**Ann Pederson, Fall 2006**



**Technology, Spirit, and the Beginnings and Endings of Life: A Crisis of Interpretation for Ordinary Christians?**

"It was society who told these stories—we ourselves. The stories are our ways of contextualizing technology. . . . Are there better and worse, more or less adequate, ways of creating and telling stories? Are there criteria governing our stories? What makes a dream true? These questions are urgent when we reflect on technology."[1]

***Setting the Stage: Spiritual and Ethical dilemmas faced at the beginning and end of life***

What may seem like an ending can become complicated by a beginning. Let me explain.[2] A story shared with me by a health care professional in Sioux Falls, South Dakota illustrates how decisions about beginnings and endings of life and the nature of human personhood might be more complicated than we can imagine.[3] A young man was rushed to the ER at a local hospital after being involved in a serious car accident. He suffered major traumas including neck and head injuries, and it became apparent that he would probably not live very long. His family and his long time girlfriend rushed to the ER and stayed by his bedside over the course of a few days.

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[1] Philip Hefner, *Technology and Human Becoming,(* Minneapolis: Fortress Press, 2003), 63.

[2] I teach theology at a small liberal arts college in Sioux Falls, South Dakota. I'm also privileged to be part of the Section for Ethics and Humanities at the University Of South Dakota School Of Medicine. What I have learned from living at this intersection of medicine and religion is that the challenges raised by medical science and technology raise profound questions about what it means to be a human person. These questions are fundamental to the human story. And people tell stories to make sense of their lives. The following reflections on these questions about human personhood are told from local anecdotes and experiences. However, I hope that their universal application will become apparent as this chapter unfolds.

When it became apparent that he might not live, the family struggled with whether or not to withdraw the respirator. Over the minutes and hours, the family argued and struggled with this difficult decision. The medical team indicated clearly that he would not survive very long, and decisions were urgent. And then his girlfriend of many years requested that the parents allow the sperm of her boyfriend to be given to her so that she could become pregnant with his child. A beginning of new life for her would become possible even while his would end. The parents and girlfriend could barely cope with the present grief and yet they were being asked to think about the possibility of creating new life.

Questions followed for all—the parents, the girlfriend, the health care providers. They asked about life and death, endings and beginnings, what it means to be a person, and where God was in all of this. To withdraw the respirator would most likely bring a quick death, but it would also hasten the intensity of the family's grief for their young son. Was the family using him as a means to deal with their grief? Did they want to prolong his life for his sake, for their own, for both? Who did the sperm belong to? In the midst of such an urgent crisis, how would the family and girlfriend make these decisions? In that moment, the questions were transfigured. Decisions needed to be made, in haste. And the possibilities of beginning a new life from the end of another one just didn't make sense.

Making ethical and spiritual decisions with such urgency insures that decisions will feel ambiguous, and made in a state of bewilderment. John Lantos, a Chicago pediatrician, writes from his experience as a physician in the Neonatal Intensive Care

[3] This story was shared with me by a health care administrator. The retrieval of gametes after death has become a controversial issue for both families of the patient and health care providers.

Unity about the ambiguity of decisions that crises create. "Our practices respond to the inextricably tangled web of moral obligations within families and among family members and to the complex negotiations that take place between doctors, patients, and family members. Perhaps because these areas of human experience are so complex and so difficult to describe in general terms or to regulate in rational ways, neither law nor bioethics has done a particularly good job in exploring them. Instead, they might be better understood through a domain of inquiry that focuses on the complexity of the family decision making."[4] Where can people turn as they have to make decisions about beginnings and endings of life? What kinds of perspectives and wisdom, irrespective of what the "authorities" have to say, are ordinary people starting to figure out and articulate for themselves? As Lantos indicates, whether it is the family facing the decision, or the health care provider working with the family, no clear answers appear in the moment of urgency.[5] Medicine and technology don't solve the questions, but more likely complicate the answers. The same might be said about religion. This scenario as told above would not have even been possible a few decades before. Beginnings and endings are not discrete simple moments but are processes moving through an entire life story.

To be human is to seek meaning, to ask questions, and to tell stories. At the end of the 20th century, stories shaped by all of the scientific and technological innovations have radically altered people's lives. This story from Sioux Falls, South Dakota, while particular in its local context, illustrates the universal human search for meaning amidst

[4] John D. Lantos, *The Lazarus Case: Life-and-Death Issues in Neonatal Intensive Care* (Baltimore and London: The John Hopkins University Press, 2001), 98.

[5] "For better or worse, decisions at the end of life seem to be made as communal decisions rather than individual ones, with the patient's voice among many. The goal in these discussions for both doctors and patients seems to be a little different from the goal initially imagined by lawyers and bioethicists. It is not simply to empower the dying patient against the doctor. Instead, it is to achieve some semblance of family

the crises raised by medical science and technology. This family began to realize in the midst of a crisis that they were confronting questions that, finally, were spiritual or theological in nature. In the intensity of the moment, what once seemed familiar and secure became blurred and unfamiliar. Even the familiar spiritual foundations upon which so many Christians rely can seem to falter. This ragged edge of life is where medical science and religious beliefs intersect with profound consequences.

***Setting the Local Scene in South Dakota***

A brief history of South Dakota will help to set the local scene and the concurrent reflections about the relationship between religion and medicine. South Dakota was the last state in the United States to get a Starbucks and the first to pass legislation outlawing all abortions with no exceptions other than to save the life of the mother. No exceptions for rape or incest, or for the health of the mother. At first glance, the media tells stories about a seemingly conservative, mostly rural state that is at war over a cultural, religious, and even scientific issue. But to assume that this is all there is to the narrative is to not see the whole picture.

While the state has a relatively small population of 775,933 the state is comparably larger in its physical size (17th in the U.S.) Many South Dakotans travel great distances for services such as health care. The racial makeup is predominantly White (88.0%) with approximately 8.3% of the population being Native American (third highest in the continental U.S.)[6] South Dakota has some of the poorest counties in the United States and approximately 20.2 of children under the age of 6 live at or below the Federal

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moral harmony, some course of action that violates neither the values of the dying patient nor the values of the survivors, who must live with the memory of the action." Lantos, *The Lazarus Case*, 97.

[6] http://en.wikipedia/org/wik/South_Dakota#Demographics

Poverty level.[7] Poverty creates urgent public health care needs in South Dakota, particularly among the Native American population and populations in other isolated, rural areas. Approximately 65% of the people are Protestant and 25% are Roman Catholic. And of the Protestant denominations, Lutherans make up approximately 28% of the Christian population.[8]

Three large hospital systems span the state of South Dakota from Rapid City to Sioux Falls. Avera Health, a Roman Catholic Healthcare System, employs approximately 3100 people and has about 100 locations in South Dakota and neighboring states.[9] In recent years, tensions have developed in South Dakota regarding access to reproductive health needs for women like abortion and contraception. Most of the religious perspectives expressed in the media are from those who consider abortion a sin, except possibly to save the life of the mother. Because of the large Roman Catholic population in South Dakota, the popular press often cites Papal authority and church doctrine on the issue of abortion. And yet other denominations have much different stances, including the Evangelical Lutheran Church in America, of which South Dakota has a large population. Recently, columns by Methodists, United Church of Christ clergy, and Lutherans (ELCA) have been offering other perspectives and noting that they are Christian as well.

The other major healthcare system, Sioux Valley Health System, has 24 hospitals and about 150 healthcare facilities in South Dakota.[10] For those who live near the five major cities in South Dakota, access to healthcare is not particularly problematic.

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[7] http://www.state.sd.us/factpage.htm
[8] Ibid.
[9] Ibid.
[10] http://www.siouxvalley.org, http://www.avera.org

However, that leaves thousands of folks who are often in rural communities where getting to hospitals or even clinics can mean traveling long distances. These local statistics indicate the importance of location—in all of its cultural, religious, economic, and geographic specificities, for understanding the relationship between religion and medical science.

The religion and scientific narratives need to be told within the larger socio-political economic realities of the current culture. And the way science(s) and religions(s) are practiced in South Dakota exemplifies the broader political and cultural landscape.

## *The Larger Historical-Cultural Context: Beginnings and Endings at the end of the 20th Century*

At the twilight of the twentieth century, stories appeared in the news that changed the way people understood beginnings and endings of life. Medical technology was transforming and challenging traditional notions of what it meant to be a human person. In 1978, Louise Joy Brown was born to a British couple through the process of *in vitro* (in glass) fertilization. Unable to conceive because of blocked fallopian tubes, Lesley Brown underwent this radically novel technological procedure that created a new life in her. By the very end of the 20th century, *in vitro* fertilization, once considered very new, was nearly passé. In the 1990's, Dolly, a cloned sheep from Scotland, was born and people struggled with questions about cloning and embryonic stem cell research. The news seemed to reach every corner of the planet. All of a sudden, people realized that the potential of technology to change the human being far exceeded their ability to cope with

those changes. The plot line of the human story was moving faster than the species had expected.

At the other end of life, technology once used to save a life was withdrawn in order to end a life. Two famous stories of young women, Karen Ann Quinlan and Nancy Cruzan, brought the issues about end of life and the right to die to the public's attention. Karen Ann Quinlan's and her parent's story sharpened the culture's awareness of how technology, medicine, religion, and politics are woven together into one complex narrative web of living and dying. After collapsing in April of 1975 from a drug and alcohol overdose, Karen remained hospitalized in a "persistent vegetative state." At the request of her parents, her breathing tube was removed. Ironically, however, she continued to breathe on her own and died in 1985, two years after Nancy Cruzan's car accident resulted in a similar situation. At the sight of the accident, Nancy was pronounced dead by the local patrolman. And yet, "he could have no idea just how widely society would debate exactly the same question that he had answered so simply, perhaps prophetically—whether this accident victim was dead. Nor could he know that the accident would indeed claim other victims. But none lay at the scene that night."[11] Nancy Cruzan, a young woman whose story gripped the nation, told the public about a patient's rights to die and the struggles of her family. The story of Nancy Cruzan, while it is clearly about her living and dying, is also about her family and others who found their lives tied to this ongoing saga. Beginnings and endings ran concurrently through the legal courts—to begin what had ended, to end what had begun. The toll on her family was unimaginable and several years after Nancy Cruzan died her father committed

[11] William Colby, *Long Goodbye: The Deaths of Nancy Cruzan* (Carlsbad, CA: Hay House, Inc, 2002), 9.

suicide.[12] Death is not a solitary event. Unnecessary suffering was caused by the polarized positions of the medial, by the polarized positions of religious denominations, and by reactions of popular media figures like Peter Singer or Dr. Kevorkian.

In a recent survey, 70% of Americans said that they wanted to die at home, surrounded by their loved ones. And yet in South Dakota, about 19% of people died at home in 1997, and the rest died in hospitals or nursing homes.[13] These figures are not atypical for the rest of American culture. While many people at the moment of crisis want "everything to be done," they don't recognize the implications of how far technology can prolong life. A few decades ago, Nancy Cruzan would have been pronounced dead at the scene of her automobile accident and she would have remained dead. Due to technological enhancements, she was "revived" and then stayed in a persistent vegetative state for years. While the statistics go up for preserving life so also do the chances of staying in a persistent vegetative state. Taught to preserve life at all costs, most health care providers fight against giving up on life. This is reinforced by the public attitude that technology and medicine can "fix" everything. However, as right-to-die cases became more prominent in the news, the general public became more educated on issues around end-of-life. Beginnings and endings are not discrete simple moments but are processes moving through the entire human story.

From the incubator developed in the 1880's to the latest technologies in the NICU (neonatal intensive care unit), premature babies have a much greater chance of surviving. John Lantos relates the "narrative of progress" that has been at the heart of neonatal medicine. He notes that it became the fastest growing field in pediatrics and this success

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[12] Ibid.
[13] Steve Young. "Group's Goal: Dying Better, " in *A Time to Die*. *The Argus Leader*, 12/22/2002.

story is linked to its financial gains. The infant mortality rate between "1900 and 1960. . . dropped from 122 per 1,000 to 26 per 1,000."[14] Those statistics were cut in half again as the life expectancy in the neonatal intensive care unit increased. Technologies developed for decreasing infancy mortality came with a price, however. New moral dilemmas were raised as the technologies advanced. The courts and lawyers could barely keep up with the new dilemmas posed in the NICU. A new unprecedented interested in "medicine, neonatology, and the moral dilemmas of medicine and technology" came to the fore.[15]

Each human being has a story, a narrative that is connected in, with, and under the stories of others. As folks hear the stories of Louise Brown and Nancy Cruzan, they can't help but wonder about their own story and what it means in the larger scheme of the cosmos. These larger cultural narratives of technology, human persons, medicine, and religion sharpen the questions about the world and what it means to be a part of it. To pursue these questions is to pursue a quest for meaning. Does human personhood begin at conception? At birth? If sperm are donated, the eggs donated, and a surrogate mother utilized, who are the parents? What does it mean to be part of a family? If someone is in "persistent vegetative state", does our culture consider them to be a person? Is it ethical to "do everything" in order to keep someone alive? Beginnings lead to questions about endings.

Many people imagine a fairly clear, simple, straightforward story about what it means to be human. Lines between death and life, science and religion, humans and nature have appeared to be separate, distinct, and clear. However, the stories of

[14] John Lantos, *The Lazarus Case*, 15-17.
[15] Ibid., 17.

beginnings and endings of life at the end of the 20th century tell about a much more complex web of technology and nature; humans and machines, religion and science, nature and culture, than could have been imagined. The boundaries that were once unambiguous (or so some hoped) were revealed as fuzzy and permeable. What folks once thought was "true" and "right" shifted faster than they could manage. Religious people, caught in these cultural stories of life and death, floundered to make sense of their faith's convictions and the concomitant realities of technology and science. And so the stories of who humans thought they were no longer had simple plots and characters, with clear beginnings and endings. Making sense of the human story is more akin to jumping into the middle of the story, where beginnings and endings collapse into one another and the characters move through a plot like an endless maze. Beginnings and endings will cross one another, move through each other, and define where the path leads. While many Christians will desire clarity and direction, the ambiguous and messy may be the only guide. Ordinary Christians are caught in the midst of dramas of life and death for which no clear directions are given, no map is provided. How they find their way is of utmost importance to the ongoing story.

Birth and death: no other events in human lives are more mysterious or have created more spiritual and ethical questions. Medical science and biotechnological advances have drastically altered the way life and death is defined and understood, and about what it means to be human in relationship to technology. Human beings are tethered in, with, and under technologies that shape and define human nature. People become who they are amidst and in these new technologies, and not apart from them. Lives are extended by respirators, premature babies are kept alive in the NICU,

computers take vital signs, and pacemakers are implanted. And in the middle of it, people try to make sense of it all, asking questions along the way. And these questions are at the heart of what it means to be human, to be related to God and creation.

How do Christians struggle with these spiritual questions in light of recent discoveries in medical science and biotechnology? To answer this question requires telling yet more stories, reflecting on the questions, and thinking about the quest for meaning. If people truly become who they are *in, with, and under* technology, then technology and their relationship to it is a spiritual struggle. Human beings can no longer afford to think that they are separate from nature, the apex of God's creation. New boundaries and new stories define the human person. The ways people struggle with these difficult questions is shaped by larger cultural narratives that include, of course, the religious and scientific stories.

## *A Cultural Legacy: Technology, the Market, and Medical Science*

Nothing can tell reveal more about human beings than what they see and hear on their television sets at night as they flip through the channels. Commercials advertise that medicine and doctors can provide some sort of eschatological salvation; they can save people from their humanness. Local hospitals advertise the *wonders* of medicine and the advances of technology for problems ranging from infertility to heart disease. The business of health care delivery reaches out to consumers with messages of hope and promise of relief from their illnesses. And consumers expect these results, even demand them. As soon as a new technological advance is promoted or a new pill advertised, American consumers expect that it is their right to have access to them. However people

have faced not only the wonders of technology, but also its limitations and horrors. Television seems to ignore these realities except through occasional sound bytes on the evening news. The future seems up for grabs; what once seemed safe and secure is not the case anymore (or never really ever has been). Ironically, while some of the technological innovations have led to "bigger and better" ways of living; the public has become more restless, more dis-eased than ever. The world changes so fast that folks can't keep up. And they expect a quick fix for this spiritual malaise.

The questions that face people about technology and medicine are just a tip of this age of anxiety. The late twentieth century shares both the hopeful and fearful attitudes that the Enlightenment twilight brought to them. As a do-it-yourself, future looking culture, Americans expect that the limits of the human condition can be overcome or escaped. Much like their cultural expectations about life and death, their religious expectations reflect the culture. People don't really want to think seriously about death, illness, and human frailties. Many people shop for church like they do for food—they want something to provide immediate comfort. Ironically, the price they ultimately pay for such comfort foods and quick fixes is denial of and postponement of their pain. The questions will always be there; they don't go away.

### *Different Religious Responses to Tough Questions*

Different religious traditions have approached these spiritual questions with responses that while similar are also very diverse. The many faces of the Christian tradition live with these questions in different ways. Some avoid the questions, and simply pronounce answers by quoting sections of the Bible. Others leave the meaning up to each individual believer. Some denominations write position papers while others have

authorities issue statements on behalf of people. These statements of the various denominations illustrate not only different approaches to issues in religion, technology, and science, but the approaches are often so divisive that ordinary people are bombarded with confusing messages about what *the Christian* response should be. Sometimes the messages come in sermons, or played on tape to a congregation at the request of a bishop, or are studied in groups. How religious traditions wrestle with these difficult and often ambiguous questions will reveal much about the stories of the relationship between religion and science at the end of the twentieth century. Three different religious traditions are examined for their responses to the questions and dilemma about beginnings and endings of life in an age of technology.

A few comments need to be made about the roles that scripture, tradition, and ecclesiastical structures play in wrestling with these difficult dilemmas. Some Christian denominations, usually Protestant, elevate the written text of the Bible above all other authorities. Other denominations like Orthodox and Roman Catholics also include the role of tradition, experience, and reason. And most parishioners are in between all of those. No wonder people have a difficult time wondering how to discern a path through these difficult questions when the official guides are so diverse. This is not necessarily a hazard, however. The diversity amongst Christians can either produce angst and fear, or it can be seized as on opportunity to expand the question for truth through incorporating many voices. Whether the ultimate authority is the written text, a papal writing, or one's individual inner voice, the way people come to spiritual discernment mirrors not only their religious background but also their cultural values. The authority of texts and

traditions more often than not results from the relationship between the readers, the selection of texts and traditions, and the specific contexts addressed.

The following three traditions span some of the variety of Christian responses to ethical and spiritual dilemmas about beginnings of life. Their written documents embody the cultural and religious themes that shape the way religion is practiced in the late 20th century. They are a part of the story, but not its totality by any means. They reflect a diversity of their respective Enlightenment and Reformation inheritances. The three positions are: The Evangelical Lutheran Church in America's (ELCA) statement on abortion, the United Church of Christ (UCC) statement on Reproductive Rights, and the Roman Catholic 1987 Document, "Respect for Human Life."[16] The statements are created in different ways which indicate how the direction of lay people's perspectives are gathered, evaluated, and formulated. Of course it must be said that within each denomination great variety exists. Often "liberal" Roman Catholics will have more in common with "liberal" Lutherans than conservative Roman Catholics. This variation in part exists because of the culture wars that occur in the political and religious arenas. In a time in which warfare seems to pervade these difficult issues, rhetoric escalates and political lines are drawn.

All three denominations seek counsel from a number of sources including scientists, ethicists, and theologians to formulate their statements. How the statements are considered authoritative and what role they play in parishioners' lives varies among

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16 http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en/html
http://www.ucc.org/justice/choice
http://www.elca.org/dcs.abortion.htm

the denominations. For example, the ELCA's statement came after much deliberation with lay people, holding regional hearings in various synods, and by taking a final vote of the national body represented by lay people and clergy. The process is somewhat similar in the General Synods of the United Church of Christ. Both statements leave more room for moral ambiguity and while they give counsel the final decision about an abortion is left to the individual. The Congregation for the Doctrine of the Faith issued the 1987 statement "Respect for Human Life" from the Magisterium and reflects previous authoritative teachings and traditions. No votes were taken by lay people. The statement is much less ambiguous than the Protestant ones and doesn't leave the same room for individual decisions. This examination of the how the statements are constructed by denominational bodies provide insights into the web of narratives that shape laity when they confront difficult moral issues like abortion or end of life decisions.

All three statements begin with a theological affirmation that life is a gift from God and is good. Not inconsequentially, all three denominational positions acknowledge that the issues raised by technology at the beginning of life are morally freighted and require careful discernment. The ELCA document on abortion acknowledges the differences that people have and the life circumstances that shape these differences. This was an important statement to include because the ambiguous conclusions of the statement itself created differing receptions among lay people. Some Lutherans would like to have seen a more definitive statement that clearly condemned abortion. For others, the strength of the Lutheran tradition is precisely in its ability to relate the texts of its tradition (Scripture and the Confessions) to the particular contemporary context. Lutherans have always understood themselves to be a part of the church as one which is

always undergoing reformation. This is exactly what the ELCA document on Abortion reiterates—the context and text as an interactive process of interpretation.

Both the United Church of Christ and ELCA acknowledge that women often face difficult and even dire circumstances that shape their individual reproductive needs and decisions. Such circumstances might include a forced pregnancy, poverty, violence, and abuse. The ELCA states that neither the pregnant woman nor the "developing life in the womb" has a *right*. In fact, the language "of rights" is not helpful because this implies an absolute for either the woman or fetus.[17] To quote at length from the statement on abortion of the ELCA: "The language used in discussing abortion should ignore neither the value of unborn life nor the value of the woman and her other relationships. It should neither obscure the moral seriousness of the decision faced by the woman nor hide the moral value of the newly conceived life. Nor is it helpful to use the language of 'rights' in absolute ways that imply that no other significant moral claims intrude. A developing life in the womb does not have an absolute right to be born, nor does a pregnant woman have an absolute right to terminate a pregnancy. The concern for both the life of the woman and the developing life in her womb expresses a common commitment to life. This requires that we move beyond the usual 'pro-life' versus 'pro-choice' language in discussing abortion."[18] These different views on abortion and reproduction are related to both denominations' understandings of authority that are very different than that of the Roman Catholic Church. Theology is after all a practice.

However, the UCC statement indicates that it has affirmed and "reaffirmed since 1971 that access to safe and legal abortion is consistent with a woman's right to follow

[17] http://www.elca.org/dcs./abortion/html

the dictates of her own faith and beliefs in determining when and if she should have children, and has supported comprehensive sexuality education as one measure to prevent unwanted or unplanned pregnancies."[19] The UCC's statements are clearer than the ELCA's about affirming that women have access to safe and legal abortions. The UCC takes very seriously the context of the moral dilemma and makes this a priority in the statement. The decision clearly resides within the woman's autonomous prerogative.

Finally, the Roman Catholic statement on "Respect for Human Life," claims that from the moment of fertilization a human being is created and that this life is sacred. The focus is clearly on the sacred nature of human life and that the proper context for creating human life should be within marriage. Abortion and other reproductive issues are considered from these priorities. The statement reminds people that society often commodifies and commercializes human life and that this is problematic from a Christian perspective which declares life as sacred, created by God. The Roman Catholic document also cautions that the biological and reproductive sciences have powers which may have reached beyond what should and could be done. The language of individual rights should not be the first concern, but instead the goal of the common good comes first—preserving and honoring the sacred nature of all life. The Roman Catholic Church continues to and constantly "reaffirms the moral condemnation of any kind of procured abortion. This teaching has not changed and is unchangeable."[20]

In many ways, the issues and dilemmas around the end-of-life are similar in the three perspectives. And lay people are caught somewhere between their own operating

[18] Ibid.
[19] http://www.ucc.org/justice/choice

theology and the statements and beliefs of their religious denomination and tradition. For some, personal beliefs are consonant with denominational beliefs. While for many others, personal beliefs are at odds with that of the religious body. Then the beliefs become more complicated because life is more complex. Stories are also complicated because neither the sciences nor religious traditions are monolithic. And the relationship between them is multi-layered.

### *Specifics Stories: Beginnings and Endings in South Dakota*

One way to see what is happening on a college campus is to read what's posted on the walls. A few years ago many of us couldn't miss a poster on the wall sponsored by two campus groups asking people to pray for a woman who was going to have an abortion (selective embryo reduction). Her name was not given but the details of her situation were apparent. The poster claimed that the woman's husband had asked for the prayers from groups and was pleading with his wife not to have the abortion. Furthermore, the poster claimed that if she went through the abortion she would be murdering her own child. Even though the poster's information was rather "anonymous" the gossip began to spread around campus and it created a very heated debate on campus about abortion. Were the campus bulletin boards the right place to display such information? Was this woman's right to privacy being violated? Somewhere in South Dakota a woman's life and her relationship between her physician and husband became fodder for public warfare. Other campus groups and religious communities figured that they needed to respond. And since the rhetoric had escalated the exchanges between both "sides" was not helpful for anyone in creating a safe place for discussion. This example,

[20]http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respec

while rather localized, symbolizes the incredible emotion tension that an issue like abortion can elicit. People line up to take figurative and real shots at each other. Soon, protective gear is needed! Battlegrounds include school classrooms, church sanctuaries, medical clinics where abortions are performed, political campaign advertisements, and personal friendships. In all cases, rhetoric heats up and both sides want to claim their way is the only way, and even God's way. Both claim to have the god's eye view of life. If one is trying to discern their way through this landmine, battle wounds often seem the only reward.

In the 1980's and 1990's, both medical sciences and religious traditions faced new questions of what it means to be human in light of such rapid technological and scientific transitions. One way to face such change is to answer the question in different ways by viewing science and religion as independent spheres that offer different answers. Religious or theological language is supposedly subjective, answers the why questions, and belongs in church or in one's own private life. Scientific-speak is public, answers the how questions, and is objective. When I have listened to medical faculty give lectures to residents I have heard an occasional doctor say that all religious, political, emotional, and cultural biases should be checked at the door on the part of the physician or health care worker. Their hope is that some kind of objectivity and distance can be maintained from the patient so that the proper treatment isn't compromised for the patient.

And the church is hardly exempt from such a world view about the relationship between religion and science. The realm of faith is reduced to a privatized world in which the purpose of Christianity is for the individual alone. While an occasional adult forum might address complicated issues around the end of life, how often does one hear a

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thoughtful sermon or prayers or other liturgical forms address these difficult moments in one's life? And actually addresses them in such a way that the worshiper doesn't feel "told" what to believe? Catechetical materials don't adequately prepare young adults to face questions about life and death, at least not in ways that prepare them for the pain and difficulty of such questions. In just recent years seminary curricula have just begun to address the questions involving what it means to be human in an age of technology and science in meaningful and thoughtful ways.

When the reproductive embryologist comes to church, she leaves her scientific hat at the door. And the same happens at work with her religious beliefs. College students are educated this way. A student once remarked to me, as he saw me wandering through the Gilbert Science Center, that science is in this building or hallway and religion is in the other building or hallway and rarely shall they meet. I was notably out of place. And while this may seem convenient to separate religion and science it is also rarely the case.

What happens if the reproductive endocrinologist or palliative care physician is facing a difficult issue about the morality of his work? In South Dakota, multiple attempts have been made to either severely restrict or eliminate abortions. What if at the local level a legislative bill that eliminates all abortions and that defines human personhood from the moment of conception is passed and becomes law? Legislative bills have been introduced which would force artificial nutrition and hydration where it is not wanted by a patient. In many of these cases, religious views of the human person are at work in the legislator's production of the bills. Many of these legislative changes could have profound impact on the work of scientists, the practice of physicians, and the healthcare of patients. All of a sudden the personal becomes public. The physicians have

to decide how to work in a context that doesn't easily separate public from private, religion from science. Consequently, some physicians and scientists have begun to lobby legislatures and inform the public about the consequences of such legislation. Here the relationship between religion and science intersects in profoundly personal and political ways.

In South Dakota (and other states whose primary economic base is agricultural), human reproductive issues cannot be separated from other sciences like veterinary medicine. What ends up at the *in vitro* lab in the city probably began in the barns of the university veterinary school. At Augustana College in Sioux Falls, South Dakota, biology students under the tutelage of Dr. Maureen Diggins do research on body fat and fertility, by using the lethal yellow mouse mutant. [21] Their research is utilized by the faculty at the University Of South Dakota Sanford School Of Medicine for work on reproductive medicine. At the University Of South Dakota Sanford School Of Medicine, other faculty does research on *in vitro* fertilization and other biomedical issues related to reproduction. The relationship is fertile and has yielded multiple articles and grants.

On the other side of Sioux Falls is Hematech: "Hematech . . . is developing a novel system for production of human polyclonal antibodies."[22] Transgenic cows are "created" or reproduced to treat human diseases. "Human polyclonal antibodies can be used for a wide variety of therapeutic applications, including treatment of antibiotic-resistant infections, biodefense, immune deficiencies, cancer and various autoimmune diseases."[23] Boundaries between human animals and nonhuman animals collapse and implode to regenerate life—to create transgenic species. Humans sacrifice the lives of

[21] http://www.augie.edu/dept/biology/Web/faculty/diggins/diggins.html

mice and cows in order to understand and improve their own species. And yet these incredible and powerful scientific and biotechnological innovations are never linked to the politics of abortion and other human reproductive concerns. Abortion of human embryos and fetuses is only one small layer of a much more complicated relationship between human and nonhuman, science and religion.

Scientific evidence is utilized by both sides of the debate in South Dakota. The intersection of personal and medical opinions gives way to more division. ". . . Determining scientific fact on the abortion is difficult, medical experts say. Even within the state's medical community, the abortion debate has been divisive."[24] The South Dakota State Medical Association issued a policy statement stating that the matter of abortion is personal in nature and the SDSMA should not attempt to change personal beliefs. Whether or not an abortion should be performed is also a matter of personal conscience, but the patient's health should not be compromised.[25]

Dr. Maria Bell, a Sioux Falls gynecologist and member of the faculty of the University Of South Dakota Sanford School Of Medicine, has found herself in the crossfire of the debate around science, medical practice, and ethics. She said, "she wasn't looking to become involved in politics but has felt compelled to become a public face in what might become the most bitter and divisive battle in South Dakota election history."[26] Speaking out on this divisive issue can result in hate mail, death threats, and compromise in one's medical practice. "Bell said she's received many harassing e-

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[22] http//www.hematech.com
[23] Ibid.
[24] Myers, Megan. 2006, July 16. "Doctors take sides on abortion ban." *Argus Leader*.
[25] South Dakota State Medical Association Policy Statement, adopted by the Council of Physicians. June 7, 2006.
[26] Myers, "Doctors take sides on abortion ban."

mails—and a few that she considered to be threatening to herself and her family. She said she removed her children from Catholic school after they were taunted by other students. But like her counterparts on the opposite side of the debate, Bell is not deterred."[27] Maria Bell has found herself in the midst of a situation in which even she cannot be expert in all of its dimensions—legal, spiritual, ethical, and scientific. In the ongoing story of abortion politics in South Dakota, the relationship between medical science and religious beliefs unfolds in people's lives that change the very way they practice both their science and their religion. Ironically, the research on cloning cattle seems to have no direct impact in the public discussion about reproductive politics. This issue becomes more complicated in a state like South Dakota where other factors are involved where boundaries of geography, landscape, economics, and race further divide a small population.

In other stories told to me, some nurses, pharmacists, and physicians who firmly believe that personhood is established from the moment of conception find it very difficult to work with patients who demand health care procedures or protocols that go against this view. What about the young nurse who works on the floor in a local hospital where an embryo reduction might take place? Should the nurse be required to participate in the procedure against his religious beliefs, against his will? Some hospitals allow nurses to not participate in the procedure for reasons of conscience. But think about this a bit further. I have participated in lively discussions with medical residents and pre-medicine undergraduates about how physicians should handle situations where they might have to go against their conscience. For example, many physicians have refused to

[27] Ibid.

participate in or administer lethal injections to prisoners on death row. However, the situation can become more complicated when individual patients come to their physicians looking for help.

What happens when a young woman comes to her physician seeking a prescription for birth control and the physician's religious beliefs are opposed to prescribing birth control? Should the physician refuse the patient's request, or refer the patient to another doctor? If for example, the physician believes that birth control is a form of abortion, then is the physician complicit in what he or she calls sin? What happens to the young woman? Or on another occasion, the physician might refer the patient and then she receives the needed prescription only to find that the local pharmacist refuses to fill it for reasons of conscience. How do health care providers provide adequate health care without either being paternalistic or by compromising the patient's care?

In a geographically isolated area like South Dakota, health care providers have unique responsibilities to their clients. For example, when pharmacists with certain religious views object to filling an order that is prescribed by the physician, women living in rurally isolated areas may not have access to referral .to other pharmacies. This pits the needs of the patient against the needs of the pharmacist. Some states include a "conscience clause" that exempts pharmacists from filling certain prescriptions because of their religious or philosophical beliefs. If the pharmacist believes that contraceptives destroy unborn children, even the fertilized eggs not yet implanted in the uterus, and then the pharmacist need not fill the order requested by the patient/physician. With increasing political attempts backed by religious groups to limit or prohibit abortion, medical and

health care providers will find themselves in ongoing religious struggles as well as medical ones. Clearly the conservative religious climate in South Dakota (a partnership between Roman Catholicism and Protestant fundamentalist and evangelical denominations like Southern Baptists) shapes the way technology and access to reproductive health care is being delivered.

Educating health care professionals about reproductive technologies and reproductive health care issues becomes increasingly complex in a culture like South Dakota. South Dakota was the first state to require pregnant women who abuse alcohol or drugs to be rehabilitated. Women can be incarcerated for using alcohol when pregnant, and using drugs during pregnancy is defined as child abuse. While not directly religious issues, the implications for the status of both the women and the fetus have religious implications for some health care providers. Given the more conservative religious climate and geographical isolation of our region, physicians, for example, have difficulty in getting medical training about abortion procedures. In a state where only one community offers abortion services, many women must travel up to 350 miles for such services and then must return to their own communities for follow-up care. Will the follow up care be adequate for the patient if the physician has refused to learn about abortion or if they refuse to help the patient on moral grounds? If medical students are opposed to learning about contraception and/or abortion procedures, whose burden is it to offer an exemption from the requirement? Should the pressure be on the student to "opt out" and possibly face criticism from more liberal faculty and other students? Or in other cases, some students have felt criticism and ostracism for requesting such education from

more conservative faculty and students? In their stories, religious and cultural issues have shaped how their education is delivered.

To complicate the situation even more in South Dakota, access to good reproductive health care can seem a luxury for the poor, and particularly for American Indian women. Many Native women writing about reproductive health care and freedom claim that the Christian religion had a deleterious affect on native women and their needs. "With the imposition of colonization and Christianity, foreign values, belief systems, and practices were forced upon our communities. Within those foreign systems, decisions pertaining to reproductive health were made by the Church with little regard to individual rights. Traditionally, reproductive health issues were decisions made by the individuals, and was not pushed into the political arena for close examination. The core of decision-making for Indigenous women is between her and the Great Spirit."[28] From forced sterilizations to policies of incarceration for pregnant women using alcohol, Native women must overcome many barriers to trust that adequate health care can be provided by a predominantly white culture. Steven Charleston, a citizen of the Choctaw Nation and President of the Episcopal Divinity School, underlines the point that racism formed the relationship between Christian missionaries and native communities. "Exploitation, even genocide, was permissible under the cover of a racist mentality that allowed Europeans, including European Christians, to believe that they were racially superior to all other with whom they came into contact. . . . American colonizers could hang hundreds of 'Indians' because 'Indians' were only savages, not real people."[29] When

[28] http://www.nativeshop.org/pro-choice.html
[29] Steven Charleston, "The Good, The Bad, and the New: The Native American Missionary Experience," *Dialog*, vol. 40, no. 2 (Summer 2001), 103.

American Indians were classified as savages, as not fully human, policies could be justified which allowed horrific atrocities like genocide.

Such cultural and religious arrogance is still a problem in areas like South Dakota. Charleston claims that "transformation is the goal, not conversion" of missionary outreach.[30] Ironically, the same goal might be applied to the exchange between Indian and White medical practices. The institutions of religion and medicine still suffer from the problem of racism. Is there openness on the part of western Medicine to learn from and be transformed by Native medicine? The same question must be asked of the respective religious traditions. The transformation can begin at the level of the personal, with stories shared.

At various points in teaching undergraduates, I have offered courses on beginnings and endings of life and learned how incredibly painful, personal, and political these issues are. From a course entitled, *Reproduction and the Family* to one on end-of – life entitled, *Living Until We Die, Dying until We Live*, I have watched students leave their "academic façade" and enter very personal and often painful discussions about loved ones, family members, and friends[31]. For example, as part of his final presentation, a student named John told the story about the "dying" of his grandmother by using powerful black and white pictures of her life and those around her. While a local physician would have diagnosed her as a relatively healthy elderly woman, she felt she was dying. John's pictures told the story of her life: most of her friends had died, the small rural South Dakota town in which she lived was losing population, she still lived alone in her small house, and her local church was losing members. Her self-diagnosis

[30] Ibid.
[31] All the names of the students have been changed to maintain anonymity.

was one in which she experienced profound loss—all that was familiar to her was dying, and so was she.

I have listened to students talk about how painful it was to watch a grandparent have a diagnosis of Alzheimer's disease and slowly over years become a different person than the one they knew. Jane, a senior in our class, spoke about how she watched her parents struggle with the care of her grandmother. The family struggled with loss at several levels: of the person they once knew, of a hope that didn't seem to exist, and of the family that that had changed drastically.

For other students a close friend might be diagnosed with cancer and all of a sudden their world changes. Priorities shift and the friendship can no longer remain the same. For some students who marry and decide to have a family, infertility becomes a problem. I met several times with a young woman to sort out the spiritual dilemmas about the couple's discovery of infertility. Sarah and Rich tried over and over to conceive only to find themselves at their local reproductive endocrinologist's office facing decisions about *in vitro* fertilization. All of a sudden in these situations, what once seemed distant, even abstract, becomes intense, personal, and urgent. Sarah wondered if God was punishing them and John struggled to even find a way to talk about the situation. They have learned that beginnings and endings are not discrete simple moments but are processes moving through an entire life story.

One of the more amazing discussions with a student that I remember centered about the theme of "playing God." Inevitably, when discussions turn to technology and what it means to be human, Christians in turn ask what it means to be divine. The concern seems to be that when technology runs amok humans have exceeded their

capacities to benefit others and have begun to trust in technology to do more than "God intended." Christians often assume that playing God implies that God is an intervening, interfering, all-powerful know it all. Divine is the exact opposite of human. How ironic when Erin, a junior pre-med student in my class, suggested that the discussion might be framed differently. She said, "If indeed God becomes human, and takes on the suffering of humans for humans, isn't that what it means to "play" or be divine? What if playing God was fulfilling what it means to be human; that is, caring for the neighbor?" Then using technology to heal and help would be part of God's intention for humankind. Erin changed the way the class thought about what it mean to be divine and human.

Students in this course on theology and medicine often pointed out that God calls people to use what God has given them and to use it for the benefit of others. Humans are created in the image of God—they are to imagine who they from within the reflection of divine creativity. What better way to become and be a human person than to employ technology for the benefit of humanity and the created order. Christians begin to think differently about who they are and what their vocation is.

Theology emerges through the stories that are told, stories about what it means to be a human person created in the image of God. These stories from South Dakota are not unique, but they represent the broader conversations that occur among ordinary Christians. And as people think about the beginnings and endings of their own lives, they can't help but wonder where they've come from and what they are here for. Such a quest requires that Christians reflect on their place in the universe, in all of its interlocking pieces and relationships. The larger narratives about what it means to be human don't begin or end in South Dakota! When Christians listen and learn from the particulars of

their own stories they discover deeper and more meaningful connections that matter to the lives of all people. Christians learn about what it means to be a human person when they are willing to share in the stories of all people. As a people born of the incarnate one, Christians are part of story of flesh and blood, broken and shared. Living and dying is what humans were created to do. And there is no simple beginning or ending, but each day is a beginning and ending, a dying and rising rooted in the hope of God. A baptismal faith of death and resurrection. Christians have learned that beginnings and endings are not discrete simple moments but are processes moving through an entire life story, one that was begun in Baptism and ends in resurrection.

**FOR FURTHER READING**

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**Williams, Terry Tempest.** ***Refuge: An Unnatural History of Family and Place*****. New York: Vintage Books/Random House, Inc., 1991.**

**Possible pictures:**

**http://www.augie.edu/pub/values/PassagesHandout.pdf**

**http://www.augie.edu/pub/values/endoflife.html**

**from our end-of-life class**

**http://www.usd.edu/med/neurosciences/partnership.cfm**

**http://www.usd.edu/med/neurosciences/partnership/travelart.cfm**

**http://www.usd.edu/med/neurosciences/partnership/comassess.cfm this has some graphs and stuff like that**

**http://www.infoplease.com/atlas/state/southdakota.html**

**possible map of SD**

**Quotes for the five insertions**

"The way I see it, being dead is not terribly far off from being on a cruise ship. Most of your time is spent lying on your back. The brain has shut down. The flesh begins to soften. Nothing much new happens, and nothing is expected of you." (*Stiff*, 9)
"Over the last twenty years in American, both doctors and patients have tried to tell certain stories about end-of-life care in the language of bioethics and in the language of legal rights. Other stories have been told in the languages of clinical epidemiology and health services research. None of these stories captures the complexity of the drama that the people who are living their lives or dying from their deaths in the same way that fiction or poetry does." *(The Lazarus Case*, 104)

"I will pose two questions for reflection and then elaborate one theological interpretation of technology. The two questions: Where does religion take place? What shapes does religion take? My answer: If we speak about technology at its deepest levels, we are at the same time speaking about its religious dimension, even if we do not use conventional religious terminology." (*Technology and Human Becoming ,73)*

""It is her restlessness that weighs on me now. Her anguish over us—the living watching the dying—the dying watching the living. She is still the peacemaker trying to create a calm in the midst of her death. And there is nothing she can do to ameliorate the situation. . . An individual doesn't get cancer, a family does." (*Refuge*, 214)

"Bearing all this in mind, I find myself supporting stem cell research. This does not by any means indicate that I am persuaded by ethical arguments that depend on distinctions

between totipotent and pluripotent cells. In fact, I am not finally persuaded at all. I find myself in an interim state, struggling to weigh the complex factors. My theological excursis into dignity is illuminating, but it does not make answering the central ethical question clear enough to be decisive. This may be disappointing to some readers." (Ted Peters, quoted in *The Human Embryonic Stem Cell Debate*, 137)