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Christian Doctrines and Human Life

By Terry Schlossberg

Sometimes when I speak to church groups I do a quick word association exercise and ask what comes immediately to mind when I say the word abortion. Often the responses are directed at the public policy arena. *Roe v. Wade* is a common response, even if people are unfamiliar with the content of that Supreme Court decision. The reality is that church groups ordinarily do not discuss abortion. Consequently, when discussions do take place among Christians, they often are focused on the public debate over law and social policy. It seems easy to disqualify Christian faith from a place in the discussion simply by noting that "abortion" doesn't appear in the Bible.

The Christian Church throughout its history has understood the Bible to speak directly to matters affecting humans before, during and after our time on earth: to issues of life and death. When we Christians today speak to the modern phenomenon of abortion, we ought not to turn to the legal or social spheres of the society to determine our thinking, as if the Church had no word to offer on this subject. We can find the moral grounding related to abortion rooted in Scripture and the historical understanding of the Church. Only if our first resort is to the Church, to its Scriptures and its historical teachings, will we be equipped to speak rightly to the legal and social spheres. Moreover, we will be better prepared to speak and act within our own communities as we preach, teach, and offer pastoral care ministry in response to the broad scope of human needs. So basic are the theological understandings undergirding how Christians should view abortion that they have broad application to our common life as Christians.

The Christian position on the giving and taking of life is derived from the most central of Christian doctrines. It is grounded in the theology which the Church has claimed as its own for centuries.

The Doctrine Of Creation

The Doctrine Of Creation Affirms Life

The Christian Church has always confessed that the triune God is the Maker of heaven and earth (Isa. 45:18; John 1:3), and that all that exists has been made by him (Acts 4:24). We all have been fearfully and wonderfully

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formed by God—knit together with bones and sinews in our mothers' wombs by the loving hands of our Creator (Job 10:11; Ps. 139:13-14). We are not just chance happenings of the universe. We were made by our Lord. We were intended by him (Ps. 139:16; Jer. 1:5). And we, as human beings, are distinct from the rest of creation by being made in God's very image and likeness (Gen. 1:26-27; Gen. 9:6).

The Doctrine Of Creation Affirms God's Ownership Of Life

The Christian Church also has always affirmed that because God is the Creator of all things, all life belongs to him. Its creed is that of the Psalmist: "The earth is the Lord's and the fullness thereof, the world and those who dwell therein." (Ps. 24:1; 1 Cor. 10:26). "The world and all that is in it is mine," God says (Ps. 50:12). Thus, when we bring our offering, we often sing,

We give thee but thine own,
whate're the gift may be:
All that we have is thine alone,
A trust, O Lord, from thee.

These affirmations of the Church are in direct conflict with the claim that, "It's my own body." In confessing our faith, Christians cannot properly claim that our bodies are our own property, to do with as we choose. Neither our own bodies nor our unborn children belong to us, according to the Christian faith. They belong to God, for "it is he that made us, and we are his" (Ps. 100:3), and we do not have the freedom to do with our bodies as we like or to rob God of those unborn children whom he is creating and to whom he has already given life.

The Doctrine Of Redemption

The Apostle Paul spoke of our belonging to God. "You are not your own; you were bought with a price," he wrote (1 Cor. 6:23; 7:23). That is, we were bought with the redemption price of the death of Christ on the cross. And so, admonished Paul, "do not become slaves again," slaves to the powers of darkness. By his death and resurrection, Christ has freed us from our bondage to sin and death, and we are warned not to become captive again to the destroying, deadly ways of the world. We are no longer earthbound victims of circumstances but overcomers by his grace. Now we have the freedom to live as obedient disciples of Christ and as faithful parents of those unborn children who are God's children, created and loved by him.

Baptism Signifies Redeemed And Purpose-filled Life In Christ

The Christian Church emphasizes that we are not our own by its sacrament of baptism. When a child or an adult is baptized, the Church affirms, with the Scriptures, that believers and their children are in God's covenant and partakers of his promises (John 1:12-13; Gal. 4:4-7; 1 Cor. 7:14). The promise of baptism is that nothing can separate us from the love of God in Jesus Christ our Lord (Rom. 8:38-39). The Church cannot, then, counsel her people to turn away from that marvelous love as if God has no interest or say in our children or in what we do in regard to abortion. Baptism is never a private act, and it never concerns only the individual being baptized. Baptism is the Church's family affair, in which we welcome believers and their children into the Christian community as brothers and sisters of Christ and children of our heavenly Father. At every baptismal ceremony, therefore, the whole congregation accepts that familial responsibility for one another (cf. 1 Cor. 12:25-26; Gal. 6:2).

The Church knows that God creates human life for a purpose. In the Reformed faith, that purpose has been summed up in the first two sentences of *The Shorter Catechism* (Book of Confessions, 7.001). The chief purpose of our lives, it says, is "to glorify God and enjoy him forever." We exist, our Church confesses, to praise God in all that we are and do and to find our joy in fellowship with him. All human beings, no matter what their condition, are capable of living out that purpose through Jesus Christ. The Christian Church, throughout the ages has sought life and healing, and not death for all God's children. God creates the unborn to raise their voices with us in praise of God, and to enter into communion with him. We invite God's judgment by destroying those children in the womb or by implying through our silence that God is indifferent to whether they live or die. The clear claim of belonging implicit in the sacrament of baptism is a rejection both of the claim of autonomy and the claim that any child is unwanted or unintended and therefore may be killed with the sanction of the Church.

The Doctrine Of The Church

Empowered To Be Obedient In Communion With God And Each Other

The Church has always proclaimed that we are enabled to live as faithful disciples of Christ by the gift of the Holy Spirit. We are no longer dependent upon our own powers and resources, or captive to our own desires and wills, but rather we are enabled to live by God's will and to walk in his ways by the Spirit of Christ living in us. It is the Spirit who enables us to pray, "Our Father..." and who himself prays for us (Rom. 8:15, 26-27). It is the Spirit who makes it possible for us to confess Jesus Christ as our Lord (1 Cor. 12:3). And it is the Spirit who gives us the fruit of love and joy, peace and patience, kindness and goodness, faithfulness and gentleness and self-control (Gal. 5:22-23).

By the power of the Holy Spirit working in us, we sinful human beings are able to do the good that God wills for us, and not to do evil. Indeed, Paul tells us that our bodies are the temple of the Holy Spirit (1 Cor. 6:19).

The Christian Gospel rejects the notion that we are the victims of complicated and insolvable circumstances and declares us more than conquerors through Him who loves us (Rom. 8:37). By the power of the Spirit we are able to overcome those things that confront us and are able to live victoriously in obedience to God, even in the most difficult of circumstances.

The Church As A Community of Service And Blessing To All

The message and the life of the Church are God's answer to problem pregnancies in our time. Our culture's claim is that some children already conceived should not be born into poverty or abuse or rejection or a difficult life. But as members of one another in the family of God, we believe that the problem of the poverty-stricken, of the abused, of the unwanted**,** or of those needing special care is the anguished call to the Church in every community to get to work. The family of God cannot support or aid in the deaths of children regardless of their circumstances, as our culture does. Instead, the response of the faithful Church must be, in Mother Teresa's words, "If you do not want the child, give him to me; I want him." That surely is the readiness of faith with which the Body of Christ must gird itself in this age of unrestricted abortion.

God's claim on us as community means we must not say to the pregnant 15-year old teenager in our midst, "Your pregnancy is *your* problem," or to the family with a member needing special care, "Caring for that person is your problem." We are responsible for one another, and now problem pregnancies and those needing special care are *our* shared responsibility before God. The faithful Church, we believe, gathers round the pregnant mother in its midst—whoever she may be and however she became pregnant—and gathers around every person and family with special needs. It supports and provides for them in accordance with God's commands, and it cherishes every life that God has entrusted to their care.

It is the Church that knows that message and it is the Church that has been entrusted with the task of faithfully embodying the whole of the Gospel in the community of believers; and for extending the loving care of her Lord to all people. The faithful Church tries to be the kind of community which will enable all of its members to become faithful disciples of our Lord.

The Doctrine Of Forgiveness Of Sins

God's Desire To Restore Us

God's Word recognizes our propensity toward sin. Scripture is clear in distinguishing right from wrong and careful in teaching holiness and obedience to God's commands. It is vigilant in warning us away from sexual impurity and doing harm to the innocent. The Church must be faithful in teaching all of God's Word. That Word also reveals God's provision for rescuing us from our sin. It teaches us the healing and restoration that God promises when we confess and turn from sin and turn to him through faith in Jesus Christ. God knows us through and through and wants to forgive us and restore us to fellowship with himself. And he calls his people to demonstrate their faith through concrete acts of love for one another, to "be doers of the word, and not hearers only" (James 1:22).

The Grace Of Our Lord Offered At His Table

It is, above all, at the Lord's Supper that the Church gathers together as one. There at the Lord's Table, by the sacrifice of Jesus' body broken for us and his blood shed for us, symbolized in the bread and wine, Christ renews our covenant and our communion with our God and with one another. The Table is the sign of God's enabling our confession and repentance which is met by the forgiving grace extended through Christ's death on the cross. At the Table we discover that no sin exceeds God's grace to forgive; at the Table we find ourselves accepted by our Lord, and at the Table we are restored and joined together as one Body, with Christ as our Head. All persons can be forgiven and made new in Jesus Christ (2 Cor. 5:17).

The Christian Church is called to hold out that invitation of the Gospel, with its forgiveness and acceptance and communal oneness to all persons. It is through the grace of our Lord Jesus Christ, administered by his body, the Church, that the old life of sin and death, which is the end of every abortion decision, can be done away with. The new life in Christ—of faithfulness and goodness—can begin.

Abortion is commonplace in our society. Many in our congregations have participated in abortion decisions in some way and are bearing a heavy burden of unresolved guilt. At our Lord's Table we are assured again and again that because we have come to Jesus in repentance and faith, our Redeemer surely has taken upon himself the full burden and penalty of *all* our sin, and has removed them from us forever. We are freed to start anew, assured that we are fully accepted and deeply loved by our Savior. The message of the Church is the joyful news of the mercy of God: "Friends, believe the good news of the gospel: In Jesus Christ, we are forgiven."

The Doctrine Of The Resurrection

God Desires Life And Not Death For His Loved Ones

The Church in our time is called to affirm and proclaim the good news of the Scriptures and of the Christian Church,

throughout its history, that the God and Father of our Lord Jesus Christ wills for us and for our children—born and unborn—life and not death. "You shall not kill," he has commanded us. God has no pleasure in the death of anyone. And when God raised his Son Jesus Christ from the dead he broke the power of death and willed life for us—eternal life, abundant life, in the joy of his company.

We rejoice in the resurrection. God's risen Son now abides in our midst as our forgiving host every time we celebrate the Lord's Supper. We know that he is present as Lord whenever two or three are gathered together in his name. And we live by his promise that he will be with us to the end of the age (Matt. 28:20). In his Son, God has willed life for every person he creates in the womb. The Church today is called to reaffirm, with the ministry of its voice and actions, the central doctrines of the biblical faith of the Church universal for two thousand years as we proclaim and live out the joyful good news.

Advances in the Understanding of Fetal Pain

By Jean A. Wright

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Ten Questions On Fetal Pain

1. Can an unborn baby feel pain?

Up until recently, few people ever asked, "does the baby feel pain during the abortion? or how early can a fetus feel pain?" The science is available now to answer those questions.

2. When is an unborn infant viable? Don't all abortions just affect infants who could not live outside the womb?

Viability is certainly much earlier than was ever thought possible in 1973. As medical science pushes the frontier of fetal viability to 23 weeks, and perhaps sooner with the advent of artificial wombs and placental support—there is a possibility that a definition of viability based upon gestational age will soon be irrelevant.

3. What is the earliest sign of pain perception?

Unborn infants have pain receptors on their face by 7 weeks of development, and over their entire body by the 20th week of gestation in the same or greater density than adults.

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4. How do we know those pain receptors are really transmitting a pain signal?

EEGs have recorded the response to noxious stimuli as early as 26 weeks.

5. *How do we know pain is perceived the same in pre-born infants as in adults?*

The same way that children and adults respond to pain with changes in their hormones, the 20–35 week preborn infants also respond.

6. How does the threshold for pain differ from adults?

It takes less of a noxious stimulus to create pain in the unborn child.

7. Over time, adults with chronic pain learn ways to cope. Can the unborn cope?

The fibers and substances needed to feel pain are present; but the mechanisms needed to modulate and tone down the response to pain are poorly developed.

8. Do the preborn and newborns feel more or less pain than adults?

Newborns not only feel pain; they react to pain with 3–5 times the response of adults.

9. How do we know the pain impacts the baby in a substantial way?

The response to pain is not inconsequential. Infants who were not treated for their pain during operations had worse clinical outcomes.

10. Since Fetal Surgery centers provide anesthesia for the preborn, should pain to the unborn child be a consideration in an abortion?

If a preborn child requires anesthesia for fetal surgery, then shouldn't the logical extension be that children undergoing abortion also feel pain—and would have the same requirements for anesthesia?

Introduction

Why is the development of pain in the fetus and newborn important?

In the last 30 years, the fields of developmental neurobiology, perinatology, neonatology, pediatric anesthesia and pediatric surgery have exploded with knowledge. That knowledge has radically impacted how we care for the unborn infant, and the infant born prematurely. However this knowledge has lagged behind in permeating the clinical care involved in abortion, particularly in the abortion of the late-term fetus.

Up until recently, few people ever asked, "does the baby feel pain during the abortion? How early can a fetus feel pain?" The science is available now to answer those questions.

Improvements In Neonatology

Improvements in neonatology push for a new definition of viability for the premature infant.

In 1973 neonatology was in its infancy as a science and as a practice. The understanding of the physiology of the pre-term infant, the equipment, medications, physicians, and specialized units available to care for them were present but limited. By contrast, today there are thousands of neonatologists, hundreds of Neonatal Intensive Care units, and breaking discoveries in the world and womb of the developing fetus and neonate. Artificial surfactant, liquid ventilation, ECMO, and other heroic technologies support the infants who would have not survived in 1973. Specific textbooks, journals, fellowship training programs, and scientific conferences abound focused solely on the care of the premature infant.

Compare that to 1973, when the Supreme Court discussion focused heavily on the issue of fetal viability. At that time, the common understanding was that infants born before 28 weeks could not survive. And there was no expectation that the date of viability would be pushed back earlier than 28 weeks. Today that age of viability has not only been pushed back beyond 28 weeks, but even to 23 and 24 weeks.

The number of children that are born and survive at 23–28 weeks gestation is common enough now that the term Micro-premie has been coined to describe them and an additional body of neonatal science is focused upon them.

So when is an unborn infant viable?

Certainly much earlier than was ever thought possible in 1973.

More importantly, as medical science pushes the frontier of fetal viability to 23 weeks, and perhaps earlier with the advent of artificial wombs and placental support—there is a possibility that a definition of viability based upon gestational age will soon be irrelevant.

Understanding Pain Perception

Research in anesthesia provides a better understanding of the development of pain perception.

Pain is a subjective phenomenon for every one—adults, children, and the unborn. It includes the perception of noxious stimuli, remembering the event, and the processing of the event in a series of hormonal and physiologic responses. Therefore, evaluating the perception of pain is difficult in all human subjects. But identifying the structures, processes and measuring the response to noxious stimuli is increasingly done in all age groups.

Drs. Anand and Fitzgerald have demonstrated that very preterm neonates have the neuro-anatomic substrate and functional physiologic and chemical processes in the brain required for mediating pain or noxious stimuli, known as nociception. The pain receptors needed to feel pain on the skin are referred to as cutaneous nociceptive nerve endings. Recent anatomic studies have shown that the density of these cutaneous nociceptive nerve endings in the late fetus and newborn infant may equal or exceed that of adult skin. Early studies by Hooker showed that cutaneous sensory perception appears in the perioral area of the human fetus in the seventh week of gestation and gradually spreads to all cutaneous and mucous surfaces by 20 weeks.

Unborn infants have pain receptors on their face by seven weeks of development, and over their entire body by the 20th week of gestation in same or greater density than adults.

Several types of observations speak for the functional maturity of the cerebral cortex in the fetus and neonate. First, fetal and neonatal EEG patterns (which include cortical components of visual and auditory evoked potentials) have been recorded in preterm babies of less than 28 weeks gestation. Second, cortical evoked potentials from somatosensory stimuli (touch, pain, heat, and cold) were also recently documented in preterm neonates from 26 weeks gestation.

Evoked potentials and EEGs have recorded the response to noxious stimuli as early as 26–28 weeks.

A study of intrauterine blood sampling and blood transfusions in fetuses between 20 and 34 weeks of gestation showed that hormonal responses to the needle sticks were consistent with the fetal perception of pain and were correlated with the duration of the painful stimulus.

Infants Respond To Pain

The preborn 20–34 week infant responds to pain with changes in stress hormones in the same manner as children and adults.

Ultrasonographic findings report specific fetal movements in response to needle punctures in utero. When neonates are born prematurely at 23 weeks gestation, they demonstrate highly specific and well-coordinated physiologic and behavioral responses to pain—similar to those seen in full-term neonates, older infants, and small children. The responses of these prematurely born infants gives us a window in the world of preborn, validating outside the uterus what they were capable of manifesting inside the uterus.

Contrary to previous teaching, current data indicate that preterm neonates have greater pain sensitivity than term neonates or older age children and adults.

Several lines of scientific evidence support this concept.

The study of the cutaneous flexor reflex has been used to establish when connections between the skin and the spinal cord are first made in the fetus. It has also been used to study the maturation of ascending motor pathways. This reflex has been shown in man to parallel pain perception exactly in terms of threshold, peak intensity, and sensitivity to analgesics. This reflex has a lower threshold in premature neonates (and thus unborn infants) than in full term newborns or adults.

Unborn Child Is More Sensitive To Pain

It takes less of a noxious stimulus to create pain in the unborn child.

Neurotransmitter development in the dorsal horn of the spinal cord involves the early and abundant expression of the neurotransmitters mediating nociception (substance P, L-glutamate, VIP, CGRP) and increased somatosensory excitability in the premature spinal cord. In contrast, the neurotransmitters contained in descending inhibitory fibers from supraspinal centers (5-HT, Norepinephrine, Dopamine) were expressed after birth, implying poorly developed gate control mechanisms for pain in preterm infants.

Opioid receptor labeling in the brain stem of fetuses at 19-21 weeks gestation demonstrate very high densities in supraspinal centers associated with sensory perception. These inhibitory opioid receptors may be the only protection for the developing neuronal systems from constant over-stimulation, given the overall underdeveloped gate control mechanism in the dorsal horn of the spinal cord.

Pain Defense Is Underdeveloped

The fibers and substances needed to feel pain are present, but the mechanisms needed to modulate and tone down the response to pain are poorly developed.

The practice of Pediatric Surgery and Pediatric Anesthesia has shown us how preborn and preterm infants respond to pain.

The magnitude of hormonal and physiologic responses to invasive procedures or surgical operations is much greater in neonates as compared to adults. Pain in the fetus and neonate can be measured in two dimensions. Pain and surgical stress are demonstrated by a coordinated outpouring of pituitary, adrenal, and pancreatic hormones. Secondly, cardiovascular responses, such as increases in blood pressure, heart rate, dysrhythmias, or poor cardiac output may signal pain. Anand demonstrated that newborns generate a catacholamine and metabolic responses up to 3–5 times those of adult patients undergoing similar types of surgery.

Pharmacokinetic studies of anesthetic drugs have shown higher plasma concentrations were required to maintain effective surgical anesthesia in preterm neonates as compared to old age groups. The studies cited above indicate a lower pain threshold in preterm neonates, and the occurrence of further decreases in pain threshold following exposure to a painful stimulus or experience.

Newborns Feel Pain More Intensely

Newborns not only feel pain; they react to pain with 3–5 times the response of adults. They require higher doses of anesthesia during surgery, and repeated exposure to pain lowers the threshold to pain even more.

The effects of anesthesia on the neonatal stress responses are important and may contribute to the effects of stress suppression on postoperative clinical outcome. In a randomized controlled trial, preterm babies undergoing ligation of the patent ductus arteriosus were given nitrous oxide, with or without the addition of an intravenous pain medication (fentanyl). The hormonal responses of neonates receiving nitrous oxide alone were associated with significant increases in blood glucose, lactate, and pyruvate. These biochemical changes were prevented in neonates given the therapeutic doses of the pain medication. This study went on to show that aggressive anesthesia not only decreased the stress responses of neonates undergoing surgery but also improved their postoperative clinical outcome.

Research Shows Consequences Of No Pain Treatment

The response to pain is not insignificant nor inconsequential. Infants who were not treated for their pain had more stress responses and worse clinical outcomes.

In the early 1970's, many preterm infants were considered too ill and too frail to tolerate the anesthesia required for their needed surgery. Even by the early 1980's, preterm infants still received minimal anesthesia in the operating room and the neonatal intensive care unit. Two landmark articles by Anand in 1987 challenged this assumption and changed the practice of pediatric anesthesia.

Lastly, exciting surgical advances at places like the Fetal Surgery Center at the University of California allow for the surgeon to partially remove the fetus through an incision in the womb, repair the congenital defect and slip the pre-viable infant back into the womb. These procedures challenge us to reconsider the outcome and viability of many preterm infants including those with serious congenital defects. Anesthesia for the preborn child is a planned part of these surgical procedures, and every effort is made to prevent the preborn child from experiencing noxious stimuli with the hormonal and physiologic changes that accompany the surgery.

Abortion And Anesthesia

If a preborn child requires anesthesia for fetal surgery, then shouldn't children undergoing abortion have the same requirements for anesthesia?

Fletcher, in the editorial that accompanied Anand's study, comments that….

> unless a neonatologist had made a concerted effort to study the topic of pain, a subject that has not until now been in the forefront of concern in neonatal care, he or she would not have had easy access to more of the information in the Anand study.

She highlights that among the 201 references, only 20 occurred in medical journals that might have been part of a neonatologist's regular reading. She further states that "Good often comes from bad," thereby encouraging the readers to learn from their earlier misunderstandings. Her succinct statement could be applied to the topic of fetal pain today.

Anand and Hickey concluded in "Pain and Its Effects in the Human Neonate and Fetus"…

> [C]urrent knowledge suggest that human considerations should apply as forcefully to the care of neonates and young, nonverbal infants as they do to children and adults in similar painful and stressful situations.

Selected Bibliography

Anand KJS, Hickey PR. *Pain and its effect in the human neonate and fetus*. New Engl J Med 317:1321-1329.

Anand KJS, Aynsley-Green A. *Metabolic and endocrine effects of surgical litigation of patent ductus arteriosus in the human preterm neonate: Are there implications for further improvement of postoperative outcome?* Mod Probl Paediatr 1985; 23:143-57.

Torres F, Anderson C. *The normal EEG of the human newborn*. J Clin Neurophysiol 1985; 2:89-103.

Hickey PR, Hansen DD, Wessel DL, Lang P, Jonas RA, Elixson EM. *Blunting of stress responses in the pulmonary circulation of infants by fentanyl.* Anesth Analg 1985; 64:1137-42.

Anand KJS, Brown JM, Causon RC, Christofides ND, Bloom SR, Aynsley-Green A. *Can the human neonate mount an endocrine and metabolic response to surgery?* J Pediatr Surg 1985; 20:41-8.

Fitzgerald M, Shaw A, MacIntosh N. *The postnatal development of the cutaneous flexor reflex: a comparative study in premature infants and newborn rat pups.* Dev Med Child Neuro.

Berry FA, Gregory GA. *Do premature infants require anesthesia for surgery?* Anesthesiology 1987; 67: 291-3.

Yaster M. *Analgesia and anesthesia in neonates.* J Pediatr 1987; 111: 394-6.

Note: This paper, prepared in April 2002, is not an official ethical statement of the Christian Medical Association but rather an informational resource. Nothing written here is to be construed as necessarily reflecting the views of the Emory School of Medicine or its affiliates.

One Hospital's Ministry when a Preborn Child Dies

By Rhonda Lindamood and Cleo Williams

Perinatal loss involves the loss of an infant through miscarriage, ectopic pregnancy, or stillbirth. Any one of these leaves unexpectedly placed parents in a state of bereavement. In the past, parents were often not allowed a

time to experience grief. With the support of healthcare providers, this philosophy is changing and families are beginning to get the support they need to address the loss of their child.

Not so long ago, parents were discouraged from even viewing or being with their deceased infant. In society's attempt to get back to "normal" the entire pregnancy, stillbirth or miscarriage would somehow be brushed over in conversation. Comments like "the baby was never really part of the family," or "you're lucky you didn't really know the child" were meant to help the parents get over the loss. But in reality, parents were often left with guilt feelings like, "How could I have prevented this?" or "What did I do wrong?"

Obstetric nurses and caregivers have the great privilege of experiencing the joy and excitement families feel when a new life comes into the world. Unfortunately, not every delivery has a positive outcome. When the joy of birth is unexpectedly gone, caregivers also should be there to help the family process the loss and recover. That is the mission and vision undertaken by one medical center group.

In an evolution of caring for patients and families going through perinatal loss, the Mother/Baby Unit at Carilion New River Valley Medical Center (CNRV) near Radford, Virginia, began a nurturing support and resource support program for families with a focus on the long-term health and wellbeing of mothers.

Our ministry began in 1989 when Vi Gaylean, LPN, expressed her concern about the lack of perinatal grief support to the director of the CNRV mother/baby unit, Cleo Williams, RNC. Together they sought resources for education about perinatal loss.

They were not alone. In other areas of the country, training sessions for support counselors were beginning. Literature for counselors and for grieving parents was being developed where in the past there was none.

Cleo Williams, RNC, is director of the Carilion New River Valley Hospital, Radford, VA, Mother/Baby unit. Rhonda Lindamood, RN II is coordinator/counselor.

Williams was the first person from CNRV to attend a perinatal grief counselor training conference. On her return, she and Gaylean joined forces with other nurses who also felt the need to make a change in the way fetal loss was handled on a personal and professional level.

"We wanted to do more," said Williams. " We wanted to make a difference." With those thoughts, the five-member grief support group created a rich and rewarding Perinatal Loss Program that preserves as many memories for the parents as possible and helps them through the grief process. No longer would their lost children be forgotten.

One of the first gestures the group initiated was a small wreath of blue forget-me-nots placed on the patient's door to remind the healthcare staff, laboratory and food service personnel that this family has suffered a loss.

A brochure was developed for the patient that explains the support resources available. A member of the grief support group goes over this with the patient at an appropriate time.

Mothers are offered the opportunity to transfer to another unit. Some stay in the birthing unit in honor of being a mother, others choose to leave the sights and sounds of the unit. The staff respects both decisions.

The steps ahead are often unsteady. The arrangements to be made can be overwhelming for any family. The mother/baby staff nurse will talk with the patient and family, offering support and assistance in notifying clergy, funeral homes and others designated by the family. For very small infants, burial cradles are supplied by the hospital as needed. Some funeral homes and cemeteries in our town provide free burial services.

Mothers sometimes state their desire to "write everything down" so they don't forget their experience. The staff recognizes this need and provides a special memory book. Journaling is encouraged for the days and weeks that lie ahead. In six months, reflecting back, the mother will see how far she has come in the grief process.

As word of the grief support program spread into the community, a grandmother expressed her wishes to make small quilts in memory of her grandchildren who died. A nurse, Sally Simpkins, volunteered her sewing talents making white eyelet memory cases, smocked gowns of all sizes and blankets for the deceased infants and families.

A baby ring is tied to a tiny heart shaped pillow and given to all mothers.

Special photos of the infant are taken. Often the smocked gown, blanket and ring pillow are used for these pictures. For the infant photo an entire roll is used. The staff works with the developer to protect the family's privacy. When the photos are ready, they are placed in a small album for the parents. Parents may take the album home, or if they may not wish to have them at this time, CNRV mother/baby unit keeps the album on file.

Other items offered to grieving mothers include, baby bonnets lovingly hand-stitched by Virginia Absher, the 85 year-old mother of a staff member; a foot print card; a lock

of hair (if possible); a certificate of blessing and a hand written sympathy note from the nurse caring for the patient.

The caring support of the CNRV Mother/Baby Unit does not stop when the grieving family leaves the medical center. Support group meetings are held monthly by trained grief support counselors. Literature, seminars and conferences for parents of infant loss are available. Follow-up calls are also made to the family during the year. And each spring and winter the staff holds memorial services for the families to offer opportunities for remembrance.

A mother never forgets, says Rhonda Lindamood, RN II, grief support counselor. Her life will go on, she notes, but she always carries thoughts of the small one that never was. "For two years a mother came to our support group with photos of her infant daughter. One night she was in turmoil, needing reassurance that she was really a mother even if her infant daughter was only 28 weeks along in the gestation period. Were her feelings valid? I gave her that assurance. She left relieved of her anguish and sorrow. I heard from her again around the infant's birthday, she was making sure we still met on Thursdays. I thought I'd see her. She didn't show … but I think she just needed a connection, she needed to know we were still here, that we still cared."

In March, 2003, a conference "Sharing With Care…A Recipe for Comfort and Support," was organized by Lindamood and Williams in an effort to increase knowledge of available support for perinatal loss. Invitations were extended throughout the region to area clergy, caregivers, and persons who offer support to families during this time of sorrow. Speakers included nurses, support counselors, clergy, and physicians … offering a positive presentation of how care may be enhanced and continuous. The conference was offered as the group's first Sharing Day and they plan to repeat it annually.

From this one caring group of nurses, the Perinatal Loss Program has spread throughout the Carilion Health System, which serves nearly 2 million people in 10 counties of southwest Virginia. If you would like more information on this program, contact Cleo Williams, CNRV women's services director, at 540-731-2251.

A Worship Service for Families Who Have Lost a Preborn Child

By Susan Cyre

Several years ago, Christine Shaw, the founder and director of Pregnancy Loss Recovery Assistance in Pittsburgh, said to me, "The reason abortion is so prevalent in this country is that the Church has never treated unborn children as unborn children." Her words were shocking. As I reflected on them, however, I concluded that they were also true.

One hospital chaplain observed that clergy feel much less urgency to go to the hospital and minister to the parents in the loss of a preborn child resulting from a miscarriage than in the loss of a full-term child.

Often families receive no church family support because they have not told family and friends about the pregnancy. Parents are often discouraged from having a memorial service. The costs of funeral homes and burials may dissuade them from burying the child and so they may opt for hospital cremation. The family may leave the hospital and find that pastoral care is totally absent or minimal, no one knows about their loss so family and friends offer little support, a worship service which witnesses to the resurrection and gives thanks for this child's life doesn't happen, and there is no committal service.

Parents are left to suffer alone with little support either from the medical community or the church. That is changing, however. As the previous article by Cleo Williams and Rhonda Lindamood describes, some hospitals are beginning to help parents celebrate and acknowledge their child's life however brief it was. Pastors and churches are beginning to respond with pastoral ministry including memorial services.

Our congregation has begun to offer semi-annual memorial services (always the 4th Sunday of April and

October) for families who have lost a child before or after birth. We have partnered with three area hospitals that tell families about our service when they lose a child.

Still, the service has not been well attended. When I ask mothers who lost children 50 years ago, why they have not come to the service, they tell me, "Because it's too painful to open old wounds." The language of "opening old wounds" perhaps is an indication that the wounds have never healed. For too long the attitude in the culture and church has been that the miscarriage was not really a child and parents should just move beyond the event as quickly as possible—"put it all behind them." Those parents have been denied the hope of the resurrection for their child. They have not been able to grieve or to receive God's assurance in the midst of their grief. The Church's historic failure to minister to families that have lost a child before birth has left generations of families who continue to need the ministry of the church in order to celebrate the lives of their children and to affirm God's loving care for them throughout eternity.

Here's our worship service:

Worship Service to
Celebrate the Resurrection of Jesus Christ and
Give Thanks for the Life of our Preborn Children

Prelude:
Call to Worship: Romans 6:23, John 11: 25-26
Prayer of Invocation:
Hymn: *Great is Thy Faithfulness*
Old Testament: Psalm 139: 1-18
New Testament: Revelation 21:1-6
Personal Testimony:
Gospel: John 11: 17-45
Meditation: *I Have Called You By Name You are Mine*
Litany: (from Falling Spring Presbyterian Church, Chambersburg, PA, used with permission)

Blessed Jesus, lover of children in lowliness of heart we cry to you for help. Expecting the life of a child, we have witnessed its death. Our despair is profound, and we know you weep with us in our loss. Help us to hear your consoling voice.

Pour out upon us your gracious healing.

Life-giving God, your love surrounded each of us in our mother's wombs, and from that secret place you called us forth to life. Our hearts are heavy with the loss of promise. We grieve the death of the hope we anticipated, the dreams we envisioned, the relationship we desired.

Pour out upon us your gracious healing.

All-loving and caring God, Father of us all, you know our grief in our loss, for you too suffered the death of your child. Give us strength to go forward from this day, trusting where we do not understand, that your love never ends.

Pour out upon us your gracious healing

Give us the courage to admit our pain and confusion. Allow us to grieve, and then to accept this loss. Warm is the embrace of your arms. Knit together our frayed emotions, and bind our hearts with the fabric of your love for us.

Pour out upon us your gracious healing.

Sometimes the burdens of life almost overwhelm us; yet, we put our full trust in you, knowing that through your Son Jesus Christ, you are with us always. Let not our limited understanding confine our faith, but may our faith be renewed in the days ahead. Draw us closer to you and closer to one another.

Pour out upon us your gracious healing.

Help us to accept what we cannot understand, to have faith where reason fails, to have courage in the midst of disappointment. Help us to see the hope of life beyond grief. Let us feel that presence now as we seek to live in faith.

Pour out upon us your gracious healing.

We thank you for the life and hope that you give through the resurrection of your Son Jesus Christ. Keep true in us the love with which we hold one another. And to you, with your Church on earth and in heaven, we offer honor and praise, now and forever.

Our God, we give you praise. Amen.

Lighting of Candles and Writing of Prayer

(we invite people to come forward and light a votive candle from the Christ candle and if they chose to name their child and say a word about the child)

Special Music:
Prayer:
Hymn: *Jesus Loves Me This I Know*
Benediction:
Postlude:

A bulletin insert invites parents to name their child and give thanks to God for the gift of their child.

Susan Cyre is pastor of Dublin Presbyterian Church, Dublin, VA and executive director of PFFM.

Life: Defining the Begin

By Maureen L. C

Reprinted with permission from *First Things* Journal, May, 2003, pp 50-54.

What defines the beginning of human life? This question has been the topic of considerable legal and social debate over the years since the Supreme Court's *Roe v. Wade* decision—debate that has only been intensified by the recent controversies over human embryonic stem cells and human cloning. Answers to this question run the full gamut from those who argue that life begins at conception (The view of more than one major world religion) to those arguing that babies are not to be considered fully human until a month after birth (the position of Princeton Professor of Bioethics Peter Singer).

The range of dissent and disagreement on the question of when human life begins has led many to believe it cannot be reasonably resolved in a pluralistic society. Courts have ruled that the diversity of opinion on the topic precludes a judicial resolution, requiring instead that the matter be addressed in the political arena, where accommodation of divergent views can be wrought through debate and compromise. Many Americans appear equally unwilling to impose a single interpretation on society, preferring instead to allow decisions regarding the beginning of life to be largely a matter of personal choice.

While reluctance to impose a personal view on others is deeply ingrained in American society, one must question the legitimacy of such reluctance when the topic of our "imposition" is a matter (quite literally) of life and death. Few beyond the irrationally obdurate would maintain that human embryos are anything other than biologically Homo sapiens and alive, even at the earliest developmental stages. Equally few would contest the fact that, at early stages of embryonic development, human embryos bear little resemblance to anything we easily identify as "human." For most people, reconciling these two facts involves the uncomfortably fuzzy process of drawing a line somewhere during the continuously changing process of human prenatal development and asserting: "There. That's when human life begins—at least for me." It is precisely the subjectivity and inaccuracy of this decision that fuels our discomfort at "imposing" it on others.

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In contrast to the widespread disagreement over when human life begins, there is a broad social and legal consensus regarding when human life ends. Rarely has the point been made that the definition of human death can be applied to the question of when life commences with compelling symmetry. The definition of when life ends is both scientific and objective, and does not depend on personal belief or moral viewpoint. The current medical and legal understanding of death unambiguously defines both when human life ends and when it begins in a manner that is widely accepted and consistent with the legal and moral status of human beings at all stages of life.

Death is something most people readily recognize when they see it. People express very little confusion about the difference between a living person and a corpse. Surprisingly, however the distinction is not as clear from a medical and scientific perspective. There is very little biologic difference between a living person in the instant before death and the body of that person an instant after death. Yet some property has clearly departed from the body in death, and that property is precisely the element that defines "human life." What, then, is the difference between live persons and dead ones? How is death defined medically and scientifically?

The question of when and under precisely what conditions people are viewed as "dead" has itself been the subject of considerable debate. Traditionally, the medical profession considered a person dead when his heart stopped beating—a condition that rapidly results in the death of the cells of the body due to loss of blood flow. As the life-saving potential of organ transplants became increasingly apparent in the 1960s, the medical community undertook a reexamination of the medical standards for death. Waiting until the heart stops beating results in considerable damage to otherwise transplantable organs. After a long and contentious debate, a new standard of death was proposed in 1968 that defined "brain death" as the critical difference between living persons and corpses, a standard that is now widely (although not universally) accepted throughout the world.

Brain death occurs when there has been irreversible damage to the brain, resulting in a complete and permanent failure of brain function. Following the death of the brain, the person stops thinking, sensing, moving, breathing, or performing any other function, although many of the cells in the brain remain "alive" following loss of brain function. The heart can continue to beat spontaneously for some time following death of the brain (even hearts that have been entirely removed from the body will continue to beat for a surprisingly long period), but eventually the heart ceases to function due to loss of oxygen. The advantage of brain death as a legal and medical definition for the end of life is that the quality of organs for transplant can be maintained by maintaining artificial respiration. So long as oxygen is artificially supplied, the heart will continue to beat and the other organs of the body will be maintained in the same state they were prior to death of the brain.

Defining death as the irreversible loss of brain function remains for some a controversial decision. The fact that the cells and organs of the body can be maintained after the death of the individual is a disturbing concept. The feeling that corpses are being kept artificially "alive" as medical zombies for the convenient culture of transplantable organs can be quite discomforting, especially when the body in question is that of a loved one. Nonetheless, it is important to realize that this state of affairs is essentially no different from what occurs naturally following death by any means. On a cellular and molecular level, nothing changes in the instant of death.

Immediately following death, most of the cells in the body are still alive, and for a time at least, they continue to function normally. Maintaining heartbeat and artificial respiration simply extends this period of time. Once the "plug is pulled," and the corpse is left to its own devices, the cells and organs of the body undergo the same slow death by oxygen deprivation they would have experienced had medical science not intervened.

What has been lost at death is not merely the activity of the brain or the heart, but more importantly the ability of the body's parts (organs and cells) to function together as an integrated whole. Failure of a critical organ results in the breakdown of the body's overall coordinated activity, despite the continued normal function (or "life") of other organs. Although cells of the brain are still alive following brain death, they cease to work together in a coordinated manner to function as a brain should. Because the brain is not directing the lungs to contract, the heart is deprived of oxygen and stops beating. Subsequently, all of the organs that are dependent on the heart for blood flow cease to function as well. The order of events can vary considerably (The heart can cease to function, resulting in death of the brain, for example), but the net effect is the same. Death occurs when the body ceases to act in a coordinated manner to support the continued healthy function of all bodily organs. Cellular life may continue for some time following the loss of integrated bodily function, but once the ability to act in a coordinated manner has been lost, "life" cannot be restored to a corpse—no matter how "alive" the cells composing the body may yet be.

It is often asserted that the relevant feature of brain death is not the loss of integrated bodily function, but rather the loss of higher-order brain activities, including consciousness. However, this view does not reflect the current legal understanding of death. The inadequacy of equating death with the loss of cognitive function can be seen by considering the difference between brain death and "persistent vegetative state" or irreversible coma. Individuals who have entered a persistent vegetative state due to injury or disease have lost all higher brain functions and are incapable of consciousness. Nonetheless, integrated bodily function is maintained in these patients due to the continued activity of low-order brain centers. Although such patients are clearly in a lamentable medical state, they are also clearly alive; converting such patients into corpses requires some form of euthanasia.

Despite considerable pressure from the medical community to define persistent vegetative state as a type of brain death (a definition that would both expand the pool of organ donors and eliminate the high medical costs associated with maintaining people in this condition), the courts have repeatedly refused to support persistent vegetative state as a legal definition of death. People whose bodies continue to function in an integrated manner are legally and medically alive, despite their limited (or absent) mental function. Regardless of how one may view the desirability of maintaining patients in a persistent vegetative state (this being an entirely distinct moral and legal question), there is unanimous agreement that such patients are not yet corpses. Even those who advocate the withdrawal of food and water from patients in persistent vegetative state couch their position in terms of the "right to die," fully acknowledging that such patients are indeed "alive." While the issues surrounding persistent vegetative state are both myriad and complex, the import of this condition for understanding the relationship between mental function and death is clear: the loss of integrated bodily function, not the loss of higher mental ability, is the defining legal characteristic of death.

What does the nature of death tell us about the nature of human life? The medical and legal definition of death draws a clear distinction between living cells and living organisms. Organisms are living beings composed of parts that have separate but mutually dependent functions. While organisms are made of living cells, living cells themselves do not necessarily constitute an organism. The critical difference between a collection of cells and a living organism is the ability of an organism to act in a coordinated manner for the continued health and maintenance of the body as a whole. It is precisely this ability that breaks down at the moment of death, however death might occur. Dead bodies may have plenty of live cells, but their cells no longer function together in a coordinated manner. We can take living organs and cells from dead people for transplant to patients without a breach of ethics precisely because corpses are no longer living human beings. Human life is defined by the ability to function in an integrated whole—not by the mere presence of living human cells.

What does the nature of death tell us about the *beginning* of human life? From the earliest stages of development, human embryos clearly function as organisms. Embryos are not merely collections of human cells, but living creatures with all the properties that define an organism as distinct from a group of cells; embryos are capable of growing, maturing, maintaining a physiologic balance between various organ systems, adapting to changing circumstances, and repairing injury. Mere groups of human cells do nothing like this under any circumstances. The embryo generates and organizes distinct tissues that function in a coordinated manner to maintain the continued growth and health of the developing body. Even within the fertilized egg itself there are distinct "parts" that must work together—specialized regions of cytoplasm that will give rise to unique derivatives once the fertilized egg divides into separate cells. Embryos are in full possession of the very characteristic that distinguishes a living human being from a dead one: the ability of all cells in the body to function together as an organism, with all parts acting in an integrated manner for the continued life and health of the body as a whole.

Linking human status to the nature of developing embryos is neither subjective nor open to personal opinion. Human embryos are living human beings precisely because they possess the single defining feature of human life that is lost in the moment of death—the ability to function as a

coordinated organism rather than merely as a group of living human cells.

What are the advantages of defining the beginning of human life in the same manner that we define its end, based on the integrated organismal function of human beings? To address this question, the alternative arguments regarding when life begins must be briefly considered. While at first inspection, there appear to be many divergent opinions regarding when human life commences, the common arguments are only of three general types: arguments from form, arguments from ability, and arguments from preference. The subjective and arbitrary nature of these arguments stands in stark contrast to the objective and unambiguous definition that organismal function provides for both the beginning and end of human life.

Of all the arguments regarding when human life begins, the most basic, and perhaps most intuitive, is that to be human, one must look human. Early human embryos are often described as "merely a ball of cells," and for many, it is difficult to imagine that something that looks more like a bag of marbles than a baby could possibly be a human being. Fundamentally, this argument asserts that human life is worthy of respect depending on appearance. When plainly stated, this conclusion is quite disturbing and also quite problematic. What level of malformation are we willing to accept before we revoke the right to continued existence? How are we to view children whose mature form will not be completely manifest until puberty? Form alone is a profoundly trivial and capricious basis for assigning human worth, and one that cannot be applied without considerable and obvious injustice.

The superficiality of equating worth with form is sufficient for most to reject this argument and retreat to a functional definition: form per se is not the issue; rather, it is the ability to function as a human being that defines the beginning of human life. Human beings are capable of a number of distinctive functions (self-awareness, reason, language, and so forth) that are acquired gradually over prenatal life as development proceeds. Therefore, the argument goes, human worth is also gradually acquired, with early embryos being less human than more developed fetuses.

A number of seemingly independent arguments regarding when life begins are in fact variations on this argument from ability. Thus, the proposal that human life begins when the fetus becomes "viable," or capable of surviving outside of the womb, is a subset of the ability argument that gives conclusive weight to the suite of abilities required for survival independent of the mother. Similarly, the common argument that embryos are human when they are in the womb of the mother (where they can develop into babies), while embryos generated in the laboratory are not, is also a variation on the ability argument that equates developmental ability with human life and worth.

While the argument from ability is less superficial than the argument from form alone, it is no less problematic. As noted above, functional definitions have been repeatedly rejected as a legal basis for the definition of death, in part due to their arbitrary nature. One can certainly identify any number of elderly and disabled people who are less functionally adept than newborn infants—and perhaps even late-term fetuses. While Western culture has a strong tradition of meritocracy, providing greater economic and social rewards to those who demonstrate greater achievement, basic human rights are not meted out according to performance. Unless we are willing to assign "personhood" proportionate to ability (young children, for example, might be only 20 percent human, while people with myopia 95 percent), the limited abilities of prenatal humans are irrelevant to their status as human beings.

The final and perhaps the most emotionally compelling argument for assigning human status to a developing embryo is the extent to which parents desire a child. Yet the argument from being wanted, which equates status as a human being with the desire of a second party who has the power to confer or deny that status, essentially reduces the definition of a human being to a matter of preference. You are human because I choose to view you that way. The fact that human status can be positively conferred for "wanted" embryos as well as denied for the "unwanted" illustrates the fundamental arbitrariness of this argument. The preferences of individuals who possess the power to impose them on others are hardly a compelling basis for legislation on human life.

Despite the apparent diversity of views regarding when human life begins, the common arguments thus reduce to three general classes (form, ability, and preference), all of which are highly subjective and impossible to reconcile with our current legal and moral view of postnatal human worth. It is, in fact, the subjectivity and inconsistency of these views, rather than their diversity, that makes them so unsatisfying as a basis for legislation on human life.

Unlike other definitions, understanding human life to be an intrinsic property of human organisms does not require subjective judgments regarding "quality of life" or relative worth. A definition based on the organismal nature of human beings acknowledges that individuals with differing appearance, ability, and "desirability" are, nonetheless, equally human. It is precisely the objective nature of such a definition (compared to vague "quality of life" assessments) that has made organismal function so compelling a basis for the legal definition of death.

Once the nature of human beings as organisms has been abandoned as the basis for assigning legal personhood, it is difficult to propose an alternative definition that could not be used to deny humanity to virtually anyone. Arguments that deny human status to embryos based on form, ability, or choice can be readily turned against adult humans who have imperfect form, limited ability, or who simply constitute an inconvenience to more powerful individuals or groups. Indeed, such arguments can be

quite protean in their ability to deny rights to anyone not meeting an arbitrary criterion for humanity. Abraham Lincoln made this very point regarding arguments based on form, ability, and choice that were put forth in his day to justify the institution of slavery:

> It is *color*, then; the lighter having the right to enslave the darker? Take care. By this rule, you are to be slave to the first man you meet with a fairer skin than your own.
>
> You do not mean color exactly? You mean the whites are *intellectually* the superiors of the blacks, and, therefore, have the right to enslave them? Take care again. By this rule, you are to be slave to the first man you meet with an intellect superior to your own.
>
> But, say you, it is a question of *interest*; and, if you can make it your interest, you have the right to enslave another. Very well. And if he can make it his interest, he has the right to enslave you.

Postnatal humans run very little risk that embryos will someday organize politically to impose restrictions on the rights of "the born." However, once society has accepted a particular justification for denying rights to one class of individuals, the same justification can readily be applied to other classes by appealing to the simple argument: "Society has already determined that form, ability, or preference defines human life and thereby restricts human rights. Why should the same standard not be applied in this case?" In American society and jurisprudence, arguments from accepted precedent carry great emotional and legal force. Society must determine whether it is willing to accept the current subjective and arbitrary basis for determining the status of prenatal human beings as a legitimate precedent for future legislation on human rights.

Embryos are genetically unique human organisms, fully possessing the integrated biologic function that defines human life at all stages of development, continuing throughout adulthood until death. The ability to act as an integrated whole is the only function that departs from our bodies in the moment of death, and is therefore the defining characteristic of "human life." This definition does not depend on religious belief or subjective judgment. From the landmark case of Karen Ann Quinlan (1976) on, the courts have consistently upheld organismal function as the legal definition of human life. Failure to apply the same standard that so clearly defines the end of human life to its beginning is both inconsistent and unwarranted.

The conclusion that human life is defined by integrated (organismal) function has wide-reaching implications, both political and moral. While the public domain has limited authority to promote morality, it does have both the power and the responsibility to prevent harm to individuals. A consistent definition of what constitutes human life, both at its beginning and at its end, requires that current legislation dealing with prenatal human life be considered in light of both biological fact and accepted legal precedent regarding the definition of human life. If current legislation enables and supports the killing of human begins based on a scientifically flawed understanding of human life, laws can and should be revised. Clearly, such a revision would not be without political cost. Yet allowing life-or-death decisions to be based on arbitrary or capricious definitions is also a course of action that is not without considerable social and moral cost.

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Study of the Heidelberg Catechism

Study 1: Introduction

by Rev. Dr. Stephen Eyre, College Hill Presbyterian Church, Cincinnati, OH

As a pastor I find, more than in any time since I can remember, people are ill-at-ease, suspicious and easily unsettled. There are many reasons for this I suppose. The world is changing. The average person sitting in our pews might not be able to say what's bothering him. In one sense the changes are bigger than we can see, but we can feel that something is not right. The newsworthy events that we can see merely confirm and enhance our anxiety; The threat of terrorism, the war with Iraq and the instability of the financial markets …. On the day the Columbia Space Shuttle disintegrated I had a chill down my spine and a sensation that some unknown danger was stalking me.

In such times of anxiety and uncertainty I am looking for ways to encourage confidence in God and comfort for troubled hearts. I turn first to the Scriptures. "Jesus said, "Don't let your hearts be troubled. Trust in God, trust also in me" John 14:1. I turn also to the riches of Christian history: I find great confidence knowing that through each of the shifting epochs for the past 2,000 years, God's people have not only survived, but thrived. And I turn to the riches of Christian teaching: the Church has always found ways to teach God's truth in order to meet the challenges of the changing times.

In looking for ways to encourage comfort and assurance, I am especially attracted to the teaching of the Heidelberg Catechism. Written in Heidelberg, Germany, primarily as a guide for the instruction of children in the Reformed Protestant movement in 1563, it has served as a spiritual guide for generations of Reformed Christians. It has been most widely embraced by Reformed Christians of Dutch descent. However it deserves a much wider use. It is part of the PC(USA) Constitution found in the *Book of Confessions.*

The famous first question of the Heidelberg Catechism asks, *"What is my only comfort in life and in death?"* The answer it gives was sufficient for the times in which it was written and it is sufficient for us as well. "*That I belong—body and soul, in life and in death—not to myself but to my faithful Savior, Jesus Christ, who at the cost of his own blood has fully paid for all my sins and has completely freed me from the dominion of the devil; that he protects me so well that without the will of my Father in heaven not a hair can fall from my head; indeed, that*

everything must fit his purpose for my salvation. Therefore, by his Holy Spirit, he also assures me of eternal life, and makes me wholeheartedly willing and ready from now to live for him."

The Problem Of The Catechism
History And Culture

The comfort offered by the Heidelberg is sufficient for us … almost. It was written in a time when Christendom held sway. God, sin, heaven, hell, angels and demons were part of the fabric of life. In the 21st Century, a sweeping process of secularization has resulted in God and a Christian understanding of life exiled from the center of society to its edges. Likewise, God and things Christian have been moved to the edges of our minds. Similarly, instructional methods like a catechism were "normal." Today, however, people are inclined to overlook the riches of the Heidelberg because it seems "canned" and "formal." The result is that comfort offered in the Heidelberg requires some work on our part if its teaching is going to touch our hearts. In this introductory study and the ones to follow, we will seek to penetrate its comforting truths.

The Point Of The Catechism
Saving Sovereignty Of God

Central to the Reformed understanding of life is the sovereignty of God. Many have taken the doctrine of the sovereignty of God to be a cold hard doctrine that heartlessly assigned people to hell. In the first question of the Heidelberg we see the pastoral intent of caring warmth that the Reformers intended—the "saving sovereignty" of God. The good news at the heart of the Catechism is that nothing is beyond his caring providential control, "*... all things must fit his purpose for my salvation*."

The Structure Of The Catechism

The Catechism has 129 questions. For the sake of instruction, since its third edition it was divided into 52 sections so that it could be preached and taught in a yearly cycle. The second question lays out the internal structure of the Catechism. *"How many things must you know, that you may live and die in the blessedness of this comfort?"* The answer: *"Three. First, the greatness of my sin and wretchedness. Second, how I am freed from all my sins and their wretched consequences. Third, what gratitude I owe to God for such redemption."*

The knowledge of sin is developed in the first and shortest of the three sections. It contains 13 questions and is to be taught over three weeks. The second section, the longest, explores how we are delivered from our sin. It contains 65 questions and is to be taught over 26 weeks. The third section explores how we are to be thankful to God for his deliverance. It has 34 questions and is to be taught over 20 weeks. Central to the Catechism are the traditional elements of basic instruction used in other catechisms, the Apostle's Creed, the Ten Commandments and the Lord's Prayer.

The Structure Of This Study

This article is the first in a series of studies for *Theology Matters* that will explore the Heidelberg Catechism. The series is designed to have a total of fifteen installments and will follow the outline below:

1 Preamble Lord's Day 1 (2 questions)

THE KNOWLEDGE OF SIN AND MISERY
Lord's Day 2-4 3 weeks
2. The Knowledge of Sin (13 questions)

THE KNOWLEDGE OF DELIVERANCE
Lord's Day 5-31 26 weeks
3. The Nature of our Redeemer (5 questions)
4 The Content of the Christian Faith (4 questions)
5. God the Father (4 questions)
6. God the Son (24 questions)
7. God the Spirit (7 questions)
8 The Gift of Righteousness (6 questions)
9. The Sacraments (3 questions)
10. Baptism (6 questions)
11. The Lord's Supper (9 questions)
12 The Keys of the Kingdom (3 questions)

GRATITUDE Lord's Day 32-52 20 weeks
13. Good Works (6 questions)
14. The Law of God (24 questions)
15. True Prayer (14 questions)

A brief moment's reflection on the preceding outline leads to the insight that, while not an exhaustive exploration of the themes of classic Reformed theology, it addresses the essential ones.

Questions For Discussion

In addition to introductory commentary the studies in the coming months will include questions intended for personal reflection or group discussion.

1. What is your own personal sense of anxiety and where do you sense a need for comfort?
2. How does the first question of the Heidelberg Catechism address our current need for comfort?
3. The first question of the Heidelberg Catechism is a concise summary of the Christian Faith. What essential truths does it touch on?
4. How would you describe the character of God from just reflecting on questions 1 and 2?
5. Question 2 is an outline of the Heidelberg Catechism. What questions and expectations come to mind as you prepare to study it?
6. Isaiah 40 provides a scriptural background for the Catechism. Read through the chapter looking for ways in which the prophet proclaims the comforting sovereignty of God as Israel was held captive by the superpower Babylon.
7. In times of uncertainty we are tempted to feel like God is standing at a distance. How does Isaiah 40:27-31 speak to our anxiety?
8. Chapter 40:1-3 begins "Comfort, comfort my people says your God." What parallels can you find between these verses and the first two questions of the Heidelberg?

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The Rev. Dr. Kari McClellan is President of Presbyterians for Faith, Family and Ministry (PFFM). Rev. Susan Cyre is Executive Director and Editor of *Theology Matters*. The Board of Directors of PFFM includes 12 people, clergy and lay, women and men. PFFM is working to restore the strength and integrity of the PC(USA)'s witness to Jesus Christ as the only Lord and Savior, by helping Presbyterians develop a consistent Reformed Christian world view. *Theology Matters* is sent free to anyone who requests it.

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