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A Moral Appraisal of Infertility Treatment

Roughly two years after the miscarriage, John and Lizzy found themselves standing over family photos and a half-assembled adoption portfolio. The adoption agency had provided rudimentary guidelines for organizing their book—tell your story simply and directly. It's not a marketing scheme. When she wasn't at work, sleeping, or walking the dog, Lizzy was with the portfolio. She and John both felt confident about their decision to proceed with adoption. It was a confidence born of prayer and experience. And they were excited about the new venture!

A year and a half earlier John and Lizzy were not looking over family photos, but glossy brochures explaining in inaccessibly technical terms some of their reproductive treatment options. Their eyes gravitated toward familiar words like *hormone*, *artificial*, *laboratory*, *freeze*, and *cycle*. Others, like *surrogacy* and acronyms like *IVF* and *IUI*, were meaningless to

them. With the specialist's assistance, however, they were able to grasp a few of the treatments and procedures available to them, at least in theory. The cartoonish images on the brochure offered little insight. Debriefing with one another on the drive home was mostly an exercise in confused repetition.

The fact they could ease into this process slowly was reassuring. "We would begin with some simple tests and assessments," suggested the specialist in script-like cadence, "and then once we identify a potential problem, or mitigating factor, we can then devise a precise treatment regimen." He said that when a treatment produces no result, that's a sign to move along to the next one. The idea was to start with the least invasive option, and then movement up the scale of "involvement" would correspond to John and Lizzy's "comfort level."

Naturally a "mitigating factor" to their "comfort level" was the exorbitant *cost* of these specialized treatments. Elevating to a new phase of treatment also meant escalating to a new price. Excellent as John's insurance benefits were, the policy would not cover many of the optional treatments offered by the clinic. The heaviest costs would be out of pocket. IVF alone could reach upward of twenty thousand dollars. And in the end, despite all the consultations, phases, and costs there was no guarantee of a child. They were "good candidates" for more enhanced reproductive treatments, or so they were told, but John and Lizzy were grounded enough to acknowledge the unfavorable probabilities.

They would proceed incrementally.

Tests were run, scans conducted, samples studied. Lizzy was prescribed a newly developed hormone treatment, supplemented with a range of vitamins she was slightly deficient in. John's tests

were unrevealing. They had conceived before, after all. Lizzy later underwent some minor outpatient surgery to remove a cyst from her ovary, to no eventual effect. And here they would stop. They had discussed it before ever commencing with treatment, had sought the advice of family and their pastors, and were resolved not to proceed with IVF or surrogacy.

Three months after submitting their portfolio to the agency John and Lizzy were picking up some produce at the farmers market when they received a surprise phone call: an expecting mother had selected them and wanted very much to meet! Lucy, they came to learn, studied literature at a university. Her pregnancy was an accident and, although persuaded by many of her friends to abort, she felt it was her responsibility to have the baby and then place it with adoptive parents. She said she had reviewed what felt like piles of portfolios before reviewing John and Lizzy's. But when she saw their photos and read their story, she knew they were the ones.

Several months later John and Lizzy smiled broadly at one another as they unlocked the front door, pushed it open, and brought little Grace into their home.

Uncertainty

Infertility reminds us we are not always in control. We are all subject to other powers and realities. Dramatic advances in modern medicine have made it possible for many infertile couples to conceive, although no reproductive treatment enjoys a 100 percent success rate. Yet, despite these advances, we also recognize something profoundly uncertain, even risky, about procreation. Just ask one of the many couples using birth control but who discovered a surprise pregnancy a few weeks later! We haven't

the foggiest idea whether "this time" will do the trick. No one is promised children. Couples *hope* for children. Those with hope look to God, the sovereign One and giver of all good gifts. It is possible to see even childlessness as such a gift.

Conception is uncertain. Will sex at the right time of month result in pregnancy? Perhaps. The same uncertainty applies to pregnancy itself. Could it be twins? Boy or girl? Brown eyes or blue? His temperament or hers? We hope and pray for delivery of a healthy baby. "Expecting" is the word we use in this context, and it's right that we do. With only a few grainy ultrasound photos and crudely refined speculations, we wait for children to enter our world. Sometimes babies come when they're ready, and sometimes they need a little coaxing. In either case, the joy of a child's arrival is also tinged with some feeling of relief—the baby is *here* now, safe. At least one reason for this feeling is a corresponding belief, however unconscious, that life in the womb is somehow more uncertain than life outside it. Pregnancy is inescapably pregnant with uncertainties.

At the same time we are not wholly ignorant of the biological conditions and processes of pregnancy. We know more now about the hows, whats, whens, and whys of the human body than at any point in human history. The sheer scale of modern medicine's achievements is hard to capture without resort to hyperbole. Suffice to say, today we are not without remedies or therapies or medications or surgeries or treatments for what ails us. Modern health care has proved it can cure many of our diseases, relieve much of our suffering, reconstruct our appearance, and even extend our life expectancy. Ordinarily we think of health care simply as what we need when we're unwell, and for the most part that is precisely what it is to us.

But medicine can also have other applications, obviously, including treatment of infertility. Couples who experience prolonged infertility often seek the assistance of reproductive specialists. These couples have done all that they know to do—monitoring food intake, stress levels, and natural cycles—and nothing has worked. Like anyone else whose competence has reached its limit, couples understandably solicit the advice and help of an expert. It is what I call the "medical turn." What they need only the specialist can provide.

The purpose of this chapter is to survey several common forms of infertility treatment and offer a moral assessment of them. Medicine has come a long way, as I say, but just because a treatment is available doesn't necessarily mean it should be ventured. Assisted reproductive technologies (ARTs) are complex, as are their ethical implications. My aim here is to make the ethics of artificial reproduction as accessible to readers as possible. Before beginning that appraisal, however, a brief word on a delicate subject: miscarriage.

Miscarriage

Miscarriage is the spontaneous loss of pregnancy before the twentieth week of gestation. Experts estimate that approximately 10 to 20 percent of pregnancies end in miscarriage. The vast majority of miscarriages occur in the very early weeks of pregnancy, usually due to some chromosomal problem with the developing fetus. Miscarriages after week fourteen, on the other hand, are more often attributed to some underlying problem in the mother. Then, after week twenty, the "miscarriage" designation switches to "stillbirth." Although practitioners know far more about the potential causes of miscarriage than they

did even a few decades ago, the exact reasons some women are more prone to miscarriage than others remains a subject of considerable study.

The wound of miscarriage is both physical and spiritual. When a child is conceived, so are hopes and expectations. The little one in its safe, nourishing enclosure becomes an object of prayerful concern. A mother's body reacts naturally to this newly formed life, sustaining it and providing the vitality it needs for development. This intimacy between mother and child is exquisite. The mother has no choice as to whether her body will nurture this new life inside. Her body simply reacts.

During gestation mothers share a reciprocal relationship with their child. The umbilical cord linking them is something of a two-way portal. Yes, the mother furnishes far, far more for the child than the child does for the mother, obviously, but the reciprocity they share is crucial to the child's pre- and postnatal development. Mothering begins the moment new life is detected. The connection is physical, hormonal, emotional, and spiritual. Child and mother experience one another.[1] They share life. This directness and intimacy—this *bond*—is also what makes miscarriage so painful and debilitating.

Mothers say they "lost" a child by miscarriage because the term captures precisely how they *feel*. Their little child died. No summary of causes lessens the hurt. Nor does explaining why it happened help a mother fully accept why it happened. Theories are of little consolation. Miscarriage is a tragic fact of human life, a cruel and jarring reminder of the fall. We mourn it and look to a time when it will no longer occur. In the meantime Jesus receives these little ones into his eternal love and peace. Lost to us, in a way, but never lost to him.

Losing a child by stillbirth later in pregnancy is perhaps even more agonizing. A corner is turned after the first trimester, and couples allow themselves a little more hopeful optimism. They announce their pregnancy to family and friends. The loss of a child late in pregnancy is devastating, and to further compound the hardship, in some instances, the mother is required to "deliver" her child either surgically or by induced labor. For many mothers, the experience is physically and emotionally traumatizing: her baby claimed some deeply emotional part of her, and that part died with her baby. What follows, rightly and invariably, is a period of mourning. Some couples may elect to hold memorial services for their little one. It is a time of anguish.

As I have said before, "infertility" applies to a spectrum of experiences. Some infertile couples never conceive, while others conceive but remain unable to carry the child to term. The distinction is an important one because of the unique ways each experience may be treated by medical specialists. The couple that cannot conceive will be prescribed a different regimen or program than the couple that can conceive but cannot bring a child to term. Assessing the ethics of assisted reproductive treatments and technologies requires identifying exact purposes and means of treatment.

Artificial Reproductive Technology

In order to devote ample attention to reproductive technologies presenting the greatest moral challenge, I wish to focus here on two relatively common reproductive technologies: *Intrauterine Insemination* (IUI) and *In Vitro Fertilization* (IVF). By the time these technologies are recommended to a couple, all other less-involved options have been attempted, without success. The

specifics of procedures like IUI and IVF are not always clearly conveyed to couples, however, and even when they are, couples sometimes do not wish to know the clinical details.

IUI and IVF constitute more advanced forms of treatment in that they are *extra*bodily. That is, these treatments require special handling, storage, and transport of biological material in a laboratory. Before, a couple's treatments were designed narrowly to aid conception through normal sexual intercourse. Assisted reproductive technologies like IUI and IVF, on the other hand, circumvent sexual intercourse entirely.

To form an accurate Christian ethical assessment of IUI and IVF, it is crucial to understand both the technical procedures themselves and the implications those procedures carry. Too often our posture toward medicine is deferential and admiring. Medicine helps people, we say to ourselves, and the ways it goes about helping people are right because its aim is noble. Medicine does indeed have many laudable aims. But when we subject this particular presumption to closer scrutiny, we must also recognize that means do not always justify ends. There are all sorts of bad ways to go about achieving good ends. We shouldn't lie our way to a promotion, shouldn't wipe out a civilian population to win a battle, and shouldn't inject ourselves with black tar heroine because we want pleasure, to cite a few examples.

In ethics this theory is referred to as *utilitarian*. For the utilitarian, an action is right or wrong in proportion to the positive or negative consequences that action produces. Good actions, in other words, are those that maximize pleasure and minimize pain for the most people. It is easy to see why modern medicine would find this theory attractive. Medicine aspires to heal and to improve the lives of patients—a net positive social contribution.

An overwhelmingly positive social contribution does not also mean, however, that all of medicine's methods and aims are right. Whether a medical practice, procedure, or convention is ethical depends upon much more than some overall social utility. The relevant purposes, methods, and assumptions also deserve consideration.

IUI and IVF are known as assisted reproductive technologies, or ARTs. Reproduction is in this instance assisted technically, mediated by a medical specialist. Intrauterine Insemination is the less complex procedure of the two. With IUI a man's sperm is collected and "washed" to separate sperm from other seminal fluid, at which point the sperm is then inserted directly into the woman's uterus during ovulation, increasing the chances of conception. Inserting sperm directly into the uterus raises the likelihood that at least one sperm will fertilize the egg during ovulation.

Although much less complicated than IVF, IUI still requires involvement of a medical technician to facilitate conception, and thus any couple opting for it should consider the deeper theological question of whether the relation between conception and sex is sacred. Is the manner of procreation as God designed open to amendment? With IUI the amendment is light, one may say, and perhaps a matter of individual conscience.[2] But this question of whether, or to what extent, the method of conception matters to God applies equally to IVF.

In Vitro Fertilization (IVF) is a vastly more complex procedure than IUI, and as such carries more complex ethical implications. The process goes something like this: a man donates his sperm and a woman has eggs harvested, her eggs are fertilized by his sperm in a laboratory (*in vitro* is Latin for "in glass"),

and the embryos created are frozen in a clinic until the woman reaches an opportune point in her cycle. In most instances multiple embryos are implanted, on the presumption it increases the chances of at least one embryo implanting successfully. Birth of multiples is for this reason a relatively common occurrence.

A few features of this process deserve further reflection. First, the procreative process is externalized. Procreation is not sexual, strictly speaking, but clinical. Biological material is given over to specialists for fusion and deposit. The natural, intimate link between sexual intercourse and procreation being unfruitful, an artificial method is tried. Artificial fertilization should not, however, try for any *more* than would be tried for in natural procreation; that is, trying for *a* child. A couple should not utilize artificial means either for the express purpose of conceiving multiple children or to genetically enhance the child in any way.[3]

Second, a couple must resolve to set a limit upon the number of eggs to be fertilized. The more embryos created in a lab, the more storage is needed, and the less likely a couple is to have all embryos eventually implanted. It is *essential* that couples have only one egg fertilized and implanted at a time, so as to avoid creating an excess number of embryos a couple may not wish to implant.

Third, what a couple expects to happen through IVF on the front end and what actually transpires are not always congruous. That is the nature of our moral experience in general, of course. We act on expectations of a future that, for a variety of reasons both inside and outside our control, never come to fruition. Expectations may be met or disappointed. It is of great moral importance not to infuse expectations with inevitability.

Lastly, IVF is voluntary and expensive. It is not a treatment in the way vaccines or chemotherapy or angioplasties are treatments. It does not seek to *restore* health. IVF is instead a technical procedure that may or may not furnish couples with children of their own progeny. The average cost of IVF is between fifteen to twenty thousand dollars, a price that upticks with additional services.

Let me expound a bit further on a few of these points. In his prescient book, *Begotten or Made?*, British theologian Oliver O'Donovan cautions against use of IVF for theological reasons. First, there is the matter of IVF's backstory. Clinical IVF became possible because of extensive research trials to test hypotheses and to refine techniques. This research was conducted over the course of many years, and in practice required destruction of untold numbers of human embryos. This was the price to be paid for clinical application. Any Christian couple contemplating IVF must reckon with this backstory.

Second, O'Donovan identifies two "risks" associated with IVF. Natural procreation always involves acceptance of some risk. When a husband and wife conceive, they hope their child will be born healthy and whole. We just don't know for certain what sort of child is coming, or in what condition it will arrive. Pregnancy achieved through IVF, on the other hand, involves acceptance of *enhanced* risk. It is enhanced because of the various artificial mechanisms it involves: specimen gathering, fertilization, freezing, storage, handling, and implantation, not to mention reliance upon various personnel, instruments, and equipment. Compared to natural procreation there is more that could contribute to some complication or malformation to the child. The probability may not be very high, and indeed

may even be negligible. But, according to O'Donovan, it's the mere willingness to accept this risk that proves morally decisive. "There is a world of difference," claims O'Donovan, "between accepting the risk of a disabled child (where that risk is imposed upon us by nature) and ourselves *imposing* that risk in pursuit of our own purposes."[4]

Suppose a couple conceives through IVF, and the child is born with an acute cognitive impairment. Are we able to fix responsibility for the impairment with any definiteness? It would seem not, and the inability to do so presents a problem. In what other sphere of our experience, posits O'Donovan, do we observe someone imposing injury on another (in this case on a child) without the prospect of attributing responsibility? Here it cannot be determined when, who, or what may have caused the child's impairment directly, yet a condition of IVF is to accept that such a cause is possible, and ethically speaking, that's all that matters on final account. This is why the mere willingness to accept an enhanced risk itself constitutes moral error.[5]

On the other matter of a potential tension between a couple's early expectations about what IVF may make possible and the real eventualities of their experience, a delicate word is needed. Many Christian couples pursue IVF for reasons they believe consistent with their faith. I know many personally, and I've heard their stories. God has said it is good to have children, they want children, and IVF seems to offer the medical means for realizing their dreams. I have no doubt that a tremendous number of deeply faithful couples opt for IVF with pure intentions.

The moral tension has comparatively little to do with the purity or sincerity of human motivation, however. Of greater concern is the mismatch, common to human experience, be-

tween expectations obtaining *prior* to an action and the consequences *brought about* by that action. We use a peculiar word to compliment someone on their flattering appearance, and to our surprise they seem more dejected than cheered up. We pay a hefty fee to enroll in a community course, only to find that we do not have the time for such a commitment after all. We place a family member in assisted living thinking it the best arrangement for him, only to observe his steady slip into depression mere weeks after moving in. Still other examples illustrating the frequent incongruity between expectation and consequence are in great supply. You likely have your own.

As it relates to IVF, the mismatch between expectation and consequence is especially precarious. Suppose a Christian couple opts for IVF after several years of infertility. They are decently informed about the process and ask the clinic to limit fertilization to five eggs. A child is conceived on first implantation, and nine months later a son is born. After a year or so with their little boy, the couple is ready for a second child, and another embryo is implanted successfully. A daughter is born nine months later. All has gone according to plan! So it seemed, until a short ten months after the birth of their daughter, the couple discovers they have conceived *naturally*. (They never figured they'd need contraception!) This turns out not to be an anomaly, because a year after the birth of their third child, they conceive naturally yet again. So, approximately five years after opting for IVF, the couple has two children conceived artificially and two naturally, leaving three embryos still frozen in storage.

The confidence this couple had at the outset to implant all five embryos, once assailed by the pressures of parenting four young children, understandably weakens. Originally they intended to

have all five embryos implanted, except now the prospect of having the three remaining embryos implanted strikes them as physically, emotionally, and financially overwhelming. Of course they did not anticipate conceiving children naturally. Of course they did not sufficiently appreciate the range and force of demands children place on parents. Nevertheless, here they are: four children, three frozen embryos, and decisions to make.

Let me be very clear at this point: I do not mean to insinuate that couples who find themselves in the sort of hypothetical position I describe bear permanent and impregnable guilt for their decision. As I said, the initial reasons prompting a couple to opt for IVF are typically formulated on the basis of knowledge available at the time. Had they been fully apprised of the full moral complexity of their decision, perhaps they would not have proceeded in the first place. Even so, they are not relieved of the hard decision of what to do *now* with their frozen embryos. It is of great moral importance to recognize that the future often contains much more contingency than we are often able to appreciate. Some of our projects are realized, and some miscarry; that's an unavoidable feature of human life. Who knows what might happen? That's why the Bible says the proper Christian response to the future is *hope*.

For the Christian couple with frozen embryo(s) they're uncertain about implanting, two options are available: have the embryos implanted as originally intended, or place the embryo(s) up for adoption. Unless the couple faces some extenuating crisis, what Dietrich Bonhoeffer refers to as a "borderline case," frozen embryos should all at some point be implanted in the mother.[6] The extenuating crisis must therefore be very severe indeed; as in, the mother has received a hysterectomy,

or, more gravely, has passed away, at which point the biological father may justifiably place embryos for adoption. Such borderline cases aside, couples bear the responsibility to have frozen embryos implanted. A couple's decision in this instance is not whether to have more children; rather, it is acknowledging that they already have children in temporary stasis deserving a chance at full life.

The Christian couple contemplating adopting an embryo is in a slightly different position. Although it is estimated that between five hundred thousand and eight hundred thousand embryos are in frozen storage across the United States, most of which are slated for implantation with biological parents, there are no exact statistics accounting for embryo adoptions nationally. For a variety of reasons, some of these embryos are not finally implanted, and so are either stored as long as a couple leases storage, or they are destroyed or placed for adoption. Because the likelihood of an embryo being destroyed is so disproportionately high, given the surplus number in storage, it is justifiable for a couple to adopt an embryo. The couple adds a child to their family and likewise prevents its destruction.

In allowing for this sort of adoption I wish also to alert couples to two moral problems that may arise. First, the legal language associated with embryo adoption is in many states *transactional*, meaning the contract a donating couple enters with an adopting couple uses terms of *property* exchange. It is imperative that the legal terminology, which in this case is also metaphysically derived, does not in any way suggest an exchange of property. Absence of precise federal statutes on embryo adoptions means that contracts vary from state to state, and to complicate matters further, the legal status of an embryo

is a significant issue of debate. Couples considering embryo adoption should do their due diligence both to familiarize themselves with the law and to select a reliable agency.

This leads me to the second cautionary point: the majority of embryo adoption agencies are *for-profit*. Embryos should never be considered a sort of commodity, and any attempt to do so is morally odious. The profit variable in embryo adoptions raises a few other moral concerns that, although not especially prominent today, may become increasingly prominent in the near future, such as the possibility of incentivizing future embryo trading, of individuals partnering with others individuals to produce genetically superior embryo adoption markets, or agencies themselves couching their services in terms of boutique embryo selection. Again, these arrangements do not yet appear to exist, but the ways embryo adoption agencies have constituted and positioned themselves in the market make it a real possibility.

Surrogacy

Technologies associated with IVF also make surrogacy possible. In its standard form "surrogacy" refers to the practice of a couple contracting with a woman to carry their biological child to term and surrender it back to them at birth. This is the most common but by no means the only form a surrogacy contract can take. In fact, it is possible to involve as many as six parties: biological mother, biological father, adopting mother, adopting father, carrying mother, and child that will be born, to say nothing of the IVF clinicians or personnel contributing to recruitment of surrogates and their pre- and postnatal care. Dystopian as the practice may seem, it is now fully mainstream, both within the church and without.

I cannot speak here to all the technicalities of surrogacy or to all the moral repercussions following from it, but do wish to state rather straightforwardly that the dominant transactional form of surrogacy, where a couple remunerates a woman for carrying their child to term, is morally odious. It is indistinguishable from womb rental. Compounding the problem, surrogacy contracts disproportionately favor the contract parents and include few protections for carrying mothers. Even when carrying mothers enter willingly into contract, they remain vulnerable to exploitation. Almost all, for example, include at-will provisions for contracting parents, and for which the carrying mother has no legal recourse.

Alternatively, within the church, the most common form of surrogacy is not transactional but voluntary. A sister offers to carry a child for her sister and brother-in-law, for example, or a close friend for another friend. The carrying mother is compensated only for the expenses accrued by having the child. She is not paid. Why this occurs is understandable, too. Someone wishes to help out a loved one, and such sacrificial generosity seems on first glance beyond reproach.

Nevertheless, as with embryo adoption, the mistake here is in assuming that a pure or altruistic intention is enough to make the action morally right. The exclusive marital bond is, however unwittingly, decoupled for temporary incorporation of another. This is not procreation in the truest sense of the word, but reproduction. Surrogacy proceeds on a parallel assumption that the marital covenant is spiritual but not also material, that it does not make a claim on the human body.[7]

Many surrogates do not anticipate developing an affectionate bond with a child during its gestation and yet do in fact come to form visceral bonds with the child. So here we have a

"mother" who brings a child without her own genetic material into the world feeling tangibly bound to it, even to the point of loving and adoring it. Why? Because in utero the "new one" and the mother experience one another in powerful ways.[8] Forming such a natural bond is how God designed it. Surrogates often do not anticipate coming to love the life they're helping bring into the world, and so it comes as no surprise that some of these young women put up a tremendous legal fight to retain custody of children they contracted to give up. Can a surrogate "care" for her developing baby with only her head and without her heart, to simply do her contractual duty, dispassionate to the new one drawing upon her very life and breath? The answer clearly is no, and indeed she shouldn't have to.[9]

Who is the mother of the child born through surrogacy, the surrogate or the woman whose egg was fertilized? The carrying mother or the genetic mother? Our answer will depend upon what we think "mothering" means, of course, but its traditional use strongly suggests that the surrogate has mothered the child to the point of birth. Irrespective of the contract she has formed with another party, the surrogate's body reacts to the child she carries as though it were hers. Her body reacts as designed, as does her child's. In this context the contract is an abstraction. This and similar complexities strongly undercut the Christian ethical legitimacy of surrogacy, no matter how well-meaning someone might be.

Conclusion

The aim of this chapter has been to survey some assisted reproductive technologies, to assess their moral implications, and to offer some moral counsel regarding surrogacy and embryo adoption. We focused primarily on IVF and on the practices and

procedures IVF makes possible. I have cautioned against IVF for both theological and moral reasons. If you are contemplating IVF, I pray you take seriously the risks and hazards involved and elect to forgo it, with one proviso. IVF would be acceptable if only one egg were fertilized at a time, never creating more embryos than would be implanted. If you have already proceeded with IVF and as a result face a vexing moral dilemma, I advise not to place embryos up for adoption but instead to have them implanted, then, if necessary, place the child for adoption. That may be terribly hard counsel to accept, I realize; and I do not pretend to understand the struggle you have endured to this point. I can only implore you to seek God's guidance and courage, and to hear again what God has said about his purpose for human beings and their relationships.

I want also to exhort infertile couples not to allow the desire for a biological child to supersede all other biblical, theological, or ethical considerations. I caution against making use of the options above because they presume a certainty about how life will go, when in fact conception and pregnancy are notoriously unpredictable phenomena. Opting for any of the above commits you to risks and dilemmas you would do well to avoid.

Should you choose in favor of them anyway, it will be on the assumption that having a biological child is an end no means could upset, and needless to say, that is not the logic of discipleship but of utility. Speak with others you trust—family, friends, pastors—and do the hard work of listening and thinking and praying. Wise is the one who heeds a sound word of instruction. In Christ are the riches of wisdom, and if anyone lacks wisdom, "let him ask God, who gives generously to all without reproach, and it will be given him" (James 1:5).

Now a brief word for readers who have experienced the pain of infertility: *God loves you, he has not forsaken you, he comes to the afflicted.* Yours is perhaps a unique experience, and although you may often feel alone or despondent, the reassuring truth is that Jesus is familiar with your suffering. "He is actually not far from each one of us," Paul writes (Acts 17:27). In Christ alone is the peace and wisdom to consider present sufferings as not worth comparing to the glory that is to be revealed in us (Rom 8:18).

Takeaways

- Infertility reminds us we are not in control. Conception is uncertain. Nor do we have knowledge of exactly the sort of child that will be born if we do conceive.
- Miscarriage and stillbirth are tragic facts of human existence. They are wounding. These children who pass too early are received into the loving arms of Jesus.
- Of the two artificial reproductive technologies discussed, IUI is the least involved and carries few moral implications.
- IVF carries with it several significant moral implications, including the creation of excess embryos, assumed risks to the child, and expense of treatment.
- IVF may still be morally permissible if couples accept the following in conscience:
    - The remote possibility of impairment or injury to the child.
    - Circumventing natural procreation by artificial means is consistent with God's purpose for sexual union in marriage.

    - Only one egg is fertilized and implanted at a time. No excess number of embryos are created or stored.
    - Cost of treatment is not overburdening.
    - Adoption has been given due consideration, and is not ruled out on the sole basis of wanting a biological child.
- Couples should not place embryos for adoption, unless countervailing circumstances are such that it is the only justifiable course of action.
- Surrogacy is not morally permissible, both for natural and theological reasons.