. She had fewer choices, not more.

Too often, legalized abortion reduces the urgency for employers and educators to provide many true choices for women in unexpected pregnancies. Abortion becomes the excuse not to provide campus-based family housing and child care for college students who choose life. It contributes to an environment where pregnant college athletes will regretfully abort pregnancies rather than lose scholarships. Legalized abortion lessens the incentive for employers to offer flexible working conditions like telecommuting and job sharing so women can continue their pregnancies and their jobs.

That’s not empowerment. Ultimately, true empowerment comes when women know God’s truth about abortion – that it pits mother against child and violates His design for human life and family relationships. Women are empowered when they can follow their God-given instincts to protect and give birth to their child even when facing uncertain circumstances.

In the shadow of regret over my abortion, I now work to increase women’s access to the God-designed choice for life. Giving women the power to choose life over abortion can happen only by exposing abortion’s lies and closing its traps of deceit. Each of us contributes to this change when we vote for pro-life candidates, support pro-life laws and assist pro-life ministries on the front line of this issue. Real choices for women hang in the balance.
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.”

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. ¹

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. ²

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.”³

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.”⁴

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.⁵

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.⁶

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.”⁷

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 a previous child.”⁸

Sources

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.¹

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.²

- 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.³

- Research has found that women having abortions are more likely to have a low birthweight baby in a later pregnancy.⁴

- Abortion can increase the chance of having a tubal (or ectopic) pregnancy in the future.⁵

- 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.⁶

- 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.⁷

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, abrupto 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.”⁸

Sources

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. From 1973 – 2008, we estimate more than 46 million abortions have been performed in the United States since 1973.

Who Has Abortions?

- Based on current abortion rates, about one in three women will have an abortion by age 45.  
- 44 percent of women who had abortions in the U.S. had at least one previous abortion.  
- Fifty percent of U.S. women having abortions are younger than 25 years old.  
- Women aged 20-24 obtain 33% of all abortions, and teenagers obtain 17%.  
- 82 percent of women who had abortions in the U.S. were unmarried.  
- Over 60% of abortions are among women who have had one or more children.

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.

43% of women obtaining abortions identify themselves as Protestant, and 27% as Catholic.

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.  
- Less than 1 in 6 Caucasian pregnancies end in abortion.  
- Almost 1 in 2 African-American pregnancies end in abortion.  
- Hispanics are almost 3 times more likely than non-Hispanics to have an abortion.  
- The abortion rate among African-American women is almost three times higher than among white women.

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:

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

Sources

NOTE: The Guttmacher Institute is the research arm of Planned Parenthood, a pro-abortion organization.


4 Centers for Disease Control and Prevention, Abortion Surveillance, United States, 2003


6 Centers for Disease Control and Prevention, Abortion Surveillance, United States, 2003


9 Ibid

10 Ibid

11 Ibid

12 Ibid


14 Ibid

15 Ibid
Abortion Descriptions

Surgical abortion

First-trimester abortions

According to the Centers for Disease Control and Prevention (CDC), the most common form of surgical abortion is suction curettage (vacuum aspiration). This abortion method is used in 90 percent of all U.S. abortions.\(^1\)

Suction curettage involves dilating the mother’s cervix—the entrance to the uterus—in order to insert a plastic suction tube with a sharp cutting edge (cannula) into 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.\(^2\)

Another form of first-trimester abortion is dilation and curettage. 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. The CDC reports that two percent of all abortions involve this method.\(^3\)

Second and third-trimester (late) 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 2002, 13 percent of reported abortions were performed 13 weeks or later into the pregnancy.\(^4\)

Late-term abortion methods include:

- **Dilation and evacuation (D&E)**, which involves dilation of the cervix and dismembering of the developing fetus, and
- **Dilation and extraction (D&X)** also known as partial-birth abortion.\(^5\)

When are abortions done?

According to 2002 abortion statistics published by the Centers for Disease Control and Prevention, the following percentage of abortions were reported at various stages of pregnancy:\(^1\)

<table>
<thead>
<tr>
<th>Percentage of total abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-12 weeks</td>
</tr>
<tr>
<td>13-15 weeks</td>
</tr>
<tr>
<td>16-20 weeks</td>
</tr>
<tr>
<td>21+ weeks</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>

Two less-frequently used late-term abortion methods are intrauterine instillation and hysterotomy:

- **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.\(^6\)

Chemical abortion

A chemical abortion involves the use of pharmaceutical drugs with the intention to cause an abortion. This is in contrast to a surgical abortion where instruments are introduced into a woman’s uterus in order to end the life of her preborn child. The Centers for Disease Control and Prevention cite 36,297 reported chemical abortions in the U.S. in 2002—an increase of more than 70 percent from the previous year.\(^7\)

The two drugs primarily used today in the United States to cause a chemical abortion are methotrexate and mifepristone (RU-486). For years, doctors have used methotrexate to treat cancer and also to terminate potentially lifethreatening pregnancies abnormally implanted in the fallopian tube. Methotrexate 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.

The FDA approved mifepristone (RU-486) as an abortion drug in September 2000. Either methotrexate or mifepristone can be given as the first step in a two-drug chemical abortion method that requires the woman to take a second drug, usually misoprostol, to induce abortion and expel the fetus. Misoprostol is FDA-approved as an ulcer medicine, not for chemical abortion. However, like methotrexate, misoprostol is legally available and can be prescribed by doctors for other purposes.

How do the chemicals methotrexate and mifepristone cause abortions?

Both drugs are given to pregnant women early in pregnancy, generally up to seven weeks or 49 days gestational age. Both methods require at least two visits to a doctor’s office. If the chemical abortion is unsuccessful, physicians administering the drugs generally encourage women to have a surgical abortion.

Methotrexate is given to women who are up to nine weeks (or 63 days gestational age) pregnant. It is usually administered in the form of an injection or shot, although it can be taken orally. Methotrexate attacks the placenta—the food and oxygen source for the embryo. Without a placenta, the embryo dies.

A second drug, misoprostol, is taken a day or two later and causes the womb to expel the now-dead embryo. Taken in tandem, the two drugs cause an induced abortion. Mifepristone (RU-486) is given to women who are up to seven weeks (or 49 days gestational age) pregnant.

The drug acts to block progesterone—a hormone necessary to maintain pregnancy. Once in the woman’s body, it causes the uterine lining to shed, disconnecting the developing embryo. As with methotrexate, within a few days the woman is given misoprostol to trigger sometimes-severe uterine contractions to push out the embryo.

What are the side effects of these drugs?

Methotrexate

The possible side effects of methotrexate in chemical abortion include nausea, heavy bleeding, vomiting, diarrhea and headache.8

At least two abortionists, Hakim Elahi and Don Sloan, have publicly stated that methotrexate is known to be deadly to some patients.9

Mifepristone (RU-486)

To date, the FDA reports the deaths of six women in the U.S. in conjunction with mifepristone, including 18-year-old Holly Patterson. Five deaths are tied to infection; the sixth to an undiagnosed tubal pregnancy that ruptured. At least two abortionists, Hakim Elahi and Don Sloan, have publicly stated that methotrexate is known to be deadly to some patients.9

Emergency contraception

(Also known as “morning-after pill” or “Plan B™”)

The Morning-After Pill is a term coined to describe a series of pills given to women within 72 hours of sexual intercourse to prevent pregnancy. The pills, also referred to as “emergency contraception,” contain high concentrations of the hormones found in oral contraceptives. The U.S. Food and Drug Administration (FDA) first approved this off-label use of oral contraceptives in 1997. Currently, Plan B™ is the only product on the market that has been approved by the FDA for this purpose. Plan B™ contains a high dose of a hormone called progestin (levonorgestrel). The physiological mechanisms are not precisely known but there is general consensus in the medical community that these pills may operate in one of three ways:12

• To delay or prevent ovulation (the release of a woman’s egg)

• To prevent sperm from reaching the egg, thereby preventing fertilization and acting as a contraceptive

• To alter the lining of the uterus (endometrium), preventing implantation of an early embryo after fertilization.
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.13

However, groups like the American College of Obstetricians and Gynecologists define pregnancy as “beginning with the successful implantation of a fertilized egg.”14 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.

RU-486 (mifepristone)

Most people have heard of the abortion pill RU-486. Mifepristone is the generic name for RU-486, which was developed in 1980 by the French pharmaceutical company Roussel Uclaf.

Mifepristone is the first in a two-drug chemical abortion technique given to women who are up to seven weeks (or 49 days gestational age) pregnant. First, a woman is given mifepristone, which acts to block progesterone—a hormone necessary to maintain pregnancy.

Mifepristone causes the uterine lining to shed, disconnecting (and in essence starving to death) the developing preborn child. A second drug, misoprostol, is taken a day or two later and causes the womb to expel the now-dead embryo. Taken in tandem, the two drugs cause an induced abortion.

On September 28, 2000, mifepristone was approved by the U.S. Food and Drug Administration (FDA) for use in chemical abortion under the brand name Mifeprex®. The companion drug, misoprostol, was already available in the U.S. as a treatment for ulcers.

The second drug in this chemical abortion, misoprostol, is manufactured by Searle Pharmaceuticals under the brand name Cytotec®. In July 2002, the FDA approved a generic version of misoprostol distributed by IVAX Pharmaceuticals.

The FDA has never formally approved misoprostol for use in chemical abortion, although it recommends misoprostol for use in conjunction with mifepristone. Searle, a subsidiary of Pharmacia Corporation, has not studied or approved Cytotec (misoprostol) for use in labor induction or abortion.

However, one month before FDA approval for the abortion drug combination, Searle issued an alert to physicians, warning that misoprostol is not approved for use in pregnant women and that using the drug can cause “rupture or perforation requiring uterine surgical repair, hysterectomy,” “severe vaginal bleeding” and “maternal death.”15

The FDA reports 35 uterine ruptures and 10 infant deaths linked to misoprostol between 1988 and 2000.16

Since 1997, misoprostol is blamed for the deaths of two women who received the drug and then died during or after childbirth.17 A third woman died in May 2006 after taking misoprostol for a chemical abortion.18 Despite Searle’s warning and these deaths, the drug is often used by physicians to induce childbirth.

Mifeprex® is the first drug legally prescribed in the U.S. for the sole purpose of ending a human life. It is not a contraceptive, as it is used after the mother knows she is pregnant and the preborn baby is developing in her womb.19

Side effects and complications

A 2006 analysis of adverse drug reactions found more than 600 serious side effects to the drug were reported to the FDA between September 2000 and September 2004. These included more than 200 instances of life-threatening or serious hemorrhages and 46 instances of infection/four of which were life-threatening. Seventeen cases of undiagnosed ectopic pregnancies were reported, eleven of which ruptured.20

Even before the release of data documenting deaths and complications, supporters of mifepristone acknowledged that the chemical abortion it triggers is not a quick and easy process. Common side effects are potentially serious and include abdominal pain, nausea, vomiting, diarrhea and vaginal bleeding. Five to eight percent of women require a follow-up surgical abortion because the chemical abortion fails.21
Partial-birth abortion

The term “partial-birth abortion” describes a late term abortion procedure also known as dilation and extraction (D&X). This particular abortion method first came under public scrutiny after a 1992 presentation by abortionist Martin Haskell in which Haskell graphically described the D&X abortion technique.22

According to Haskell’s presentation, 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,”23 Haskell explained.

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.”24

Sources

1 Centers for Disease Control and Prevention, “Abortion Surveillance—United States, 2002” Nov. 25, 2005, Table 1 and 6, accessed online Nov 12, 2007 at cdc.gov/mmwr/preview/mmwrhtml/ss5407a1.htm
4 Ibid.
6 Ibid.
7 Centers for Disease Control and Prevention, “Abortion Surveillance—United States 2002” Nov. 25, 2005, page 4, Table 8, accessed on-line Nov 12, 2007 at www.cdc.gov/mmwr/preview/mmwrhtml/ss5407a1.htm
12 See “Plan B Prescribing Information,” at go2planb.com/PDF/PlanBPI.pdf
13 Merriam-Webster’s Medical Desk Dictionary (1996) defines fertilization as “an act or process of fecundation, insemination or impregnation” or to make pregnant.
14 “A closer look at emergency contraception” Fact Sheet, American College of Obstetricians and Gynecologists Web site, accessed online Feb. 20, 2004 at acog.org
17 Ibid.
19 Lindsey Tanner, “Doctors say label changes may increase childbirth use of controversial drug,” Associated Press, July 13, 2002
20 For more on mifepristone, see the FDA’s Web site at fda.gov/cder/drug/infopage/mifepristone.
24 Ibid.
Women Do Die From Legal Abortion

Abortion is a surgical or chemical procedure, and as such, it has risks. One risk is death. The reporting of deaths from legal abortion is a subject of uncertainty since not all abortion deaths are attributed to the abortion or reported as such. Although the actual number of abortion deaths is difficult to pin down, women die from legal abortion.

The Centers for Disease Control and Prevention reports the following number of reported abortion deaths in recent years:

- 1994: 10 legal abortion deaths; 2 illegal abortion deaths
- 1995: 4 legal abortion deaths
- 1996: 9 legal abortion deaths
- 1997: 7 legal abortion deaths
- 1998: 10 legal abortion deaths
- 1999: 4 legal abortion deaths
- 2000: 11 legal abortion deaths

Deaths Not Reported Although abortion is legal, it still carries stigma for those who may be injured or even killed during a procedure, further reducing the likelihood that an abortion death will be reported for what it is. Unfortunately, those closest to the abortion death (i.e., family, abortion clinic and hospital staff) may either not be aware of the abortion or desire to protect the deceased woman who had one.

Cause of Death Not Reported Another wrinkle in the reporting structure is that the death certificate may report the cause of death (what the woman died of) without reporting that the underlying cause of her death was an abortion. Common themes among reported abortion deaths are that the death occurred immediately or shortly after the abortion—or the woman had such serious complications that she was taken to a nearby hospital, where she died. The woman’s death is often made public when family members take legal action against the abortion clinic.

The Right to Know? Women should be informed that complications from abortion can be life-threatening or even fatal. Whether women experience complications caused by the procedure itself or by the negligence of the doctor performing it, abortion can be much riskier than many women realize.

Partial List of Known Abortion Deaths

True Stories While it would be impossible to identify the women and circumstances of every legal abortion death since 1973, newspaper reports reveal many stories. It is doubtful that any of the women who died from legal abortion realized that this procedure could result in their death. In remembrance of the women who have died from legal abortion since 1973, on the next pages are a few of their stories. If this was your daughter, sister or friend, wouldn’t you want someone to acknowledge their loss?

Tamia Russell
Age 15, died January 8, 2004 in Detroit, MI

Russell was six months pregnant when she died after complications from a second-trimester abortion. According to a Wayne County, MI autopsy, Russell bled heavily after the abortion. The abortionist at the Woman Care Clinic in Lathrup Village did not have the consent of Russell’s parents as state laws require for those under 18 years of age. Russell’s family hired an attorney to investigate legal action against the abortion clinic.
Holly Patterson  
Age 18, died September 17, 2003 in Pleasanton, CA
Patterson died at a local hospital one week after receiving the chemical abortion drug, mifepristone (also known as RU-486), from a Planned Parenthood affiliate. She was seven weeks pregnant. The Alameda, California coroner’s office reported that Patterson died from septic shock, caused by a “therapeutic, drug-induced abortion.” The U.S. Food and Drug Administration is investigating her death.

Diana Lopez  
Age 25, died February 28, 2002 in Los Angeles, CA
Lopez was 18 weeks pregnant when she went to the Los Angeles Planned Parenthood for an abortion by Dr. Mark Maltzer. According to the Los Angeles County Coroner’s Office, “she bled to death after her cervix was punctured during her abortion.” She died at a nearby hospital after an emergency hysterectomy. Lopez’ family is suing Planned Parenthood and Maltzer on behalf of her two living children.

Nicey Washington  
Age 26, died June 6, 2000 in Brooklyn, NY
Washington went to the Ambulatory Surgery center in Sunset Park for an abortion and died shortly afterward. She was rushed to the hospital and declared dead about an hour later, after suffering heart failure.

Kimberly K. Neil  
Age unknown, died May 22, 2000 in Fresno, CA
Neil slipped into a coma and died May 22 following an abortion. Abortionist Kenneth Wright and the Family Planning Associates Medical Group face a malpractice lawsuit filed by Neil’s family—which claims Neil was not properly treated after she went into respiratory arrest during the May 5, 2000 abortion.

Tamika Dowdy  
Age 22, died December 2, 1998 in Brooklyn, NY
Paramedics were called to the Brooklyn Women’s Medical Pavilion and began performing cardiopulmonary resuscitation on Dowdy when her heart stopped after having an abortion. She was transported to a nearby hospital where she was pronounced dead.

Lou Anne Herron  
Age 33, died April 14, 1998 in Phoenix, AZ
Abortion clinic employees told police Herron suffered in a recovery room for three hours after an abortion, bleeding heavily and complaining of numbness. Employees say abortionist John Biskind left the clinic while Herron was in distress. An employee called for emergency assistance; but by the time help arrived, Herron had bled to death due to a perforated uterus. In May 2001, Biskind was convicted of manslaughter and sentenced to five years in prison in connection with Herron’s death.

Gracealynn T. Harris  
Age 19, died September 16, 1997 in Stanton, DE
Harris had an abortion at the Delaware Women’s Health Organization in the morning, and by 10 p.m. was declared dead at a local hospital. According to medical reports, Harris bled to death from a perforation in her uterus caused by the abortion. Harris’ family filed a civil lawsuit against the abortion clinic and Mohammad Imran, the doctor who performed the abortion. In January 2002, a jury found both the clinic and Imran responsible and awarded $2 million to Harris’ young son.

Nichole Williams  
Age 22, died April 25, 1997 in St. Louis, MO
Williams went to Reproductive Health Services in St. Louis for a first-trimester abortion. According to news reports, her vital signs began to deteriorate during the abortion procedure and she was announced dead at Barnes-Jewish Hospital a short time later. Kansas City area abortionist Robert Crist performed Williams’ abortion. Williams was Crist’s third patient to die during or after an abortion-related procedure—including 19-year old Diane Boyd, who died in 1981 after reacting to the painkiller she received after an abortion.

Tanya Williamson  
Age 35, died September 7, 1996 in the Bronx, NY
Williamson was 13 weeks pregnant when she had an abortion at Gynecological Surgical Services. She received a general anesthetic, went into cardiac arrest and stopped breathing. Although a hospital was across the street, an ambulance was not called for at least 25 minutes. Williamson died, leaving behind a husband and four children.
Sharon Hampton
Age 27, died December 13, 1996 in Moreno Valley, CA

Abortionist Bruce Steir pleaded guilty to involuntary manslaughter in Hampton’s death (“Guilty plea entered in fatal-abortion trial,” San Francisco Chronicle, April 7, 2000). Hampton bled to death on the way home from the abortion clinic. According to The Sacramento Bee, “the California Medical Board already knew of five other similar surgeries mishandled by Steir that had resulted in serious complications.”

Linda Boom
Age 35, died September 22, 1995 in Milwaukee, WI

According to press reports, Boom died of heart damage after a doctor at the Sinai Samaritan Medical Center in Milwaukee mistakenly injected chemicals into her bloodstream rather than into her womb in an attempted abortion. A jury found the doctor’s negligence caused her death.

Lisa Bardsley
Age 25, died in 1995 in Phoenix, AZ

According to press reports, Bardsley had an abortion and was discharged an hour later. As she and her boyfriend were driving to Flagstaff, she became ill and later died after massive hemorrhaging. John Biskind, who was later convicted of manslaughter and sentenced to five years in prison for his part in the abortion death of Lou Anne Herron, performed Bardsley’s abortion.

Pamela Colson
Age 30, died June 26, 1994 in Panama City, FL

Colson was about 12 weeks pregnant when she went to the Women’s Medical Services in Pensacola, Florida. After an abortion, Colson and a friend were driving home to Port Joe, Florida, when Colson experienced difficulty breathing. Shortly thereafter, Colson went into full cardiac arrest. She was taken by ambulance to a nearby hospital, where she died. A medical examination attributed her death to a torn uterine artery, which caused uncontrolled bleeding.

Magdalena Ortega-Rodriguez
23, died December 8, 1994 in San Diego, CA

Ortega-Rodriguez, from Tijuana, Mexico, died in an area hospital after having an abortion at the El Norte Clinica Medica in San Diego. Her uterus was cut during the abortion, causing her to bleed to death. Clinic staff called emergency personnel when Ortega-Rodriguez went into cardiac arrest.

Jammie Garcia Yanez-Villegas
Age 15, died in 1994 in Houston, TX

According to press reports, Yanez-Villegas died from an infection after an abortion performed by John Coleman at the A to Z Woman’s Center in Houston. Two weeks later, a health department inspection revealed dirty and unsafe surgical instruments, inadequately trained personnel and incomplete patient records. The state went to court to shut down the clinic. In response, owner Moche Hachamovitch voluntarily closed it. Yanez-Villegas’ family named Hachamovitch in a wrongful death suit. Coleman, meanwhile, suffered from emphysema and employees reported being concerned about his ability to operate given his health problems. Coleman died three days after Yanez-Villegas.

Sources
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)

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 36 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; 23 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. Seventeen 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 2008: Proven Strategies for a Pro-Life America available at www.unitedforlife.org
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:

<table>
<thead>
<tr>
<th>As of June 26, 2008</th>
<th>AL</th>
<th>AZ</th>
<th>AR</th>
<th>FL</th>
<th>GA</th>
<th>ID</th>
<th>IN</th>
<th>LA</th>
<th>MI</th>
<th>MN</th>
<th>MS</th>
<th>OH</th>
<th>OK</th>
<th>SC</th>
<th>SD</th>
<th>UT</th>
<th>WI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound required. Women must be offered the opportunity to view image.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound required after 1st trimester. Women must request to view image.</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If ultrasound is performed as part of preparation, women must be offered the opportunity to view image.</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women must be informed about ultrasound services and how to obtain these services.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women are responsible for requesting to view ultrasound image.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Women must be informed of opportunity to hear fetal heart beat.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Women must be informed of possible fetal pain.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data has been compiled from American’s United For Life’s “Changing Law to Protect Human Life, State by State” (2008), National Right to Life’s “Woman’s Right to Know: States that Offer Ultrasound Option” (16 May 2008), and state codes. For more information see: www.aul.org/Defending_Life?p=11 or www.nrlc.org/WRTK/UltrasoundLaws/StateUltrasoundLaws.pdf
Bio-Ethical Issues at the Beginning of Life . . .

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.1

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.2 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.3

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.

3 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 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 1989.4 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.2

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

- 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/foisi/bioethics/genetics

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

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.

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.

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 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.

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.

1 For more information and citations, see www.VoteNoCloning.com web site and click on “Booklet References.”

The following references provided background information for this article:


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

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!
III. In the midst of Life
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.")
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.

Copyright © 2001 Focus on the Family. All rights reserved.

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 Matters

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.
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.

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.

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!

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).

Adoption and Orphan Care

The needs of the world are staggering, especially relating to children. Current estimates show that more than 130 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 though 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 adoption 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 127,000 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).

*www.acf.hhs.gov/programs/cb/stats_research/afcars/waiting2006.htm*
Exposing the Myths about Adoption

While more than one-third of Americans have considered adopting, no more than 2 percent have actually done it. 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 Shaohannah’s Hope, LifeSong for Orphans, and The Abba Fund. In addition, the government offers up to a $10,000 tax credit per adopted child (visit 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 130 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 127,000 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.

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

---

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 500,000 children are in the U.S. foster care system.

• 127,000 children in the U.S. are waiting to be adopted - just waiting for the right family to find them.

• More children in foster care wait for adoption each year than are adopted.

• In 2006, 79,000 children had parental rights terminated by the courts, yet:
  ➢ Only 51,000 were adopted from the foster care system;
  ➢ A child waiting to be adopted has been in foster care an average of 39 months;
  ➢ A child in foster care can wait five years or more to be adopted.

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.

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.
Identifying and Overcoming Post-Abortion Syndrome

“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

Women: The Healing Process

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 condition that they call “post-abortion syndrome” (or PAS), defined 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. There are three important aspects to this “firm grasp” on forgiveness:

- Knowing Who ultimately has paid the debt,
- Allowing intimacy with God to be restored and
- 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.

Copyright Focus on the Family

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.
“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 (post-abortion syndrome is still not recognized by the American Psychiatric Association), 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 crisis 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.

Elaine Minamide has been freelance writing since the early ’90’s. She also teaches English part-time at a community college in Southern California. She and her husband Perry have three children.
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

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.
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 a 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 . Contact Ken at kgosnell@fatherhood.org
Points to Ponder: Caring for Loved Ones

Living With Alzheimer's
by Kenneth L. Connor

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.

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

by Kenneth L. Connor

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 your 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).

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.

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.

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.

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.

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.

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 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.

*Copyright © 2007 Carol Hefferman. Used with permission. All rights reserved.*

**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, 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.

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.

Copyright © 2007 Carol Heffeman. Used by permission. All rights reserved.
IV. End of 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?

“But who will have mercy on me, even my friend? Or whom will IFraction 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
“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
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.
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.”
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 Teresa 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.

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

Copyright © September 2007 Focus on the Family. All rights reserved. International copyright secured.
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
III: Possible Interventions
IV: Considering Various Scenarios
V: Additional Topics

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:
• 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

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.
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.
• **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.
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.
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.
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 aids, 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.
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.
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.

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.
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 undertreatment 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.


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.”

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.”

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.”

Kathleen Foley, M.D., Chief of Pain Service
Memorial Sloan-Kettering Cancer Center
New York City

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. 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. 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. 6

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**

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.

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.”

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 and Planned Parenthood v. Casey.

Just as Supreme Court justices discovered a right to abortion in Roe and its companion case, Doe v. Bolton, 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.”

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. 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 and Vacco v. Quill. 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.


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.

Likewise, the Alaska Supreme Court ruled in 2001 that physician-assisted suicide goes too far and is not protected under the state’s constitution.

References:

1. Kevin Johnson, “High court to hear right to die,” USA Today, October 2, 1996, p. 1A.
2. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).
7. Quill v. Vacco, 80 F.3d 716 (2nd Cir. 1996).
Who are we?

Through initiatives, resources and training, our goal is to equip you for success in the battle for life—to the glory of God!

Yvette Maher, Vice President
Sanctity of Human Life Division

For more than 30 years, Focus on the Family® has been based on five core principles. Among them is the sanctity of human life—which is the foundation for all we do. As our founder, Dr. James Dobson, so eloquently describes, “We believe that all human life is fearfully and wonderfully made, and is of inestimable worth and significance.”

Our Sanctity of Human Life (SOHL) division is dedicated to nurturing and defending human life. We do so by increasing awareness of life issues through radio programs, publications, resources, media campaigns, web sites, community impact efforts and national initiatives. It’s our hope that by planting seeds of change, we can dispel the lie of “choice” and change our nation.

We’re here to help

Stretched thin, but motivated. Facing huge obstacles, but pressing on. Sound familiar? It’s the story of countless right-to-life organizations, adoption groups, pregnancy resource centers and pregnancy medical clinics across the nation. The letters, calls and e-mails we receive daily are great motivation to keep us going. We recognize that in the fight for life, we have a unique opportunity to truly impact our culture for the life. We also realize that this great cause is often hobbled by tight budgets and limited resources. This is why we’re here to help.

How Focus on the Family nurtures and defends life

Each life matters because each one is created in the image of God, and so we have integrated several SOHL initiatives that provide strategic support to individuals and organizations seeking to live out a consistent sanctity of human life ethic in their own walk of life. In addition, our Public Policy Department helps to equip and inform Focus constituents about issues in the public square that have implications for life issues, and they have provided all of the statistical and legislative information in this SOHL Guide.

Option Ultrasound™ Program

In 2004, Focus on the Family asked the question, “How can we help a pregnant woman to understand that what she carries in her womb is more than just a blob of tissue?” The answer: Let her see for herself!

Thus was born the Option Ultrasound Program, which provides grants for ultrasound machines and sonography training to equip Pregnancy Medical Clinics (PMCs) to better serve women at-risk for abortion. Through the generous gifts of our donors, over 400 grants have been approved in 49 states in the last 5 years. OUP is not just an investment into a machine or training, but into the organization as a whole – it’s a committed process that helps a PMC provide medical services with excellence.

Ultrasound services help women understand their bodies, their pregnancy and their baby’s development. During the ultrasound exam a woman has the opportunity to see what the abortionist likely will not disclose – her preborn baby – and this can help a woman to make a more informed decision consistent with her own values and priorities. An ultrasound exam also gives a woman an important bonding opportunity with her baby, which encourages her to seek early prenatal care, protecting her own health and the health of her developing child.

Finally, providing ultrasound services to women gives them hope! These women are provided ongoing support by the local PMCs as they go through their pregnancies – and even beyond birth if needed. Each year across the country, thousands of women return to say “thank you” to these clinics for helping them make positive decisions to carry their babies. Virtually none return to say they regret the decision to give their baby life.
How does viewing an ultrasound impact a woman’s decision about abortion? We’ve found that the combined provision of counseling and ultrasound results in at-risk* women being twice as likely to express their intent to carry their baby to term as those who receive counseling alone. Through the end of October 2008, we estimate the potential number of babies saved as a result of Option Ultrasound could be as high as 63,000 precious babies, little ones who might otherwise have been aborted if their mothers had not had the opportunity to see for themselves. For more information, visit www.HeartLink.org.

I.M.P.A.C.T. Training™
Focus on the Family is conducting I.M.P.A.C.T. Training, which helps PMCs become Influential, Medical, Professional, Accountable, Culturally relevant and Trustworthy. By providing comprehensive education for leadership teams and board members of PMCs in high-abortion areas, these clinics are equipped to operate with excellence, focused on reaching women in their community who are at-risk for abortion.

Benevolent Resources
Each year, Focus on the Family offers hundreds of thousands of dollars of free counseling resources to thousands of domestic and international PMCs, PRCs and Maternity Homes. These booklets, fetal models, DVDs and CDs (in English and in Spanish) equip them to deliver medically accurate, life-affirming information to at-risk clients. In addition, a monthly e-newsletter called BoardLink helps to equip PRC/PMC board members and executives to fulfill their unique roles.

Adoption and Orphan Care Initiative™
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 children need love, security and a permanent family as much as any of God’s children.

At Focus on the Family, we believe that every child deserves to know the love of a forever family. Therefore, our goal is to raise awareness of and recruit families for these waiting 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. To that end, we are working collaboratively with state, county, church and adoption agency leaders to help find families for waiting children and youth in foster care.

Our first collaborative event, a pilot project titled “Wait No More: Finding Families for Colorado’s Waiting Kids” was held in November 2008 in Colorado Springs. More than 1300 people representing 730 families from more than 130 churches came to learn more about the kids in their community waiting for adoptive families. The result: More than 260 families started the process of adoption from foster care, vastly exceeding our goal of 100 families. Colorado’s Department of Human Services officials described the event as “phenomenal” noting “It’s never happened before.” Because of its dramatic success, the Wait No More adoption event will take place in other cities around the country so that more of America’s legal orphans in foster care can finally come home to their forever adoptive families.

Our awareness and recruiting efforts are complemented by desperately needed post-placement benevolent resources for adoptive families - resources that are both biblically-based and relevant to their unique struggles. These resources also provide practical ways for churches and individuals to support the adoptive families in their communities.

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. We believe 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.

BEAVOICE.NET Web Site
As we live out a Sanctity of Human Life ethic from day to day, it influences how we see and treat others at every stage of life. Focus on the Family provides resources on this web site that help equip you to be a voice for life, whether it’s honoring those created in God’s image at the beginning of life, in the midst of life or in life’s final chapters. Here, you’ll find free downloadable resources, such as this SOHL Guide, videos, PSAs, posters and more! Visit www.BEaVOICE.net.

God calls each one of us to be a voice for life – won’t you join us and find your voice?