Faith and Society Files: Created in God's image - Report

An ecumenical report, written in 2008 and supported by the Joint Public Issues Team, on contemporary challenges and principles relating to early human life. An accompanying study guide is also available.

CREATED IN GOD'S IMAGE
THE BACKGROUND TO THE REPORT

1 The origin of this report lies in a Notice of Motion on Early Human Life brought to the Methodist Conference in 2007 and referred to the Methodist Council:

> In the light of technological and medical developments in issues concerning early human life (including abortion, therapeutic cloning and pre-implantation genetic diagnosis) and the consequent changes in legislation in these areas, the Conference directs the Methodist Council to set up a Working Party to produce both a Report which will address the theological, ethical and social principles by which decision-making on such development is properly to be exercised, and to provide an accompanying study guide.

2 The Methodist Council agreed to appoint a working group to be supported throughout by the Joint Public Issues Team[1]. The Joint Public Issues Team obtained agreement from the Baptist Union of Great Britain and the United Reformed Church that such a piece of work was also a priority for them, and so should be undertaken jointly. As such the Working Group contains members of all three denominations and the report of the group is for the three traditions to be received, adopted or used in ways appropriate to each denomination. A variety of opinion, experience and expertise is represented in the group. The group has met on three occasions, one of those being a 24 hour residential meeting, and has communicated by email between meetings.

3 The terms of reference of the working group were as follows:

The working group shall:

a. consider the range of challenges arising from aspects of human life before birth, including but not limited to: abortion, therapeutic cloning, pre-implantation genetic diagnosis
b. review the historic positions of the various denominations on issues relating to the pre-birth period
c. identify current developments in scientific understanding and activity, and suggest responses to these developments
d. suggest ethical and theological principles to guide responses to future developments
e. resource the Joint Public Issues Team, during the life of the working group, in contributing to the political debate, whilst recognising the complexities of speaking on behalf of the Church
f. produce a study guide for church members available by June 2009, covering the issues involved

In respect of the Methodist Church:

g. make recommendations whether, in the light of such developments, the historic statements of the Methodist Church need to be re-visited
h. present a report to the Methodist Conference of 2008 to be discussed and received.

In respect of the Baptist Union of Great Britain and the United Reformed Church:

i. make appropriate reports to those denominations.

4 This report is appropriate for presentation to each contributing denomination. There are no recommendations contained within the report as our differing ecclesiologies must be respected. Where it is appropriate, recommendations are presented as an appendix to the report.

[1]The Joint Public Issues Team was established in autumn 2006 as a way of ensuring the Baptist Union of Great Britain, the Methodist Church and the United Reformed Church could work together effectively on issues of public policy. Members of staff of the three traditions work as a single team to priorities set by the Churches. The aim of the Joint Public Issues Team is to promote equality and justice by influencing those in power and energising and resourcing local congregations. For more information visit www.jointpublicissues.org.uk

CREATED IN GOD'S IMAGE:

AN ECUMENICAL REPORT ON CONTEMPORARY CHALLENGES AND PRINCIPLES RELATING TO EARLY HUMAN LIFE.

CONTENTS

INTRODUCTION

So God created humankind in his image,
In the image of God he created them;
Male and female he created them[2].

1. What does it mean to describe humankind as created in the image of God? If nothing else, it means that human beings have a distinctive relationship with God and the author of the first chapter of Genesis talks of God's blessing and commissioning of humankind in the context of that relationship. In this report it is argued that we are created in the image of the trinitarian God whose very being is relational. We are shaped and formed by the network of relationships in which we live and grow, a network that includes our relationship with God. Not all relationships are good or health-giving relationships. Authentic relationships are those in which we are respected as 'other' (that is to say as discrete individuals) and in which we are enabled to grow in relationship with God. From this understanding of God and human being it is possible to derive theological principles which guide us in our decision-making. These principles are summarised in the conclusion to the report.

2. The challenges arising from aspects of early human life are wide ranging and change fast. It is not possible to present a simple check-list against which decisions can be made. We cannot avoid the hard work of engaging with the issues on the basis of broad theological principles which are applied in the context of particular ethical models. It is hoped that the publication of a study guide in 2009 will help people to work at the issues and engage with the pastoral challenges and opportunities that arise.

TERMINOLOGY

3 Previous church reports and statements have referred to the embryo (more than 14 days after the egg is fertilised) and the pre-embryo (before 14 days). The term "embryo" is used in the UK, whilst the term "pre-embryo" is used in the US, though it has increasingly crept into UK usage. The Human Fertilisation and Embryology Authority (HFEA) chose to use the term "embryo" to cover all stages of development up to the eighth week after fertilisation when it is termed a fetus. The term "pre-embryo" is often used by those wishing to ascribe a different moral status to earlier stages of development, with the word "embryo" then used for later stages. The working party does not ascribe a different moral status to earlier stages of development and the term pre-embryo is not used in this report. The churches are generally in agreement that human status should be accorded to the embryo from the moment of fertilisation; the disagreement is about the nature of this status. A recent publication of the Church of Scotland makes a helpful distinction between 'absolute' and 'gradual' positions held in relation to the human status of the embryo[3]. According to the 'absolute' view, the human embryo has the status of a person from the moment of conception. This view means that from the moment of conception the embryo should be afforded the dignity, and given the protection that would be given to a fully formed child or adult. According to the 'gradualist' view, the process of fertilisation is regarded as one in a series of morally and theologically significant developments. The gradualist view is that the embryo has human status from the moment of fertilisation but not that it is to be accorded the same dignity and treatment as the fully formed child or adult[4]. The working party notes that within the Christian traditions, as within this working group, both the 'absolute' and 'gradualist' positions are represented.

4 The term `early human life' is used throughout the report to refer to life before birth. This form of words was preferred to 'pre-natal life' as there is no implication that such life would necessarily result in birth.

THE CONTEXT

A. Social and political

5 In this section of the report we examine briefly the context in which we have sought to identify the challenges and principles relating to early human life. An attempt is made to reflect the social and political context at the time of writing, whilst acknowledging that in this volatile field the debates are ongoing, research and development continues, and nothing remains the same for very long.

6 The current Abortion Act has been in place for 40 years, with just one amendment in that period reducing time limits from 28 weeks to 24 weeks. Whilst there have been sporadic attempts by individual MPs to change the legislation, there has not been any significant Government support for these. The last major review of issues of embryology and human fertilisation took place in the late 1980s, chaired by Baroness Warnock, and resulted in the legislation which put in place the regulatory body, the Human Fertilisation and Embryology Authority. After an apparently settled period the political horizon now appears to be one of flux. The Human Fertilisation and Embryology Bill before Parliament at the time of writing aims to bring the guidelines up to date and permits new types of research. The passage of the Bill may also enable proponents and opponents of abortion to amend the

[2] Genesis 1:27 (NRSV)
[3] Report of the Working Group on Embryo Research, Human Stem Cells and Cloned Embryos, Church of Scotland 2006, available at http://www.srtp.org.uk/ga06stem-full.doc
[4] the gradualist view is expressed in the Methodist report referenced later, *Status of the Unborn Human*.

current abortion law. Debates in this area have been heightened by the 40th anniversary of the Abortion Act and a high profile House of Commons Select Committee report into scientific developments relating to abortion[5].

7 Outside Parliament, early human life issues have proved increasingly controversial over the past few years. The debate over abortion has continued on a number of different fronts. In recent years the Archbishop of Canterbury and the Cardinal Archbishop of Westminster both called for an urgent review of the abortion law in advance of the 2005 election. A Church of England curate, the Revd Joanna Jepson, went to the High Court to try to block abortions for "trivial" disabilities such as cleft palate. The argument over the provision of "the morning after pill" to young women of school age caused a major debate in the Methodist Church. More recently, Amnesty International caused international controversy by supporting women's access to abortion as part of its campaign for human rights and against the use of rape as a weapon of torture. Growth in the use of IVF for infertility treatment in the UK is cited as the likely cause of a significant increase in multiple births between 1975 and 2005[6]. There has also been a rapid growth in research into, and claims for, stem cell therapies. Human embryos have increasingly become the subject of scientific research[7].

8 This has happened in the context of a growing exploitation by some sections of the media of public disquiet over scientific interference in that which is "natural". This is illustrated by the depiction of genetically modified foods in the media as "frankenfoods". Similarly, campaigns against the creation of cytoplasmic hybrids[8] for research have been accompanied by photomontages of creatures which are half-cow, half-human. Society is wrestling with scientific discoveries which are advancing faster than our ethical understanding, in the context of public opinion which is often ill-informed or scared. At the same time, the applications that might result from a particular line of research are not always evident when a research project begins. The distinction between the aims of a research programme and its, sometimes unexpected, results is an important one which is often not taken into account in public debate.

9 The social and political context is a rapidly changing one and consideration of the ethical dimension of the issues around early human life cannot take place outside the context in which we understand our relationships. The ethics of various medical and scientific procedures are strongly contested. Some would say that the sharp differences within public opinion demonstrate concerns about science leaping ahead of ethics, whereas others believe they highlight our scientific illiteracy.

B. The Churches

10 The Churches have been, and continue to be, involved in debate around these issues. A substantial amount of material has been published by the Churches and it is impossible to review it all in this report. There follows a brief survey of the historic positions of the denominations; this is not exhaustive, but rather indicative of the range of opinions held across and within a number of denominations on some issues as they are represented in formal statements, reports and discussion documents.

11 In 1990 The Methodist Conference received a report for discussion and comment entitled *Status of the Unborn Human*[9]. This comprehensive report contained a summary of the scientific background with reference to the techniques and treatments available. It also included sections dealing with the bases for moral decision-making and theological reflection. The significance to the unborn human (a term used to cover all the stages from fertilisation to birth) of being in a state of development, in the state of becoming a person and the significance of being human are all considered in the light of the scientific background and moral and theological principles. Finally, the report considers the implications of the status of the unborn human for decision-making in a number of situations (specifically abortion, issues associated with infertility and research on human embryos and fetuses) and the implications for pastoral care and public policy. *Status of the Unborn Human* draws on earlier Methodist reports including *A Methodist Statement on Abortion* (adopted by the Methodist Conference of 1976).

12 In 1977 The Church and Society Department of the United Reformed Church prepared a discussion paper on the issues surrounding abortion. In this paper facts and figures were presented, there was a brief review of the variety of Christian opinion, an introduction to some ethical considerations and a summary of the legal position at the time.

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[5] Scientific Developments Relating to the Abortion Act 1967, 12th Report of the Science and Technology Select Committee, October 2007. HC1045-I

6 Office for National Statistics, Social Trends No. 37 (2007). Available electronically at http://www.statistics.gov.uk/downloads/theme_social/Social_Trends37/Social_Trends_37.pdf

[7] Research is carefully monitored and can only take place for up to 14 days after fertilisation or until the development of the primitive streak, whichever is sooner. The development of the primitive streak occurs at the point where there is a distinction between the cells which will form the fetus and other cells.

[8] see paragraph 47 for definition of cytoplasmic hybrids.

[9] www.methodist.org.uk/downloads/pi_statusoftheunbornhuman_90.pdf

13 The reports referred to above are now out of date in terms of their reference to the medical and scientific context. This is inevitable given the speed of developments in research, clinical practice and in the social and political framework. It is particularly evident that reports, papers and official statements associated with the decade following the Abortion Act of 1967 contain language and cultural references that are no longer appropriate. This is true of *A Methodist Statement on Abortion* and for these reasons the working group recommends that a group should be appointed to reconsider that statement in the light of contemporary medical, social and scientific developments.

14 In October 2007 the Joint Public Issues Team published a briefing paper on abortion that explored some of the political, ethical and scientific issues around abortion in the UK[10]. The paper refers to the Abortion Act (1967), The Human Fertilisation and Embryology Act (1990) and the proposed Human Tissue and Embryos Bill[11]. It also summarises the positions of the three traditions (Baptist, Methodist and United Reformed) on abortion.

15 Two documents are of particular note from the Roman Catholic tradition. The papal encyclical *Evangelium Vitae* (1968) deals with 'The value and Inviolability of Human Life', focusing particularly on abortion and euthanasia. *Donum Vitae* (1987) concerns 'Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation'. *Donum Vitae* is not a papal encyclical but comes from the Congregation for the Doctrine of the Faith, and gives an official Roman Catholic position on matters including the dignity of the human embryo, prenatal diagnosis, embryo research, IVF to generate 'research embryos', embryo hybrids, and the various techniques and practices surrounding assisted reproduction. The Roman Catholic position may be summarised in the following quotation from *The Catechism of the Catholic Church* (1992), which quotes from *Donum Vitae*:

> The inalienable rights of the person must be recognised and respected by civil society and the political authority.
>
> These human rights depend neither on single individuals nor on parents; nor do they represent a concession made by the society and the state; they belong to human nature and are inherent in the persons by virtue of the creative act from which the person took his [sic] origin.
>
> Among such fundamental rights one should mention in this regard every human being's right to life ... from the moment of conception until death.

16 Of particular note from the Church of England are two publications from The Church of England General Synod Board for Social Responsibility: *Response to Warnock* (1984) and *Personal Origins* (1985). The Free Church Federal Council and the British Council of Churches published *Choices in Childlessness* (1982) which surveyed the issues surrounding childlessness and the options available at that time for those who wanted children.

17 Much of the material published since 2000 has been in response to calls for evidence and consultations by Government or statutory bodies. The Science, Religion and Technology Project of The Church of Scotland has published a number of papers relating to embryology and early human life. The most recent publication is the Report of the Working Group on Embryo Research, Human Stem Cells and Cloned Embryos[12], which was presented to the 2006 General Assembly. In the report there is detailed discussion of the scientific, moral and theological issues and reference to earlier reports. This report was the basis for the response of the Church of Scotland to the public consultation on the review of the Human Fertilisation and Embryology Act.

18 The Church of England has published responses to the HFEA consultation on hybrids and chimeras, the Donor Information Consultation (Department of Health), the House of Lords Select Committee on Stem Cell Research, the Human Fertilisation and Embryology Authority's consultation document on sex selection and to the call for evidence from the Joint Committee on the Draft Human Tissue and Embryology Bill. Additionally, in 2003, the Mission and Public Affairs Council produced *Embryo research: some Christian perspectives*. This builds on previous material to offer 'some reflections on the science, theology and morality of using human embryos for therapeutic research purposes'[13].

19 In December 2007 the Catholic Bishops Conference in England and Wales published a Parish Resource Pack for all those interested in an in depth briefing from a Catholic perspective on the Human Fertilisation and Embryology Bill including possible changes to the law on abortion[14]. The resource pack includes an introduction to the issues, summaries of the teaching of the Roman Catholic Church and detailed briefings on issues including hybrid embryos and abortion.

[10] Available from www.jointpublicissues.org.uk
[11] Subsequently renamed the Human Fertilisation and Embryology Bill.
[12] Summary report available at www.srtp.org.uk/ga06stem-sum.doc
[13] Mission and Public Affairs Council of the Church of England, *Embryo Research : Some Christian Perspectives* (2003), available at http://www.cofe.anglican.org/info/socialpublic/embryos_research_-_mpa_council.doc
[14] The pack can be found at cathoclicchurch.org.uk

20 Though the political, social and scientific context is continually changing there are certain principles and themes contained in these and other sources that remain important as we consider issues around human embryology and early human life. For example, the Christian traditions agree that human life exists from the moment of conception (though there are differing views as to the status of that life), that human beings exist in community, in relationship with one another and with God, and that the human response to God centres on God's love and requires a loving response to those around us. The principles that the working group has identified build on the work already done.

THE BIG ISSUES

21 The working group was asked to identify current developments in scientific understanding and activity and to suggest responses to these developments. Here, as in consideration of the social and political context, we have been very aware of the provisional nature of anything we report. There have been many developments and changes in clinical practice since Parliament last legislated on major aspects of human reproduction in 1990 and these developments continue apace. Within the short life of this working party a number of developments have occurred which might significantly change the way in which certain issues are approached. Recent reports indicate that some research groups have achieved the artificial production, of pluripotent stem cells, or cells which might be grown into multiple types of human cells, from human skin rather than from embryos[15]. This has provoked some debate on the need for continued research in human embryonic stem cells, particularly amongst those who oppose such research[16]. Further, press reports of 'secret trials' of chemical abortions in 'non-traditional settings'[17] (such as GP surgeries) have fuelled concerns that there are hidden moves towards the increasing liberalisation of abortion practice. Against such a background of rapid change, it will be better to consider how we approach the issues rather than trying to make bold statements.

22 What follows is a succinct description of some aspects of the continuing "big issues" identified by the working group at the time of writing. In each case there is both a description of the clinical practice and an exploration of some of the issues involved for Christians. The issues identified are: abortion; assisted reproductive technologies (ART); pre-implantation genetic diagnosis (PGD); donation; and stem cell technologies. This is not an exhaustive list but is intended to represent important areas where there have been significant advances in technology or other changes since the publication of *Status of the Unborn Human* in 1990.

A. Abortion

23 It has been argued elsewhere that it is not possible to determine the moment when personhood begins in the developmental continuum of the embryo and fetus[18]. It has also been argued in *Status of the Unborn Human* and elsewhere that the embryo is, from the moment of fertilisation, to be afforded human status. As such the embryo exists, grows and develops in the context of a complex network of relationships. If we recognize the human status of the embryo and fetus, then the general guiding principle has to be established that abortion constitutes the ending of human life. In adults there are occasions when the ending of human life is seen as the lesser of two (or more) evils, and a blanket statement against abortion is difficult to maintain. Certainly, abortion should never be undertaken lightly or without proper consideration.

24 Illegal induced abortion was the major cause of death in pregnancy in England and Wales prior to the passing of the Abortion Act (1967). There are now virtually no maternal deaths attributable to abortion[19]. Increasingly, a woman's choice is to use a service that offers a drug treatment regime[20] before 7 to 9 weeks of pregnancy (medical abortion). To be able to access these services a woman needs to have an early diagnosis of pregnancy, to make a clear early decision about the fate of the pregnancy, to achieve referral through her GP to the appropriate provider and have an appointment in time. These criteria are often not met, resulting in her requesting abortion later in the pregnancy. There are fewer medical problems with an early abortion and there may be fewer long-term psychological problems. For those holding a gradualist view of the development of human life an earlier abortion is likely to be morally more acceptable. Some holding an absolute view might also be able to accept that, as a consequence of the reduced medical problems, where termination is to take place it is morally more acceptable that his happen earlier in pregnancy.

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[15] Takahashi, K., et al., Induction of Pluripotent Stem Cells from Adult Human Fibroblasts by Defined Factors. Cell, 2007. **131**: 861-872.
[16] *An inconvenient truth. Research on human embryonic stem cells must go on.* Nature, 2007. **450**: 585-586
[17] Coates, S., *Secret trial to let GPs carry out abortions* The Times, December 5, 2007
[18] E.g. *Status of the Unborn Human* 5.2.1
[19] The current maternal death rate from pregnancy is 13.95/100,000 and the current maternal death rate from abortion is 0.14/100,000 (295 and 3 respectively from 2,114,004 maternities, Lewis, G (ed) 2007. The Confidential Enquiry into Maternal and Child Health (CEMACH). *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005.* The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH. Vice Saving Mothers' Lives, Confidential Enquiry into Maternal and Child Health in the United Kingdom, 2003-5 www.cemach.org.uk)
[20] The two drugs used are: Mifepristone, which blocks the hormone support of the pregnancy, and subsequently a prostaglandin, orally or vaginally, which induces contractions of the uterus to expel the products of conception.

25 From 9-12 (and sometimes 14) weeks termination of pregnancy is usually by vacuum aspiration (surgical abortion) and beyond that usually a drug-induced procedure which requires the woman to go through labour. Pre-abortion counselling should always be offered, but many women are clear in their own minds and do not wish to take up that offer. Effective contraception is always offered after termination, but may not subsequently be used.

26 Most women that seek abortion do so by 12 weeks. Those seeking later abortions may do so because they are ambivalent about the pregnancy or have been given a late diagnosis of fetal abnormality. Women are routinely offered a blood test at about 16 weeks to identify those with offspring at high risk of Down syndrome and neural tube defects (eg spina bifida)[21], followed at about 20 weeks by an ultrasound examination to check that the organs are normal. Those in whom the blood test is positive are offered an amniocentesis – removal by needle and syringe of a small amount of the fluid that surrounds the fetus. Examination of this fluid and the cells within it normally show whether Down syndrome or neural tube defect is present. Other tests such as Chorionic Villus Sampling (CVS)[22] may take place at an earlier stage in order to test for a range of genetic abnormalities, although some women prefer not to undergo such invasive techniques, which carry a low risk (<2%) of precipitating miscarriage. Some time passes to allow for counselling and reflection, decision and organisation of any procedure, further extending the duration of pregnancy[23]. Discussions about the fate of the fetus in these circumstances are immensely difficult for all concerned.

27 Advances in neonatal paediatric care have reduced the gestational age (the length of time in the womb) at which a premature infant may survive. A baby's chance of survival rises dramatically from 24 weeks onwards, with the impairment rate falling as the gestational weeks increase[24].

28 British law permits abortion if two registered medical practitioners agree that at least one of the following conditions is met:

a. The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;

b. The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

c. The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman

d. The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing children of the family of the pregnant woman;

e. There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The law also permits *one* doctor to carry out an abortion in an emergency without seeking a colleague's agreement if the doctor finds it immediately necessary

f. To save the life of the pregnant woman; or

g. To prevent grave permanent injury to the physical or mental health of the pregnant woman.

29 Abortion facilities are offered in the NHS hospital sector, but increasing numbers of gynaecologists are opting out of providing these services on the grounds of conscience[25]. It is no longer permissible to enquire at interview about a candidate's views for appointment to a consultant post unless it has been specified in the job

[21] The triple test is offered to all women attending an antenatal clinic. It is a ratio of three substances in a blood sample: βhCG (βhuman chorionic gonadotrophin, the hormone of pregnancy produced by the placenta), oestriol (a hormone produced by the fetus and placenta together) and α fetoprotein (αFP, produced by the fetal liver and leaking out through the open spina bifida).The βhCG/oestriol provides a probability that the fetus has Down's syndrome. An increased risk, especially if the person is >35 years of age, would lead to the suggestion of having an amniocentesis to test directly the chromosomes from shed skin cells of the fetus. An alternative method is to measure nuchal translucency, an ultrasound assessment of the thickness of the skin at the back of the neck which is substantially increased in fetuses with Down's syndrome. A raised αFP concentration suggests that there has been leakage from the fetus's central nervous system through the defect in the skin of the back (spina bifida). This would be confirmed by ultrasound and may be so obvious that an amniocentesis is not necessary. It would also confirm anencephaly, where the whole of the cerebral cortex of the brain is missing, although this is dramatically seen on ultrasound. The latter is not compatible with life.

[22] For suspected major chromosomal abnormality, such as the markedly increased risk of Down syndrome in those > 39 years of age, a diagnosis may be made by testing some components of the placenta.

[23] In 2006 201,173 abortions were carried out in England and Wales, of which 193,737 were in residents. Of the latter, 2948 (1.5%) were at 20 weeks or beyond, including 136 (0.07%) at 24 weeks or beyond, Most if not all of these 136 were on the ground that the child was likely to suffer severe physical or mental handicap. *(Department of Health Statistical Bulletin: Abortion Statistics, England and Wales: 2006).*

[24] Larroque B, Ancel P-Y, Marret S, Marchand L, Andre M, Arnaud C, Pierrat V, Roze J-C, Messer J, Thiriez G, Burguet A, Picaud J-C, Breart G, Kaminski M for the EPIPAGE Study group Neurodevelop[ment disabilities and special care of 5-year-old children born before 33 weeks of gestation (the EPIPAGE study): a longitudinal cohort study (2008) Lancet **371**: 813-20. This is a study of 2901 live births between 22 and 32 completed weeks of gestation from 9 regions of France from January-December, 1997 with 77% follow up and a reference group of 667 children from the same regions born at 39-49 weeks of gestation and with 60% follow up assessed at 5 years of age. Disability was highest at 49% in children born at 24-28 weeks of gestation. Special health care resources were used by 42% of children born at 24-28 weeks of gestation. An earlier delivery is classed as a miscarriage. Under UK law the distinction between miscarriage and stillbirth applies at 24 weeks.

[25] Royal College of Obstetricians and Gynaecologists, 16 April, 2007 http://www.rcog.org.uk/index.asp?PageID=1918

description[26]. In order to cope with the demand, contracts to provide abortion services funded by the NHS are also given to charitable and private agencies. Services are also provided totally outside the NHS, potentially facilitating earlier access[27].

30 Pressure is increasing in some quarters to reduce the requirement for the signature of two doctors to just one, at least in the first 12 weeks of pregnancy. For example, the House of Commons Science and Technology Committee has recently advocated this and other changes to the law which would make it easier and less time-consuming to arrange an abortion and so facilitate termination in the first three months of pregnancy. These proposals are designed to benefit the woman in terms of her physical, mental and emotional well-being. Those holding a 'gradualist' view of the moral status of the fetus may support such measures. Others, however, may view such changes as an unacceptable reduction of protection for the fetus.

31 If cases arise where the continuation of a pregnancy is likely to cause the death of the woman then a very strong argument arises to allow abortion. This does not, of itself, suggest that the life of the woman has greater value, but simply that it is not reasonable to require an individual to risk her own life for another. In such a judgement the risks must be weighed carefully for in any pregnancy there is inherent risk to the woman and the simple existence of risk would not therefore be sufficient to justify an abortion. Similarly this line of thought challenges us to consider what constitutes sufficient risk in terms of the woman's mental health to justify the abortion of a fetus. There will be cases when an unplanned or unexpected pregnancy will cause distress. The difficulty lies in deciding what circumstances constitute a level of distress for the woman where the pastoral imperative is to terminate the pregnancy. These are not easy or clear cut issues. Christians will have different ethical responses, but are challenged to frame them within sensitive pastoral approaches.

32 Recent press reports of the ease with which (illegal) abortions can be obtained overseas on the grounds of the sex of the fetus[28] indicate that there is still significant cause for concern regarding social and cultural reasons for abortion. This is especially relevant when global travel is readily available. The ease of obtaining such treatment does not in any way give it validity. As we believe that all that men and women are equal before God, we cannot suggest that individuals have greater or lesser value because of their gender, and so cannot support the ending of a life on those grounds alone. Different considerations may apply to those cases where impairment might be the result of gender-related chromosomal abnormalities. Issues relating to impairment are discussed at a later stage in this report.

33 Over the last 40 years there has been significant progress in our ability to identify genetic disease *in utero* and even before implantation (in the case of embryos formed by *in vitro* fertilisation). Unfortunately this is not necessarily matched by our ability to treat such diseases. For many conditions, which can be diagnosed in the embryo or fetus, there is no effective treatment available and the result is that the advice normally received from medical staff in such circumstances recommends abortion as a 'treatment'. Anecdotal evidence suggests that it is often not fully conveyed to the mother prior to ante-natal testing that abortion could be the recommended outcome following the test. This means that mothers (the father has no consent status in this) may feel pressured to give consent to the test. Anecdotal evidence suggests that it can be very difficult for prospective parents to feel able to refuse such testing on the grounds that they do not wish to consider the option of abortion.

34 Once prenatal testing has identified a potential hazard or 'abnormality', a dilemma arises as to whether or not to abort the fetus. The decision is informed by what is considered 'normal' for a human being, and what is considered to be an unacceptably high level of suffering or impairment. There is evidence for a high incidence of spontaneous abortion of embryos with severe defects[29] but the working group do not believe that we can argue from this fact to an ethical statement that the abortion of an impaired embryo or fetus is automatically and on every occasion in accord with God's loving purpose. If we hold that all that is human is of special (intrinsic) value to God then no matter how 'abnormal' or impaired a baby is likely to be we must still uphold its basic status as a human being. This does not mean that we can ignore the likelihood of suffering, but that we should afford the fetus an appropriate level of care which may, or may not, result in birth. Opinions will differ as to the level of care appropriate for the fetus; some will want to say that it should be the same as would be offered in later life; others that the intensity of suffering changes the parameters for decision making pre-birth [or something similar, just thought there needed to be on one hand/one the other]. It must be acknowledged that the appropriate level of care, at any stage of life, is not an absolute measure but is determined in relation to medical, social, economic and other factors affecting each individual.

[26] The National Health Service (Appointment of Consultants) Regulations, Good Practice Guidance Item 6.4 Jan 2005 .
[27] In 2006, among abortions up to 12 weeks in residents of England and Wales, 40% took place in NHS premises, 46% in other agencies for the NHS, and 14% outside the NHS. For abortions after 12 weeks, the figures were 29%, 63% and 8% respectively.
[28] Rose, D.,` British Asians aborting unwanted girls', *The Times,* 3 December 2007
[29] Hassold, T, Hall, H & Hunt P The origin of aneuploidy: where have we been and where are we going *Human Molecular Genetics* 16: R203-8, 2007

35 This leads us to an area of concern that has wider implications. It can be argued that there is a discrepancy between current attitudes to disability discrimination and medical advice to abort a genetically 'flawed' fetus based on the outcome of diagnostic testing. Rightly, legislation is now in force in the UK to prevent discrimination against individuals with physical or mental impairment. This move towards affirming the rights of those with impairment after birth does not seem to extend to the fetus before birth. In discussions regarding the potential 'quality of life' the fetus has no voice to speak for itself. We should not understate the real challenges that physical or mental impairment might entail, but we cannot suggest that such individuals are less beloved of God or of less value. Indeed the very notion of 'quality of life' is complex and fraught with difficulty. 'Quality' cannot be objectively assessed, and recognising the pressures, concerns and hardships that may face couples presented with news that their child may carry a serious impairment or genetic disease, the church needs to offer a sensitive and appropriate pastoral response, whatever their decision might be.

B. Assisted Reproductive Technologies (ART)

36 It is estimated that about 16% of the population is infertile, defined as taking more than 12 months to achieve a pregnancy with regular intercourse. Half of these patients are suitable for assisted conception using assisted reproductive technologies, including *in vitro* fertilisation (IVF) [30]. Some milder forms of infertility can use ovarian stimulation and intra-uterine insemination (IUI)[31], the more complex require IVF. Severe sperm problems require intracytoplasmic sperm injection (ICSI), where a single sperm is injected directly into a mature egg.

37 The fact that an IVF embryo is cultured in the laboratory for some days gives an opportunity to select the best embryos for transfer[32] or to take one or two cells from say, an 8 cell embryo, to analyse a number of its chromosomes. These analyses will only demonstrate abnormalities of specific chromosomes and the specific diseases associated with them; not all abnormalities or diseases are associated with gross chromosomal abnormality. It is also possible to identify the presence or absence of a specific disease if it is the result of a single gene defect (a monogenic defect). The technique which involves removing a cell from an early embryo and testing it for genetic disorders is termed pre-implantation genetic diagnosis (PGD). This is particularly valuable for families which have already had a child with a lethal genetic abnormality. Many diseases or body characteristics, however, are influenced by a number of genes (polygenic), so cannot be identified in this way. The concept of a "designer baby" is unrealistic at present, as most `desirable' characteristics, such as intelligence, memory or physical appearance are polygenic.

38 Currently most IVF programmes attempt major ovarian stimulation ('superovulation'), yielding perhaps 6 – 25 eggs. This can have a major impact on the woman, and probably yields poorer quality eggs than milder regimes, but seems to allow greater choice of embryos for replacement. If embryos for replacement require specific characteristics, such as particular tissue types for so-called "saviour siblings"[33], then even more embryos would be needed to secure those tissue types[34]. Not all women produce as many eggs even with heavy stimulation. There is a move at present[35] to use minimal stimulation resulting in fewer eggs, perhaps of better quality and with better outcome. *In vitro* maturation (IVM) uses mild stimulation and more prolonged culture to achieve egg maturation and is now yielding live births. The optimum outcome for all ART pregnancies is a single, term (more than 37 completed weeks of gestation) birth. The Human Fertilisation and Embryology Authority recently advocated replacing a single embryo, and perhaps freezing (cryopreserving) other quality embryos for replacement in subsequent cycles. The replacement of more than one embryo is likely to increase the number of multiple pregnancies, which have much higher mortality and impairment rates. There is pressure on clinics to have the best "success rates", as determined by "league tables" published by the press, which emphasise birth rates and ignore the number of multiples. Increasing the number of embryos replaced beyond two has little impact on improving the pregnancy rate, but using single embryo transfer (SET) requires higher laboratory standards. In Scandinavia and Belgium SET is now the norm.

39 Fetal reduction (where one or more fetuses are terminated to reduce the number to two or one) is rarely used in the UK as the number of embryos replaced is already small and embryo reduction is never carried out as part of a planned reproductive regime, but with SET, it will not occur at all.

40 Where we uphold the human status of the embryo and fetus, fetal reduction can only be supportable in extreme circumstances. The current practice of normally limiting transfers to two embryos is to be commended.

[30] IVF comprises ovarian stimulation, egg retrieval, fertilisation *in vitro* (extracorporeal - outside the body) growth of the embryo in the laboratory, and transfer of the embryo(s) back to the uterus.
[31] A sperm sample is washed and the sperm are concentrated then, using a tube placed through the cervix, instilled directly into the uterus
[32] Embryos may be returned at 8 cells on day 3 or grown to more than about120 cells by days 5-6. The longer the time in culture the greater the opportunity to identify an abnormal appearance or growth pattern and select those that are most likely to be normal, which have the greatest probability of implanting in the uterus and growing to a term pregnancy
[33] A baby wanted/conceived not only for itself, but also to offer stem cells from its umbilical cord blood to a sibling suffering from a genetic disease, such as sickle cell disease.
[34] One recent study suggests 16 embryos are needed. Born and Made, an Ethnography of Preimplantation Genetic Diagnosis, Franklin, S. & Roberts, C. Princeton University Press, 2006.
[35] Promoted by ISMAAR, The International Society for Mild Approaches in Assisted Reproduction see www://ismaar.org/Objectives.htm

However the difficulty of obtaining IVF treatment through the NHS means that many have to bear the cost of obtaining treatment privately. This results in an additional pressure to raise the number of embryos transferred to increase the overall probability of at least one embryo successfully implanting. The implications in terms of maternal mortality, impairment of the children and the overall cost to the NHS of multiple pregnancies may mean that it would be more effective in terms of resources to increase the amount of support given for IVF through the NHS in return for a lower number of embryos transferred.

41 Cryopreservation of unfertilised eggs is now feasible and is used to protect future fertility in young girls and women suffering from various cancers or having chemotherapy. The eggs are retrieved before the start of any treatment. The technique is not yet widely used, and although there is speculation that "career women" may use it to preserve their fertility, this is not yet the case.

42 Some Christians are entirely opposed to IVF on the basis that it can result in the destruction of human embryos. In many IVF procedures (but by no means all) more eggs are harvested and fertilised than can be transferred. The question then arises of what should happen to these 'spare' embryos. There are at present four possibilities: disposal, frozen storage, donation and immediate use for research. What is right will depend on what we consider to be the appropriate level of care for the embryo at this stage in its development. Opinions will range from those for whom disposal and research are unlikely to be acceptable options to those who might find no intrinsic difficulty with careful disposal at a point before differentiation has occurred[36]. Storage is not without potential problems, and cases have come to light showing the problems (legal and emotional) that can result from relationship breakdowns, or even the death of a partner, with regard to the storage of embryos, sperm or eggs. The use of 'spare' embryos for research can be ethically justified, at least for some, provided that the embryos are otherwise destined for disposal, and the research is carried out on an embryo less than 14 days old as required by current UK regulation. The creation of embryos purely for the purposes of research, in effect treating the unborn human as a means to an end is problematic for those approaching these questions from a variety of positions.

43 The ability to create embryos *in vitro* has been a major step in the treatment of infertility. The difficulties faced by couples as a result of infertility can be severe, however, and the Church needs to accept that it can (even if unintentionally) add to these difficulties with its stress on 'family' and through poorly thought out theology which all too often talks of children as 'gifts' without taking into account the nature of gift or the significance this might have for those who are denied such a 'gift'. For those trying to cope with infertility occasions such as Christmas and Mothering Sunday can become an experience of marginalisation and pain rather than inclusion and joy. For some couples the possibilities of adoption may be a means to fulfil this part of human life, but this is not an option for all. IVF can offer hope but, like many medical treatments, brings with it a number of significant moral and ethical questions. Others, through choice or necessity, embrace childlessness as their vocation and this needs to be recognised, supported and affirmed by the church[37].

C. Pre-implantation Genetic Diagnosis (PGD)

44 The technique of PGD (defined in paragraph 34 above) can be used to screen for chromosomal abnormalities in the fetus in older women (over 35 years) who have a greater risk. It can also be used for those having repeated spontaneous abortions, however the evidence that this improves outcome is not yet clear. Social screening for sex selection is not acceptable in Britain; across Europe it is carefully monitored[38]. PGD can also be used to screen for specific single gene disorders for which there is a known risk for a particular individual/couple.

45 The use of PGD presents a number of ethical questions. In the selection of those embryos that are free from the genetic factors under consideration a number of 'spare' embryos will be produced. Some of the issues around the production of spare embryos have already been discussed. The selection of embryos on the basis of their genetic profile raises serious issues about how we value a person. Whilst selecting against certain genetic conditions may be seen to avoid suffering in the child who will be born, there is an ongoing debate about whether such selection will cause persons already born with these conditions to be less valued. To suggest that a physical impairment (including one which is genetically determined) changes the value of an individual, is contrary to our understanding of the all embracing love of God and of human beings as created in the image of God. This danger therefore deserves careful consideration by Christians considering the morality of genetic screening for deleterious conditions.

46 One particular use of pre-implantation genetic testing is the selection of embryos for suitability as donors of blood stem cells from a length of umbilical cord that will be discarded. With such a process there are issues that

[36] Differentiation begins at around 14 days of development with the development of the primitive streak which marks individualisation. Twinning cannot occur after this time.

[37] For further consideration of childlessness see Howdle S, Howdle P, Harrison M (1993) *Childlessness* Foundery press; Free Church Federal Council and The British Council of Churches (1982*) Choices in Childlessness* (London: Free Church Federal Council and The British Council of Churches).

[38] Monitoring is in the context of Guidelines issued by the powerful European Society for Human Reproduction and Embryology (ESHRE) ESHRE PGD Consortium data collection IV: May-December, 2001, Sermon *et al*. Human Reproduction 20: (1)19-34, 2004.

have to be faced for the child, whose existence may be seen to be intended primarily to support the well-being of an older sibling. Does this accord proper value to the child as a person in her/his own right? There are issues around the question of consent. The cells being sought for therapeutic use are genetically those of the embryo, and yet when using umbilical blood stem cells they are being drawn at a point when the individual concerned cannot offer consent (informed or otherwise). The parents give consent, as they do for all paediatric procedures, where it is presumed that the parents will act in the best interests of the child(ren). Furthermore, the selection of an embryo for similarity, in tissue type, with a sibling may place them in a position in later life where they feel themselves constrained to give consent to an organ or tissue transplant, (given that they were chosen to be born, to some extent for the benefit of their sibling) when such consent should not only be informed but free[39]. It should however be acknowledged that familial ties and expectations may affect decisions around organ donation, even where the person involved is not a 'saviour sibling'. The question to be asked is whether there is a qualitative difference to this decision for the 'saviour sibling'.

D. Donation

47 Gametes (sperm or egg) may be frozen for use many years later. Likewise, frozen embryos may be implanted up to five years later for another pregnancy. All persons must state, at the time of freezing, what is ultimately to happen to their frozen cells. Frozen/thawed cells could be used for the relief of infertility of another person, such as through sperm donation (donor insemination or DI), egg or embryo donation, for research into IVF or even research into stem cells. Donation opens the possibility of offering gametes or embryos to single women or lesbian couples for surrogate motherhood eg for two male partners, or where there is an abnormality of or even absence of the uterus. Such options would be offered in the context of counselling for the couple with consideration of the welfare of the future child (although what constitutes the child's welfare may be redefined by proposals in the Human Fertilisation and Embryology Bill). Another possibility is for a woman undergoing IVF, having a number of eggs surplus to her requirements, to offer "egg sharing." This is where a woman donates eggs to another woman who requires donor eggs because her own are too poor in quality to achieve a pregnancy. Sometimes the donor's IVF fees are paid by the recipient. Since recent legislation removed anonymity from donors, there have been far fewer sperm donors. Irrespective of legislation, there are too few egg donors because of the invasive nature of the egg collection procedures, so all requests for donation face long waiting lists. This has fuelled a search abroad for gametes, the so-called "reproductive tourism" which raises questions about the abuse of power, wealth and privilege, as well as highlighting the levels of need felt by some couples

48 Deciding what is to happen to frozen gametes or embryos raises issues of ownership. This is highlighted when there are disputes about the use of such embryos, for example, when the relationship between the parents has been broken[40]. Such cases illustrate the argument that it is not appropriate to treat embryos as commodities in the application of reproduction technologies, if they are regarded as having human status[41].

E. Stem Cell Technologies

49 When an embryo reaches more than about 120 cells (after 5-6 days of development), some cells aggregate at one pole, the inner cell mass (ICM), separated by fluid from cells around the circumference, and it is then termed a blastocyst. The ICM will form the fetus and the cells around the edge form the placenta. At this stage the cells of the ICM can make any cell in the body, because of this they are called totipotent stem cells. If removed from the ICM they could still grow into human tissue if we knew the correct stimulus to apply. These cells are identical, clones, and have the best chance, although currently not great, of being grown into a predetermined tissue. There is thus the potential to grow "spare tissues", which could be used for repair or replacement of damaged tissues caused by diseases such as in Parkinson's disease, diabetes or Alzheimer's disease, though the growth of whole organs may be a long way off. Scientists even anticipate the creation of gametes.

50 Because of the difficulties discussed earlier in supplying embryos for research, alternative sources are being explored. There are some stem cells in umbilical cord blood which may well prove satisfactory for specific purposes, although these are not totipotent. Although there have been previous reported successes in developing stem cells from adult cells rather than from embryonic cells, it is only recently that anyone has reported discovering a more efficient process for achieving this[42]. This approach, avoiding the use of spare embryos, is attractive, as it would not generate such great ethical issues. Much research and many questions remain before stem cell technologies can be used routinely. Researchers would require a supply of stem cells, and would need to be able to ensure the precise localisation and function of the new cells.

51 Hybrids are embryos consisting of elements from different species. Hybrid embryos are those in which the egg and the sperm come from two different species. It is not permitted to develop hybrid embryos where a human

[39] Terry, L.M. and Campbell A., 'The child that might be born ...', *The Hastings Center Report* 32.3 (May / June 2002) Here it is suggested that there is a potential psychological burden on a 'saviour sibling' of feeling they have a lifelong obligation to donate to its sibling.
[40] Woman takes frozen embryo case to European Court The Tmes, September 27, 2005
[41] This case is argued by Oliver O'Donovan, *Begotten or Made* 1984 OUP
[42] Induction of pluripotent stem cells from adult human fibroblasts by defined factors, Takahashi, K. *et al*. Cell, **131**: 861-872, 2007

gamete is used[43]. Cytoplasmic hybrid embryos are those in which the nucleus and the cytoplasm (the contents of the cell outside the nucleus) come from different species. Where non-human material is combined with human material it is always in the context of research and, at the time of writing, never for therapy.

52 Embryonic stem cells can be created using the technique of somatic cell nuclear transfer[44]. The nucleus is removed from a mature body cell (not sperm or egg), and placed in an egg from which the nucleus has been removed, as in the creation of Dolly, the sheep. This cell is induced to divide, grown to blastocyst (5 days after fertilisation) and ICM stem cells retrieved. This process is extremely inefficient, although more efficient methods are being developed. To understand the process better, nuclei from human body cells have been placed into bovine eggs from which the nuclei have been removed[45]. The procedure allows the study of the separate roles of the nucleus and the cytoplasm in the cytoplasmic hybrids. There are many modifying influences which this research aims to better understand. "Transfusion" of cytoplasm has been used as treatment for a poor quality egg, although the efficacy of this procedure has not been established. Reports of such procedures in the media have highlighted the creation of hybrids but shown little understanding of the application of the technology which might increase the efficiency of IVF.

53 All of these techniques for tissue development are referred to as "therapeutic cloning" and much work is being done on this under strict ethical committee and regulatory control (in the UK by the HFEA). The creation of another human being with an identical genome to an existing individual, as happens naturally in identical twins, is referred to as "reproductive cloning". There is generally a world-wide moratorium on work on artificial reproductive cloning despite occasional, alleged work by mavericks. The possibility of artificial reproductive cloning in the future is an area that causes great concern. All too often it is not realised that the attempt to make an exact copy of an existing individual is likely in any event to be of limited success. Human beings are more than genetic machines and our full humanity stems from relationships that are not amenable to reproduction. Those relationships include the combination of genes from two parents at conception and the aim of reproductive cloning (which uses the genes from only one person) is one that is and should continue to be opposed by the Church.

54 When used for therapeutic purpose, cloning might seem to offer significant possibilities. The production of totipotent embryonic stem cells as means to overcome serious diseases offers some hope of increased health and ability to prosper. Any problem is rooted predominantly in the means rather than the end. The use of embryos in this manner treats them as mere objects (even if therapeutic objects), which some might be considered inappropriate for that which is recognised as having human status.

THEOLOGICAL, ETHICAL AND PASTORAL PRINCIPLES

A. Introductory comments

55 The working group commends the work already done in *Status of the Unborn Human* in exploring theological and ethical principles. The work of that study and of other church publications cited is not repeated here; rather building on that work, ethical and theological principles are offered which might guide responses to future developments[46]. As an aid to the reader sections B and C include boxed sections which contain a summary of the material which follows. Some may find it adequate to read only the summary, others will want to explore in more depth. This section begins with God then moves on to consider the relationship between God and human beings and specifically the relationship between parent and child, finally focusing on our pastoral response to the complex issues around early human life. The image of a dance is used to represent the dynamic, interactive nature of these relationships: it has limitations, as do all images, but will be helpful for some. Finally there is a brief survey of the moral theories that might inform our decision-making.

56 All the reflections that follow are encompassed by the self-giving love of God, most fully revealed in the life, death and resurrection of Jesus Christ. That love continues to be expressed in the church for the world through the power of the Holy Spirit. Within that framework principles are identified which help us to frame our responses to the emerging issues.

57 Scripture is an important basis for our ethical decision–making. The working group, however, agree with the authors of *Status of the Unborn Human* that:

> There is, in fact, little biblical material that bears explicitly on the specific issues involved, and traditional teaching can in some cases be shown to be based on inaccurate understanding (as,

[43] The one exception is a standard test for sperm viability where human sperm is put into a hamster egg. The resulting hybrid self-destructs at 2 days.

[44] Somatic cell nuclear transfer involves taking an unfertilised egg cell and removing the nucleus. The nucleus is also removed from a somatic cell (a body cell which is not egg or sperm) of the donor, and this nucleus is inserted into the egg cell from which the nucleus has been removed. This cell is then electrically stimulated to cause it to divide. The genomic DNA of this new cell is identical to that of the nucleus donor (although the cell still contains the mitochondria and mitochondrial DNA of the egg donor). This technique was used to create Dolly the sheep and other cloned mammals, and can also be used to create embryonic stem cells which have an identical genome to the nucleus donor.

[45] Inter-species embryos, A Report by the Academy of Medical Sciences, 2007

[46] Terms of Reference as quoted in introduction.

for example, that a woman is the passive recipient of the life-giving male seed). Isolated texts can be ambiguous and point in different directions.[47]

58 The Bible is not primarily a book of law or a study of ethics; it is a collection of writings which, together, constitute the sacred scripture of the Christian faith. The literature is varied in form but has in common that it is an account of the relationship of the people of Israel and the early Christians with God. The application of biblical teaching to issues in the modern western world, such as those around early human life, is perhaps best achieved through the recognition of the dynamic relationship between communities in the Bible and contemporary Christian communities. Communities that are very different from each other in many respects share their insights best when they recognise their differences and look for ways in which barriers to understanding can be overcome so that each is informed by the other. Biblical teaching is relevant to people beyond the Christian community when they are enabled to enter into a conversation about Christian values and beliefs and the way in which these are relevant to their lives and decisions.

59 Where it is appropriate direct reference is made to biblical texts. We believe that our theological reflection is firmly rooted in the revelation of God in scripture, in Jesus Christ and through the work of the Holy Spirit in our tradition, experience and the exercise of human reason.

B. Our understanding of God

God is trinity. This means it is the nature of God to be in relationship. Relationship between the persons of the trinity means that the `otherness' of each is respected. This relationship is grounded in love. God's love is generous and overflows to all creation. Because God is in a loving relationship with creation, it should be respected. Human beings are stewards of creation and share in God's creative work which is open-ended, a work in progress.

60 Our Christian understanding of God as trinity means that we believe relationality is the very nature of God. To talk of trinity is to talk of others in relation. Each person of the trinity is other and each is eternally in dynamic relationship with the other. God is eternally in relationship, a relationship characterised by love that is self-giving, dynamic and overflowing in abundance. In love God creates and sustains all that is. It is in the very nature of God both to be in relationship within godself and to relate beyond godself with creation. God does not need the creation in order to be complete, rather God desires to relate beyond godself because beneficent relationality is of the being of God.

61 This understanding of God as one who created the world out of love and is in a continuing beneficent relationship with the created world necessitates a respect for creation. Such respect for creation is found in the biblical tradition which affirms God's love for that which has been created and specifically with the unborn human (eg Psalm 139:13-16) and speaks poetically in terms of the whole created world praising God (eg Psalm 148). It also must be recognised that there are aspects of the biblical tradition that speak of human dominion over creation. Such dominion is exercised in the context of God's love for creation and the relationship of human beings with God. We are stewards of creation not the masters of creation and whenever we act in ways which affect fundamental aspects of creation we must make every effort to act as faithful stewards. God has created human beings as participants in creative work. Creation is under-determined (open-ended) and human persons are those who creatively develop their own network of relationships in participation with God[48]. The creation has not been 'designed' in every detail by God, it is under-determined and so, in our creativity, we participate in the work of the creator.

C. Our understanding of human being

Human beings are creatures and so are in relationship with God. Being created in the image of God means that human beings are created to be in the right relationship with God. The right or authentic relationship is that which is shaped, energised and determined by the divine relationship. This does not mean that human beings are divine, they cannot experience the same quality of relationship as that within the trinity. It does mean that the right or authentic human relationships are those which are grounded in the love of God. This relationship can be illustrated by the invitation to join a dance.

I. Dancing with God

62 It is in the very nature of God to be in relationship with the created world and all creatures, including human beings, are in relationship with God. That human beings are in relationship with God does not, of itself, require that the trinitarian model of divine relationality should apply in any way to human persons, but what is distinctive about the relationship of human beings with God is that they alone are described (in the Judaeo-Christian tradition) as being created in the image of God: 'Then God said, "Let us make humankind in our image, according to our

[47] *Status of the Unborn Human* 4.0
[48] Hardy, D.W. (1993) 'The Spirit of God in Creation and Reconciliation', *Christ and Context* (eds Regan, H. and Alan J. Torrance; Edinburgh: T. & T. Clark) 237-258., 244.

likeness"...'[49] To be created in the image of God is to be created as relational beings and as such we find our identity in and through our relationships with one another and our relationship with God. Indeed, we are only fully and authentically human insofar as we are `other' or distinctive in relation with one another and with God. To the extent that a human person participates in the relationality of God that person is enabled to be authentically human, and to be authentically human is to be in the image of God.

63 A number of theologians reflecting on ethics and human genetics have interpreted the human calling to reflect the image of God as meaning human beings are to act as 'co-creators' with God. They have accordingly encouraged the prudent development and application of techniques of genetic intervention as a way of collaborating with God's creative work in the world[50]. The idea receives a qualified approval from writers such as Ronald Cole-Turner, who concludes that "when through genetic engineering [natural] processes are used by human beings to expand the purposes and the glory of God, must it not be said that genetic engineering is an extension of God's activity."[51] More recently another writer, Ted Peters, has enthusiastically embraced this concept, endorsing it as a theological basis for supporting, in principle, stem cell research, human cloning, and germ-line engineering[52]. The theologian Philip Hefner, generally credited with popularising the concept of human beings as 'co-creators' with God in recent decades, intended to emphasise the subordinate place of human creativity in relation to God's creativity by insisting humans were '*created* co-creators' with God[53]. Nevertheless, objections to this claim typically argue that it aggrandises the role of human agency in God's creative and redemptive purposes, misrepresenting what is really implied in the biblical mandate to be God's 'stewards' in creation[54], and tempting us to transgress creaturely boundaries by understating the extent to which our finite and fallen condition limits our understanding[55]. It has also been observed that appeals to the human being as 'co-creator' tend, albeit implicitly, to promote consequentialist approaches to moral decision-making[56].

64 Of course, we must recognise that human beings are not divine and the relationship we have with one another and with God is not identical with the relationship within the trinity that is fundamental to the being of God. The relationality of God might be described in terms of a dance, where the persons of the trinity are pictured as participants in an eternal grand chain ('perichoresis'). When we consider the relationship of God with creation the picture is one of an invitation to others to join the dance, the basic rules of which have been defined by the original dancers who continue to interact with one another in a variety of ways which sets the pattern for others. The dance cannot continue without the original dancers but their exuberant dynamism overflows and inspires and involves others. The other dancers weave their own patterns that intersect with the patterns of the original three dancers. If the new patterns break away from the original they soon become stale, as they have no energy or inspiration to draw on, they are pale shadows of what they could have been. This is only an image, but it points towards a dynamic relationship between human persons and God that does not assume that the co-inherence of the trinity is replicated in finite human beings.

II. A child joins the dance

All human life is in the image of God. All human beings are created to be in relationship and are, from the earliest stages of life shaped and affected by the network of relationships in which they find themselves. A child born as a result of assisted reproductive technologies is one who is created in the image of God. The use of the technologies will affect the immediate network of relationships in which the child participates alongside other factors such as culture, parental life-style and genetic make-up. It is important that the child is accepted as an other in relation and able to grow in his/her own relationship with God and with others.

65 Some of the reproductive technologies offer new possibilities for determining what kind of person will be born. The screening of embryos is not the only way in which parents can influence the character of their child but it is the only way in which they can determine that an embryo with particular genetic characteristics will, or will not, be given the opportunity to be implanted and to develop into a child. When a child is born as a result of the new reproductive technologies there is no doubt that this is a human person who will grow and develop in the context of a network of relationships which will shape and form his or her personality. The fact that a child has been selected before implantation into the womb does not change the nature of that particular child as one who is a human person in the image of God. Use of assisted reproductive technologies does, however, affect the immediate network of relationships in which the child participates. It is necessary to ask whether there is a point at which the choices made by the parents change the character of the relationship between parent and child in a way which is incompatible with the Christian understanding of that relationship as one in which the 'otherness in relation' of each

[49] Genesis 1:26 (NRSV)
[50] This account of the use of 'co-creator' by theologians in reference to genetic intervention draws particularly on Deane-Drummon C. (2001), *Biology and Theology Today* (SCM Press), pp. 96-110.
[51] Cole-Turner R. (1993), *The New Genesis: Theology and the Genetic Revolution* (Westminster / John Knox Press), p. 109.
[52] Peters T. (2003), Playing God: Genetic Determinism and Human Freedom (2nd ed., Routledge)
[53] Hefner P. (1993), *The Human Factor* (Augsburg Fortress Press). See especially ch. 2.
[54] Hauerwas S. (1995), 'Work as Co-Creation: A Critique of a Remarkably Bad Idea' in Hauerwas S., *In Good Company: The Church as Polis* (University of Notre Dame Press).
[55] See, for example, the discussion in Deane-Drummond C., *Biology and Theology Today* (SCM Press), pp. 101-103
[56] For a definition of consequentialism see paragraph 98 below.

person is respected and in which the parents seek to grow, and to enable their children to grow, in relationship with God, within the community of faith and in the world. This question is not limited to decisions around the use of reproductive technologies but is sharpened in this context.

66 The relationship that we have with God is the result of God's unconditional outpouring of love; it is gifted to us from God. The Christian community seeks to witness to the outpouring of God's love as the members of the community relate to one another and to those who are not members of the community. Because Christians as finite beings are not perfect, the expression of love within and beyond the community is imperfect and finite. In so far as the Christian community contextualizes (understands and locates) itself in the outpouring and overflowing energy that is God it witnesses to God's love and to the redemptive process.

The Christian community seeks to model the way in which imperfect beings try to develop their relationships within the love of God. This means loving others without expecting a return or evidence of prior satisfactory performance. This is part of the witness of the Christian community to the world. Children are received as gifts from God which are not subject to our limitations. We receive such gifts as they are given and not as we would wish them to be. Such gifts do not always bring joy, indeed they may bring pain for the parent or the child. Having children is not primarily a matter of self-satisfaction but a sign of Christian hope which is grounded in the unconditional love of God.

67 Within the Christian community children are perceived as gifts[57]. As gifts they are to be received as they are given and not as we would wish them to be. The consequences of receiving children as gifts are explored by Stanley Hauerwas in an essay where he asks why parents choose to maintain a relationship with children with profound learning impairments[58]. The fact that such relationships are maintained and that such children are received into family and community life, is an indication that we do not choose to have children only for our own satisfaction or happiness. As those who are created in the image of God we should not receive the gift of a child from a position of self-interest but as those motivated by unconditional and generous love.

68 Hauerwas describes having children as 'one of the most highly charged moral events of our lives'. He contrasts the perception that we choose our children with that of children as gifted to us by God. The reason for having children has become, for many, a matter of personal choice and such choice implies responsibility for both choice and outcome. Where such choice and responsibility are felt, it is likely that there will be encouragement to ensure, as far as possible, that the children conceived will develop into healthy individuals. The screening of embryos prior to implantation and the selection of sperm and egg donors is one way to fulfil this perceived responsibility and is a way that was not available to parents until the development of the new reproductive technologies.

69 One of the consequences of regarding children as gifts coming to us as given is that they will not always bring joy.

> For children are not beings created by our wills - we do not choose them - but rather they are called into the world as beings separate and independent from us. They are not ours for they, like each of us, have a Father who wills them as his own prior to our choice of them.[59]

Gifts from God are not subject to our limitations and so do not simply meet our perceived needs. Rather they create needs; they teach us what we really need and remind us how limited we were without them. Children teach us to value and love other persons as they are and not as we would have them be. Children do this as 'others in relation' to their parents. To receive a child as a gift does not imply possession but involves entering into a relationship that is grounded in self-giving love. Such love involves giving up self-interest.

70 We receive children from God as signs of our Christian hope, which is based not in human strength, but in God. Seen in the context of the Christian story, children with impairments can be seen to be gifts as any other children. Hauerwas argues that the perception of all children as gifts only makes sense within the context of the believing community. It is only when we accept that our love for our children, like God's love for us, is unconditional that we are able to understand why we have and maintain our relationship with children who we might otherwise regard as imperfect or disappointing. Our human relations should not be conditional upon the expectation of a return or on the prior performance of the other. When we accept children as gifts we accept them as 'others in relation' and we do so in the context of our otherness in relation to God. The acceptance of children unconditionally

[57] This widely held perception of children as gift or blessing has its roots in biblical literature. It is not possible to explore this fully here but see, for example, D.J.A. Clines, *The Theme of the Pentateuch* (JSOT, Supplement Series 10; Sheffield: JSOT Press, 1978), 31-32. In the Pentateuch children are received as gift and blessing and are essential for the continuity of the covenant people, through whom the promises of God will be fulfilled. There was an obligation to have children as a surety of future hope. Also E. Spitz, 'Through her I too shall bear a child: Birth surrogates in Jewish Law', *Journal of religious Ethics* (1996 Spring, 24;1: 65-97), 72.

[58] S. Hauerwas, with R. Bondi, and D.B. Burrell, 'Having and learning to care for retarded children' *Truthfulness and tragedy: Further investigations into Christian Ethics* (Indiana: Notre Dame Press, 1977, 147-156).

[59] Ibid. 153.

as gifted to us is not easy. Pain and heartache are part of the experience of most parents, to different extents, and this must be recognised. Those who allow children to be other and accept them as given relinquish self-interest.

71 The relationship of God with the created world and with human beings is most fully expressed in the incarnation. In Jesus we have the model of a life lived in unbroken relationship with God and in fully authentic relationship with others. In Jesus, God embraced human being and demonstrated divine involvement in creation. Within the Christian community we witness to the promise of redemption and restoration. Preserving and passing on the faith and modelling life and relationships on the example of Christ are important emphases in the life of the community. These ideals are represented in those liturgies that are used following the birth of a child when children are welcomed by the church through baptism or in services of thanksgiving and dedication. This understanding of children as gifted to us as signs of hope and received into a community that looks forward in hope of redemption and restoration challenges us to consider our responses to those technologies that offer the opportunity of the genetic screening of embryos and to prenatal screening.

III. The impaired dancer

Those who are disabled share in the dance but their participation is not always recognised or enabled by others. Models of disability are limited. The social model, which is increasingly used in the UK when policy decisions are made, challenges some negative attitudes. There is need for further theological reflection and possibly the development of models that are based not on power but on recognising the other and sharing in the love of God. Those with impairments are created in the image of God as beings in relationship. They should be afforded every opportunity to attain their full potential in terms of their relationship with God and with others.

72 Among the clinical practices associated with early human life are those that allow the identification of potential impairment. In the light of this it is important to consider our understanding of, and attitudes to disability. In the following paragraphs particular models of disability are discussed. These are models in use in social and political contexts and apply largely to physical rather than mental impairment. The models are limited in a number of respects and they are not appropriate when considering the situation of those who are most severely disabled. In paragraph 77 some of the implications of these models are considered in the context of an understanding of human beings as created in the image of God.

73 In the last few decades of the 20th century a shift occurred in the way disability is understood. Since the rise of medical science disability has been understood in clinical terms and focused on a person's physical, mental or emotional loss of function. Disability is then seen as the resultant inability to function in a way considered normal for non-disabled people. This view of disability is termed the 'Medical Model'. It has its valid use within the appropriate clinical setting but is open to abuse when used beyond this, particularly when applied in a social setting.

74 More formally this model uses the following definitions:

- Impairment – "Any loss or abnormality of psychological, physiological or anatomical structure or function."
- Disability – "Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being."
- Handicap – "A disadvantage for an individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role (depending on age, sex, social and cultural factors) for that individual."[60]

This has several implications for how disabled people are viewed and in turn this affects how a fetus with a potential impairment is treated. These implications include, but are not limited to the following:

- Defining a person by their impairment and therefore assuming the needs of everyone with the same impairment are identical, rather than meeting particular needs.
- Focusing on removal or cure of impairment rather than removing the impact caused by societal barriers.
- Placing power in the hands of professionals rather than with disabled people. This includes provision of facilities for rather than by or with disabled people.
- Promoting and sustaining the view that disability is a wholly negative experience, for individuals, families and society.

Of particular relevance to issues around early human life is the resultant focus on removal of any fetus that is likely to develop a specific impairment, either by screening out at implantation stage or by abortion upon determination of an impairment. It can also affect treatment given after birth. These assumptions and attitudes can be seen to foster some negative attitudes towards impairment. There is no evidence that those who are disabled are subject to reduced medical care[61] but it can be argued that the fact that it is regarded as desirable to screen embryos in order to prevent the birth of children with impairments reflects social values that foster negative attitudes.

[60] Barnes, Mercer & Shakespeare, 1999, 22-23 citing WHO (1980) *International Classification of Impairments, Disabilities and Handicaps,* Geneva, World Health Organisation.
[61] Wald N & Leck I (2000) 548 *Antenatal and Neonatal Screening* OUP

75 Disquiet with the Medical Model began to arise in the 1970s and 1980s in both the USA and Britain. In the USA this has given rise to a new model, the 'Minority Group Model', where disabled people are seen as a minority group defined by their experience of discrimination by the majority non-disabled group on the grounds of their impairment. This has overcome some of the problems of the 'Medical Model', particularly in the area of disability rights and politics.

76 The model being increasingly adopted in the UK is the Social Model. This model is defined in the following way:

- Impairment – "lacking part or all of a limb, or having a defective limb, organ or mechanism in the body."
- Disability – "The disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have a physical impairment and thus excludes[62] them from participation in the mainstream of social activities."[63]

Again there are a number of implications of using this model:

- The issue is shifted to the problems caused by societies' failure to include disabled people in everyday life
- It focuses on removal of physical and social barriers to the integration of disabled people
- It firmly places the power in the hands of disabled people
- It distinguishes clearly between impairment and disability, leading to a more positive view of impairment and therefore a reduction on the focus of removal/curing

77 The working group believes the Social Model is preferable to the Medical Model in the discussion of matters relating to early human life but also recognises the need for further theological reflection possibly leading to the development of models which are less power based. The Social Model challenges the negative attitudes towards impairment/disability common in society which affect parents and prospective parents. When confronted with a diagnosis of an impairment, viewed negatively by many professionals in the medical sphere and under the Medical Model, this Social Model can assist in developing an alternative, positive view of impairment and its implications. Use of the Social Model would also lead to an emphasis to work on the problems society causes for those with impairments, rather than an emphasis on the removal of impairments to a degree that neglects them. This could affect the way in which parents respond to tests which identify potential impairment. This model is able to broaden the discussion of how disabled people are to be integrated into all areas of public life. Theologically we can reinforce the need to deal with social exclusion, which is not acceptable to God, and to adopt a positive attitude towards disabled people as full members of society. It can be argued that a more positive view of impairment will affect attitudes to the screening of embryos for potential impairment. Those with impairments are human beings in relationship with others and with God, and should be afforded every opportunity to grow and attain their full potential (which may be at any stage of development).

IV. Dancing in hope

Jesus is the only person to have been fully and always in the right relationship with God. Jesus is the only person who can be described as fully in the image of God. Human beings are free to make choices. Our tendency to self-interest means that we sometimes move away from the self-giving love which underpins our relationship with God. Self-interest should not be the basis of our relationship with other human beings at any stage in their development. Our own welfare should always be considered in the context of our relationship with God and with others. Decisions around issues relating to early human life should never be based on self-interest. The Christian vision is of harmony renewed and restored, of authentic relationships. Renewal and restoration of harmony does not mean returning to what once was. The dance goes on and we have to respond to new possibilities as they emerge. This means we have a responsibility to grapple with the difficult questions around early human life.

78 Our relationship with God includes the God-given freedom to make our own choices and to create our own context. We are able to choose whether or not we relate to God and to others on the basis of the love that God shows in creation and to each one of us. We participate in creation with God, and such participation is only possible because God has allowed us freedom and responsibility. In the Genesis story, the Garden of Eden is portrayed as a place where the whole created world exists and flourishes in a harmony that is rooted in intimate relationship with the God who walks in the garden (Genesis 2:4-25). That harmony is lost through the self-interest of human beings who break away from God putting their self-interest in the place of the self-giving love that underpins the relationship of God with creation, as is illustrated in the story of the fall (Genesis 3:1-24). Self-interest with no thought for the other should not be the motivating force in our relationships with others, at any stage in their development as human beings. This is not to say that we should never consider our own welfare, or even that our own welfare should never take precedence. It is to say that we should always consider our own welfare in the context of our relationships with others and with God. An individual's welfare is not well served by actions that dislocate their network of relationships.

[62] For discussion of concepts of exclusion and embrace see Volf M, (1996) *Exclusion And Embrace: A Theological Exploration Of Identity, Otherness And Reconciliation*, Abingdon, Nashville

[63] Barnes, Mercer & Shakespeare (1999), 28.

79 With respect to early human life and associated technologies and clinical practice this means that self-interest should not be the basis for decision-making. The current grounds for termination as specified in the Abortion Act were not designed to allow for abortion on demand, but to require proper consideration of the consequences of continuing the pregnancy for the woman, the unborn child and those in close relationship with them.

80 The often stated claim of the 'right' to a child is generally based on self-interest and it is right that proper consultation and counselling should take place to ensure, as far as possible, that the child will be born into a network of relationships that will enable him/her to be welcomed as 'other' and to grow in relationship with others.

81 As human beings we are created to grow in relationship with others and with God, but only Jesus Christ has lived a human life with no contextual loss of God for self or others. This is to say that only Jesus has lived a human life in a fully authentic relationship with God at all times and in all circumstances. In Jesus Christ God is most fully revealed to us because Jesus Christ is the only human being who has ever been fully in the image of God. Jesus also lived his life in authentic relationship with others and through Jesus we are able to know God and live in relationship with God.

82 It is when we are in relationship with Christ that our creativity is interwoven with the creativity of God. It is only through being enabled by the Spirit to share in the redeeming activity of Jesus Christ that human beings can be reoriented into authentic relationships with one another and with God.

83 Our vision is of harmony restored, of authentic relationships, a vision found in the New Testament (Romans 8:12-21; Ephesians 1:9-10). Restoration of harmony does not mean going back to what once was; God's relationship with creation is active and dynamic, the dance keeps moving. We cannot turn the clock back and ignore the development in science and technology. The working group has been continually reminded that it is often not possible to predict the outcome of a particular line of research. We have to respond to new possibilities as they emerge. Our responsibility as those created in the image of God is to work towards the vision of restored harmony and authentic relationships as we participate in the processes of creation. We cannot and must not ignore or disclaim work that offers much in terms of real benefit but we must accept our responsibility to grapple with the difficult questions around the scientific and clinical procedures that affect early human life.

D. Our Pastoral Response

84 God is relational and human beings are created in the image of God. Christian relationships are worked out in the context of the community of faith, which acknowledges need and hopes for redemption. Within this community the parent-child relationship can be described as one in which the "otherness in relation" of each person is respected. The parents seek to grow, and to enable their children to grow, in relationship with God within the community of faith. The community of faith looks forward in hope to the establishment of the Kingdom of God and seeks to live according to Kingdom values as a model for the world.

85 Bryn Rees's hymn, which has found its way into most recent hymn books, says, *The Kingdom of God is justice and joy*[64]. Christians are called to develop the Kingdom here on earth. Justice and joy should be vital players. Joy is very much an inner feeling and not something that can be manufactured. However issues of justice associated with human reproduction are rather more fraught.

86 The bio-ethical principle of justice builds on part of the Christian concept. One definition of this term, widely adopted in deliberation about public healthcare policy, is "*a group of norms for distributing benefits, risks and costs fairly*"[65]. The National Institute for Health and Clinical Excellence (NICE) was set up partly to address these issues and so reduce the so-called postcode lottery of who can have which treatments funded by the NHS. In parallel, however, technical developments combined with easier access to information by non-specialists, particularly via the world wide web, have increased people's expectations. In cases that hit the media it is often evident that justice is all very well when it applies to someone else's treatment, but individual stories seem to escalate from, 'I want,' to 'I need,' to 'I have a right to . . . '. This has frequently become the attitude towards having children and, where it is so, presupposes a primacy of self-interest that contradicts Christian understanding.

87 Scientific developments and societal change have provided opportunities for people in the developed world to become biological parents where previously that would not have been possible for them. Conversely, it is feasible for people to choose to terminate a pregnancy for impairments . Some believe this is in contrast with the understanding of Christian community, which has traditionally seen children as a gift from God, most often given to husband and wife into the context of a family. The choice may be determined by self-interest or by the parents' desire to act in the best interests of the child, but in either case the choice involves working with our understanding of children as gifted to us by God. In most cases new life is associated with joy. Traditionally, however, churches

[64] Rees, Bryn*, The Kingdom of God is justice and joy*, verse 1 Baptist Praise & Worship 321, Hymns & Psalms 139, Rejoice & Sing 200
[65] Beauchamp, Tom L. & Childress, James F. 1994 Principles of Biomedical Ethics (Fourth Edition) Oxford University Press, New York Oxford Page 38

have focused so much on the joy of new life and the centrality of marriage and family life, that those who are single or married and childless can easily feel excluded[66]. Yet the Kingdom, as described by Bryn Rees, is one of *mercy and grace*[67]. God's love is wide enough to encompass all; the church, which witnesses to God's love supremely revealed in Jesus Christ, should reflect this.

88 The ministry of Jesus Christ, however, was not all accepting. His pastoral care went alongside a prophetic attack on those aspects of first century society that did not fit with the pattern of the Kingdom of God. If the Churches' role is to encourage the development of the Kingdom of God here on earth, then they need to remember another of Bryn Rees's phrases; *The Kingdom of God is challenge and choice*[68].

89 Christians and Churches go about this challenge in different ways. Some Christians oppose proposals in the Human Fertilisation and Embryology Bill, which apply definitions of 'mother' and 'father' within a variety of relationships, including same sex relationships. Whereas some denominations have clear rules around which members are expected to frame their lives, others, including mainstream Free Churches take a different view, where more emphasis is placed upon individuals either making their own decision or being part of corporate decision-making under the guidance of the Holy Spirit. This sometimes means that denominations do not draw lines in the sand but challenge societal trends or prospective legislation in different ways. It also means that, where people face ethical dilemmas, churches and believers must choose their own balance between pastoral care and ethical challenge.

90 Christian justice is not just about fair shares, it is also about right paths being followed. Nevertheless, a plethora of new contexts is emerging within which the churches have to choose their course of action, to challenge or to care, and even more so to discern whether there is a way of challenging the principles upon which people's situation rests, whilst still handling individuals with pastoral sensitivity and the love of Christ. Maybe the way to the Kingdom of justice and joy is across a tightrope. In all of this Christians may find themselves living with contradictory convictions, as has been true of the church throughout history, and which is sometimes both necessary and productive[69].

91 The pastoral issues can be very complex as can be illustrated by the following example[70]. How should pastoral care be offered to those who have chosen to use pre-implantation genetic diagnosis (PGD) in order to avoid the inheritance of a genetic disorder by the child? How will our understanding of our relationship with God and with others help us in this situation? What is the tension between gift and choice? How does the church respond pastorally?

92 Where embryos have been selected in order to avoid specific genetic disorders there may be an increased tendency to regard the child as chosen rather than as given. Currently, only one specific chemical characteristic can be chosen, one that prevents a specific disease. The desire to ensure that a child does not suffer unnecessarily from severe genetically related illnesses can be understood as a natural expression of parental love and care. Brent Waters has suggested a model for the parent-child relationship in the context of a theology of 'procreative stewardship'. He makes a distinction between the intention to prevent the birth of a severely ill child and the pre-selection of a more desirable one[71]. Such a choice is limited and any developing fetus is subject to random events that may affect development. Where the intention is prevention of an illness which might, in fact, prohibit the development of the parent-child relationship, Waters writes that 'Employing a quality control technology should not diminish the sense of *unconditional belonging* between parents and children.'[72] Waters makes a distinction between the intention to satisfy the longing for a desirable child and the intention to prevent illness which would adversely affect the parent-child relationship[73]. Jesus healed individuals as a sign of the restoration of wholeness and restored relationships in the Kingdom of God. Where the intention is to prevent illness rather than to determine favourable characteristics and satisfy parental preferences, it is still perfectly possible for the parents to regard their child as 'other in relation'. The desire to prevent illness and the desire to receive a child as one who is given are not mutually exclusive. It would be difficult, probably impossible to decide which motive was predominant, the two are interwoven. It is also difficult to decide when the nature of impairment is such as to prohibit a life in authentic relationship with God and with others.

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[66] For examples of work on marriage, family life and childlessness see Free Church Federal Council and The British Council of Churches (1982) *Choices in Childlessness* (London: Free Church Federal Council and The British Council of Churches), Church of England Board for Social responsibility (1995) *Something to Celebrate: Valuing Families in Church and Society* (London: Church House Publishing).
[67] Rees, Bryn *ibid* verse 2
[68] Rees, Bryn *ibid* verse 3
[69] See the Report to the Methodist Conference 2006, *Living with Contradictory Convictions*, http://www.methodist.org.uk/downloads/Conf06_Faith_and_Order_committee_pt2.doc
[70] Further examples will be given and explored in the study guide available in summer 2009.
[71] Brent Waters, *Reproductive Technology: Towards a Theology of Procreative Stewardship.'* (London: Darton Longman and Todd. 2001) 114-115.
[72] Brent Waters, Ibid. 114.
[73] Brent Waters, Ibid. 114.

93 It is possible to argue that a child may be received as a gift by parents who have exercised a proper stewardship of care to ensure that the child does not suffer from a serious genetic disorder. It could indeed be argued that having developed the technology which enables us to prevent children being born with serious disorders, failure to use it to avoid the birth of seriously impaired children is failure to fulfil our calling to be those who participate in the work of God to redeem a fallen, imperfect, creation[74].

94 Potential parents may try to think from the perspective of a future child, with a high chance of impairment, which may be gross and ultimately lead to early death. The acceptance and "joy" experienced in dealing with impairment which has not, or cannot be predicted may be different from the experience of dealing with a high (say 50%) possibility of a child having a specific impairment. The couple may have had a child with the same condition, who has already died, one that they have looked after for some years. At that point the couple may choose, for the benefit of the future child, to have a child without that disability. That can be seen as a positive choice, not a negative one. It is also important that pastorally the impression is not given that their decision was negative. We should not underestimate or deny the pain that is experienced by some parents. Before PGD was available, parents who previously had a child with major impairment often chose not to have any more children.

95 It is difficult to be sure of the intention of the parents and, indeed their intentions may be complex. When the decision to use PGD has been taken it is probably both improper and impossible for one in a pastoral relationship with the parents and child to attempt to work with the family on the basis of the perceived intentions of the parents. This is not to say that the technology itself should not be subject to critique. It is not to say that the processes leading to human embodiment are unimportant. It is to say that the primary pastoral concern for one working alongside those involved in these complex decisions should be for the development of authentic relationships between the members of the family in the context of the believing community. Here is the opportunity to accompany the parents as they share the experience of receiving the gift of a child who will be nurtured by them and will enter into relationship with them. Where the pastoral care offered is informed by the understanding of the nature of the parent-child relationship proposed here, the believing community lives out its calling to witness to the promise of redemption and restoration.

96 The pastor can and should rejoice with the parents when a child is born. The child should be received as a gift and as one who will surprise the parents however much they knew about her/him before her/his birth. S/he will surprise them because s/he is 'other' and together with her/his parents s/he will grow in relationship with those around her/him and with God. The pastor's task is not, primarily, to work from the intentions of the parents before the child was conceived. It is to encourage and support the family as they seek to contextualise their relationship with each other, in relationship with the community of faith, and in relationship with God. Through the nurturing of such relationships individuals grow towards authentic human being and the community is reoriented in relationship with Christ.

MORAL THEORIES

97 Christian decision-making takes place in the context of a number of ethical models. Christians may work within one or more of these models. There are two main categories of moral theory, consequentialist and deontological, which are described in *Status of the Unborn Human'* (3.1) and so are dealt with only briefly here. Rather more space is given to a consideration of Virtue Ethics, a moral theory which receives little attention in *Status of the Unborn Human*. In section D a common assumption in contemporary western society – the privileging of choice above other possibilities - is identified in the context of issues around early human life. This example illustrates the way in which ethical models (in this case consequentialism) provide the context for decision-making.

A. Consequentialist theories

98 Consequentialist ethical theories assert that it is solely by considering the consequences of accepting or rejecting an action or proposed course of action that its moral value is to be defined. The best known form of consequentialist theory is the utilitarianism associated with Jeremy Bentham and John Stuart Mill, which seeks to maximise good and minimise evil. The good to be maximised can be characterised as '*the greatest good for the greatest number.'* The ethical framework within which issues around early human life are reviewed by the regulatory bodies is not strictly defined, but could be said to be largely utilitarian.

B. Deontological theories

99 Deontological theories of ethics require obedience to a set of rules, laws or prescriptions. The major religions require obedience to rules, which are derived from the perceived will of God. The German philosopher, Immanuel Kant argued that the basis of the moral experience was obligation to duty, the moral imperative. The test of a genuine moral imperative is that it can be universalised. In its crudest form, 'don't do something unless you believe everyone should do it', is the basis of the pragmatic approach of some people to moral issues.

[74] Waters makes this point in the context of his discussion of our nature as embodied creatures living in a good but imperfect creation. Ibid. 39-40

100 There is fuller discussion of these main categories of moral theory and the language of rights and their implications for decision making in the context of early human life in *Status of the Unborn Human* (chapter 3), a conclusion of which should be noted:

> Each of these various attempts to get to grips with the question of the human raises many additional questions. In effect they all appear to want to solve the problem by reference to some external criteria which might be objectively determined, either by definition or enquiry. Whatever external authorities or criteria we choose to accept, we cannot escape the exercise of personal judgement and the acceptance of personal responsibility. (3.4)

C. Virtue Ethics

101 The dominant tendency in the categories of moral theory described above and in *Status of the Unborn Human* is to focus on appropriate action to be taken. The fundamental moral question in deontological or consequentialist approaches to ethics is 'What should I do?' (The differences between these approaches come out of the questions they ask on the way to answering the question about action, eg 'what are the circumstances around an action?' or 'what are the likely consequences of any possible action?'). For virtue ethicists, the fundamental moral question is 'what sort of person ought I to be?' The primary focus is on people forming a virtuous character. In St Thomas Aquinas' words, virtues are 'dispositions to act well,' developed using examples of virtuous behaviour to cultivate virtuous habits by continuous practice. The thinking is that directing attention to forming these dispositions equips a person to make fitting choices and undertake judicious actions (which in turn contribute to the ongoing development of a virtuous character).

102 Understanding ethics in terms of virtue originates in ancient Greek philosophy. Plato was an important early contributor to this tradition, proposing the list of the four 'cardinal virtues' (prudence, justice, courage and temperance) and insisting that they were interdependent, such that each of us needs all four virtues working together in any given situation (this is often called the doctrine of 'the unity of the virtues'). Aristotle later distinguished between 'intellectual' and 'moral' virtues, and is renowned for discussing virtues as traits which enable human beings to move towards their proper goal (*telos*), which he called *eudaimonia* (often translated as 'happiness', but only properly understood if this is interpreted in a richer sense as something like 'human flourishing' or 'fulfilment').

103 Several early Christian writers adopted the language of virtue from Greek philosophy and used it as a way of interpreting certain New Testament passages, eg 'lists' of the fruit of the Spirit in Galatians 5:22-3 and the account of the characteristics of love in 1 Corinthians. The priority given to faith, hope and love in 1 Corinthians 13:13 is essentially what distinguishes theological treatments of virtue from their Classical counterparts. St Augustine argued that true virtue must be rooted in the knowledge and love of God - hence pagan virtues may be admirable in their way, but cannot be regarded as virtuous in the true sense. St Thomas Aquinas further proposed that whilst 'cardinal virtues' directed humans to their natural goals, the ultimate goal of human life was a supernatural one, namely personal union with God. Moving towards this supernatural goal required the theological virtues – faith, hope and love – which were not innate to our being but 'infused' in us by divine grace.

104 Proponents of virtue ethics maintain that it has advantages over other forms of ethical reasoning – they argue that virtue ethics is properly concrete because it grounds morality in what is known of human nature (and it therefore draws on the social sciences/psychology as well as other disciplines, such as theology, in terms of what constitutes human flourishing). James F. Keenan[75] summarises virtue theory in three questions: Who am I? Who ought I to become? How do I get there? Virtue theory is therefore 'person-centred' ethics – by knowing and understanding ourselves we can practice to be better. Virtue ethics accepts that 'we cannot escape the exercise of personal judgement and the acceptance of personal responsibility'[76]. One of the best-known modern proponents of virtue ethics is Alisdair MacIntyre, who sees a moral society as one in which people recognise commonly agreed 'virtues' and aspire to meet them. Stanley Hauerwas is one of several theologians whose interest in virtue ethics has shaped his approach to the sphere of bioethics[77].

105 More recently Celia Deane-Drummond has sought to demonstrate the relevance of a theologically informed virtue ethics to moral discussion concerning genetic intervention[78]. For example, when considering the morality of the genetic testing and screening of human embryos,she proposes that adherence to the virtue of prudence suggests a positive but delimited endorsement of this practice. She argues that testing and screening human embryos should not be used for trivial reasons or to identify late onset conditions. Rather it should only be used for diseases whose diagnosis at this early stage would provide reliable and helpful information about the health of the ensuing offspring, which could guide parental decisions.

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[75] Keenan JF 'Virtue Ethics' in Hoose B *Christian Ethics, An Introduction*, ed, London: Cassell, 1998

[76] Status of the Unborn Human 3.4

[77] See for example his essay 'Practicing patience: how Christians should be sick' in Hauerwas S. and Pinches C., *Christians among the Virtues* (University of Notre Dame Press, 1997), ch. 10.

[78] See especially chapter 1 of her book, *Genetics and Christian Ethics* (Cambridge University Press, 2006).

D. The privileging of choice

106 One aspect of the dominant contemporary approach to moral decision-making, recognised as significant by the working group, is a privileging of choice. The privileging of choice has proved a conducive setting for the adoption of a consequentialist approach to moral questions. The tendency of several reports on the ethics of genetic applications to cast moral enquiry as the calculation of risks and benefits gives some indication that the consequentialist approach, though sometimes unacknowledged, exercises an extensive influence over moral deliberation concerning early human life[79].

107 The following example illustrates the way in which the privileging of choice influences decision-making. Nowadays, parents of an impaired child who suggest that their parenting experience is enriching may well be confronted by a question along these lines: "But were you in a position to choose whether to have this child or another, healthier one, would you choose the same child again?"[80] The fact that nowadays the "position" to which such a question refers is not merely a hypothetical one, but one that prospective parents actually occupy, is the result of ongoing developments in reproductive technology and gene identification. The fact is that nowadays there are grounds for thinking such a question indicates the pervasiveness of an assumption which has proved decisive in promoting the norms and objectives currently dominating public moral deliberation about early human life. This assumption is that in order to affirm a particular experience as good, we must be able to say we would choose it, irrespective of whether we actually did choose it on any given occasion. Hence, underlying the dominant contemporary approach to bioethical reflection, and therefore exercising a formative influence over moral enquiry regarding early human life, is the assumption that 'goodness' and 'choice' are intrinsically connected, such that "[t]o have a life is to be its governor in the sense that the more of its conditions are under control the more reason we have to affirm its goodness"[81].

108 The privileging of choice in moral deliberation has found expression in debates about abortion in various ways. These include the affirmation of a woman's right to choose whether or not to terminate a pregnancy, and advocacy of pre-natal screening techniques, such as amniocentesis and chorionic villus sampling, that expose the likelihood of certain disorders so that an 'informed choice' about the propriety of termination can be made. But extending our control over human procreation not only facilitates our choosing. Arguably it impregnates our ways of thinking about early human life as well. It has been argued, for example, that the ability to conceive an embryo through *in vitro* fertilisation does not simply widen choice in the obvious sense of giving a broader range of procreative options. Abstracting the conception of a human embryo from its 'natural' context in a mother's womb has fostered the assumption that the question 'what *kind* of being is an early embryo?' is itself a matter for our determination[82].

109 The prominent role of choice in deliberation about bioethical issues is both facilitated and encouraged by the many convictions and claims sometimes dubbed the 'liberal convention'[83]. This is widely acknowledged as the philosophical framework which dominates contemporary deliberation about public policy. Under the terms of this convention, the fact that society evinces a plurality of world views with corresponding moral diversity is presented as a clear reason for restricting public policy to the objective of enabling equal opportunity to exercise individual freedom of choice. The ideal liberal self is an individual able to determine his or her life's path entirely at will[84]. Some legislative constraints are of course necessary to distribute the benefits and burdens of social co-operation fairly, and thereby to secure freedom for the whole collection of individuals comprising a society. However, the primary objective of public moral deliberation should remain the creation of maximum opportunity for the exercise of individual self-determination. This liberal framework has proved a conducive setting for the adoption of a consequentialist approach to moral questions where the most appropriate course of action is that deemed to maximise beneficial consequences, and 'benefit' is typically construed in terms of freedom of opportunity.

110 This understanding of freedom of choice and individual self-determination does not accord with the Christian understanding of human being as fully realised in the context of a relationship with God and others which has its foundation in self-giving love. The privileging of choice is not the only way of thinking in society which needs to be challenged, readers of this report may well identify other examples.

[79] Such reports would include The *Report of the Committee on the Ethics of Gene Therapy* (London 1992), and the BMA Report *Our Genetic Future: The Science and Ethics of Genetic Technology* (Oxford, 1992).
[80] Reinders H., 'Life's Goodness: On Disability, Genetics, and 'Choice'' in *Theology, Disability and the New Genetics: Why Science Needs the Church* (T&T Clark, 2007), p. 168.
[81] Ibid. p. 169
[82] Northcott M., 'In the Waters of Babylon: The Moral Geography of the Embryo' in Deane-Drummond C. and Manley-Scott P., *Future Perfect? God, Medicine and Human Identity* (T&T Clark, 2006).
[83] See Reinders H., *The Future of the Disabled in Liberal Society* (University of Notre Dame Press, 2000), p. 22ff
[84] See e.g. Song R., *Christianity and Liberal Society* (Oxford University Press, 1997), p. 40ff

CONCLUSION

111 In this report we have considered a range of contemporary challenges relating to early human life, always recognising that the scientific, political and social contexts are fast changing. We have pointed to theological principles that might guide our response to future developments. These principles, which will be applied in the context of a variety of ethical models, may be summarised as:

i. The belief that human beings are created in the image of God;
ii. Understanding that to be created in the image of God is to participate in relationship with the trinitarian (relational) God;
iii. Respecting creation which is grounded in the overflowing love of God;
iv. Recognising that human beings are stewards of creation;
v. Understanding that, as stewards of creation, human beings participate in God's creative work.
vi. Respecting the 'otherness' (distinctiveness) of every human life;
vii. Enabling authentic relationships with God and others, authentic relationships being those which are grounded in self-giving love;
viii. Receiving children as gifted by God;
ix. Being motivated by unconditional and generous love (not by self-interest) when receiving children;
x. Ensuring that human beings are given the opportunity to fulfil their own full potential in terms of their relationship with God and with others;
xi. Holding to the Christian vision of renewed and restored harmony and authentic relationships;
xii. Understanding the parent-child relationship as one in which:
    a. The otherness in relation of each is respected
    b. Growth in relationship with God within the community of faith is enabled;
xiii. Offering pastoral care which 'walks the tightrope' of justice and joy and challenge and choice.

112 We have briefly considered models of moral-decision making and believe that no particular model can or should be recommended as that to be exclusively espoused by the churches. We note that a consequentialist model is generally preferred by the scientific and medical community and that a significant contemporary approach, the privileging of choice, is conducive for the adoption of a consequentialist approach.

113 In our discussions we have become aware of a need, beyond our terms of reference, to consider the issues and challenges around perinatal and neonatal care. Here, as in developments around pre-natal life, there are important moral and pastoral concerns.

114 In view of the fast changing context of these issues the working party suggests that it would be beneficial for an informal network, based on the membership of working group but with additional expertise where necessary, to continue to monitor and update information in the area of prenatal, perinatal and neonatal issues and challenges. Such a group, communicating electronically, could help to resource accurate and thoughtful material including theological and ethical reflection, for the churches through the appropriate channels of communication.

115 The contemporary challenges around early human life are many, varied, complex and fast-developing. We approach them as those assured of the love of God who invites us to join in the dance of creation and offers us healing and hope, challenge and choice, justice and joy.

APPENDICES

APPENDIX I

Some suggestions for further reading:

Beauchamp, T. L. and Childress, J. F. (1994) *Principles of Biomedical Ethics* (4th edn), Oxford: OUP

Bowers, Faith (1997) *Treat with Special Honour: People with Learning Disabilities in the Life of the Church*, Didcot, Oxon: Baptist Union of Great Britain, (currently in revision for October 2008)

Bowers, Faith ed. (1996), *Complete in Christ: People with Physical Disabilities in the Life of the Church*, Didcot, Oxon: Baptist Union of Great Britain

Buchanan, Brock, Daniels and Wickler, (2000) *From Chance to Choice* Cambridge University Press

BUiLD: The Baptist Union Initiative with people with Learning Disabilities: buildtogether@northern.org.uk .

Cole Turner R. (1993) *The New Genesis: Theology and the Genetic Revolution,* Westminster: John Knox Press

Deane-Drummond C. (2001) *Biology and Theology Today* SCM Press

Deane – Drummond C. (2006) *Genetics and Christian Ethics* Cambridge University Press

Eisland, Nancy L (1995) *The Disabled God: Toward a Liberating Model of Disability* Abingdon Press

Ford, N. (2002) *The Prenatal Person: Ethics from Conception to Birth* Oxford: Blackwell.

Jones, D.A. (2004) *The Soul of the Embryo: An Enquiry into the Status of the Human Embryo in the Christian Tradition* London: Continuum

McFadyen, A.I. (1990) *The Call to Personhood: a Christian Theory of the Individual in Social Relationships* Cambridge: Cambridge University Press.

Peters T. (2003) *Playing God: Genetic Determinism and Human Freedom* (2nd edn) Routledge
Scully J L. (2002) *Playing in the Presence*, London: Quaker Books.
Volf M, (1996) *Exclusion And Embrace: A Theological Exploration Of Identity, Otherness And Reconciliation*, Abingdon, Nashville
Song R. (2002) *Human Genetics: Fabricating the Future* Darton, Longman and Todd Ltd.
Swinton J. and Brock B. (eds) (2007) *Theology, Disability and the New Genetics* T&T Clark
Waters B. (2001) *Reproductive Technology: Towards a Theology of Procreative Stewardship* Darton, Longman and Todd Ltd.
Waters B. and Cole-Turner R. (eds) (2003) *God and the Embryo: Religious Voices on Stem Cells and Cloning* Georgetown University Press

APPENDIX II
Membership of the Working Group

Professor Ian Cooke (URC)	Emeritus Professor of gynaecology
Deacon Margaret L Cox (Methodist)	Deacon serving in Barking Dagenham and Ilford Circuit, East London
Revd Ruth Gee (Methodist)	Presbyter in the Halifax Circuit and Chair Designate, Darlington District. Chair of the working group
Revd Martin Hobgen (Baptist)	Minister in Coventry
Dr Helen Jenkins (Methodist)	Student Presbyter studying in Durham
Revd Dr Rosemary Kidd (Baptist)	Faith and Unity Co-ordinator, member of the Joint Public Issues Team
Ms Rachel Lampard (Methodist)	Secretary for Parliamentary and Political Affairs, member of the Joint Public Issues Team
Revd Michael Peat (Baptist)	Minister in Whalley Bridge, Derbyshire
Revd Dr Jonathan Pye (Methodist)	Principal of Wesley College Bristol
Revd Allan Smith (URC)	University Chaplain
Rev Daphne Williams (URC)	Chaplain at Whittington Hospital, London.

The working group on Human Embryology and Early Human Life contained members with a range of experience and expertise. Several members of the group have scientific backgrounds, including expertise in reproductive technologies, pathology and human genetics. Others have experience of reflecting on issues of early human life through their academic work in medical ethics, theology, teaching and disability issues. Several members have personal experience of the issues raised in this report including bereavement, physical impairment, involuntary childlessness, and the process of assisted reproduction. Many have worked pastorally or in a hospital chaplaincy setting with people affected. Members of the group came from a range of theological traditions. The group also benefited from advice received from a wide range of people acting as readers or consultants to the group.

APPENDIX III
Recommendations to the Methodist Conference

XX/1 The Conference receives the report and commends it to the Methodist people for reflection and guidance

XX/2 The Conference requests the production of material by summer 2009 to enable church groups and individuals to study the issues raised in this report.

XX/3 That, in the light of the changed social and political context and scientific and medical developments including reduction in the gestational age at which a premature infant may survive, there should be further work on the issues surrounding abortion, revision of the Methodist Statement on Abortion (1976), and a working group should be established for this purpose.

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