The Incredible Value of Women as Daughters of God

Some months ago, a film did the rounds captured by a Students for Life group during a campus event at a U.S. university. The group had a display containing hundreds of crosses, representing the number of abortions carried out by Planned Parenthood every day. Counter-protesters pushed their way into the middle of the crosses, bragging about their abortions. “That’s mine over there!” called one, “I’m so slutty, I got pregnant and had to have an abortion!” “Let’s piss on the foetus graveyard!”

 It was a disturbing but familiar sight for anyone who has been involved in pro-life activism and it provoked some pretty pithy responses from the pro-life side. But the only emotion I ever feel watching those ugly, hate-ridden, potty-mouthed displays is sadness; because all I can see there is pain and guilt. I find myself wanting to ask these scowling, swearing women some questions – were you loved when you were growing up? I mean, really loved? Nurtured? Valued? Did anyone ever tell you that your life is inherently valuable, that you have a higher purpose in this world that you may not even understand in this life? Did anyone tell you that you have nothing to prove? Because it is my profound belief that no one who grows up safe in the knowledge that they are loved, that they are valued, that they have dignity and worth beyond measure, ever turns out so spitefully nihilistic.

 If I were to tell any of the rage-filled women I have encountered that they are God’s daughters, it is unlikely that I would get a positive response. But that in itself is very telling, and not just because of widespread secularisation. Increasingly, the dichotomy between the Catholic understanding of womanhood and the image of womanhood promoted through radical feminism, is so great as to feel insurmountable.

It is not clear whether it was Florynce Kennedy, Gloria Steinem or an elderly Irishwoman in the back of a taxi, who first made the declaration: “If men got pregnant, abortion would be a sacrament.” However, it is not a bad place to start in terms of understanding that dichotomy, with its deliberate misappropriation of Catholic and Orthodox terminology. Abortion is increasingly regarded as a sacred doctrine within contemporary feminism, it is as central to feminism as the sacraments are to the lives of the faithful. Abortion only fails to be elevated to a sacred status because it involves women and women are profoundly misunderstood. Nor is it the only abortion-endorsing mantra to misappropriate and parody the truly sacred. My Body, My Life, My Right to Decide, mocks the words of Christ – This is my body, which is given up for you – and expresses in vivid colours a destructively self-centred vision of womanhood – destructive in every sense of the word.

Now, for all my harsh criticism of some strands of contemporary feminism with its idols of abortion and contraception and its nihilistic vision of womanhood, I would be the first woman to say that we should not forget the world in which feminism emerged, not should we willfully ignore the considerable progress there has been in some areas at least, in granting equality between the sexes. I think we have to acknowledge those positive changes. As a woman, I enjoy rights, every single day of my life, that were denied previous generations. The fact that I am here, taking part in a conference on a par with men, bears tribute to the tireless work of generations of women who fought for the right to be taken seriously.

But are women *valued?* Does the way the medical profession interacts with women in any way reflect *the value of women as God’s daughters?* The Aristotelian tendency to view women as faulty men casts a long shadow over women’s healthcare. For all the talk of autonomy and empowerment, there remains an ingrained sense that the female body is problematic in itself, even – and in particular – in its healthiest state. I have heard the contraceptive pill referred to as ‘the cure for being female’ partly because of the tendency by some doctors to prescribe the Pill for everything from the desire to avoid a pregnancy to period pain. The many side effects suffered by women as a result of swallowing a grade one carcinogen are accepted as a necessary sacrifice on the part of women for being liberated from motherhood.

This cavalier attitude to women was thrown into relief by the male contraceptive trials some years ago. Was I the only woman who giggled over my cornflakes, hearing that the trials had had to be cancelled, because men were suffering such terrible side effects – migraines, depression, weight gain, acne – in short, the very symptoms women have been expected to put up with for years! The very different approach to male health vs female health that this decision appeared to imply, did not go entirely without comment in the media.

It was pointed out to me in another forum that two of the men involved with the contraceptive trials committed suicide and I in no way wish to trivialise that tragic outcome. However, in both cases, it was unclear as to whether the drugs themselves were responsible as both men had a history of mental illness. More seriously, when we consider that depression is one of the many side effects of the Pill, when we also consider the numbers of women who are prescribed the Pill who have a history of depression, given its prevalence within society, it is unlikely that there have been no suicides of women as a result of taking the Pill. But I have never heard calls to ban it on those grounds. And I should also clarify that I think it was perfectly correct to halt those male contraceptive trials. My point is that women have never been treated with the same care. I don’t think men are wimps, I just don’t think women should be expected to be martyrs to the pharmaceutical industry.

Without wishing to ignore the very real advances for women, I would argue that the ability of a woman to give fully informed consent is still seriously limited within some areas of medicine and most egregiously, this failure to treat women with dignity and respect is hidden away behind lofty promises of respecting female choice. As part of my research, I have had the misfortune to look through the ‘factual, balanced’ literature of several UK-government-funded abortion chains to see just how informed they permit a woman to be when she enquires about abortion, and it makes for pretty depressing reading.

It is instructive to compare the patronising, almost coaxing tone employed to describe the abortion procedure compared with descriptions written for patients of elective caesarean, hernia repair or even tooth extraction.

Like nervy children, women considering abortion are reassured that “a gentle suction method is used to remove the pregnancy from the uterus”, “a suction machine will be used to gently complete the evacuation”, the Dilapan works by “gently opening the cervix” and the cervix must be prepared “to cause it to gently dilate over a few hours”. I have never seen the word “gentle” used so frequently and so pointedly in medical literature except in the supposedly factual, balanced information handed to women enquiring about abortion.

 So much time and energy is expended selling abortion and contraception, that other areas of medicine can be easily overlooked. We all know that there is a great deal more to women’s health than not getting pregnant but the use of abortion as a kind of safety valve does not just have an impact on attitudes towards sexuality, it can also have an impact upon the level of care women in problem pregnancies are permitted.

A study by Pregnancy Sickness Support in the UK of women who underwent abortion whilst suffering from Hyperemesis Gravidarum, found that 85% of the women surveyed said that the healthcare professionals they turned to simply did not understand how ill they were, leading to around 40% being offered no help whatsoever and others complaining that they were treated like silly children making a fuss about nothing or actively faking symptoms for attention. The overwhelming majority of women surveyed desperately wanted their babies and would not have had abortions if they had been properly supported.

As this study was conducted in partnership with an abortion chain, the emphasis was very much on reducing the stigma associated with abortion rather than the more obvious need to avoid women being pushed into abortions they don’t want.

This is an issue of personal importance to me because I suffered form severe HG during all my pregnancies, with my last pregnancy being particularly bad. On one occasion, I staggered into my doctor’s consulting room on my fifth day without fluids because I seriously thought I was going to die. As I drifted in and out of consciousness, my doctor treated me to a lengthy telling off – complete with eyerolls, smirks and weary shakings of her head – on the subject of why I was purposefully dehydrating myself and this was dreadfully silly, wasn’t it? It particularly disturbs me that, in Britain, GPs are the ones who sign the referral forms for abortion. By what peculiar logic should a doctor have the power to end a pregnancy but not be obliged to care for pregnant women who are suffering?

Some years ago, I heard a NaPro technology practitioner from Dublin make the point that he could not get any support for natural fertility awareness because there was very little money to be made unlike the lucrative field of ART, but if the dignity and wellbeing of women really mattered, resources would be invested in assisting women in ways that work best for them rather than that generate the highest profits.

One of the most attractive aspects of NaPro technology, speaking as a pro-life feminist is the way in which it respects the whole woman: the way it does not simply see a malfunctioning body, NaPro Technology respects the woman physically, emotionally, mentally and spiritually. It is heartening to hear doctors in this field speak of the need to pray for and with the couples who come to them, to know the moment when a couple need a break from treatment to focus on their marriage, the way in which the couple’s welfare comes first. If we consider the terrible strain fertility treatment can put on a marriage, there is surely no better way to care for women than to acknowledge the value of marriage and the uniqueness of the female experience.

 And part of the journey doctors take with couples who are struggling to conceive, is the sad realisation sometimes, that a couple will never conceive a much-desired child. Some years ago, I had the privilege of attending an NFP conference in the north of England, during which couples who had successfully conceived came along with their children to talk about their experiences. At the end of that session, a beautiful young woman stood up, supported by her doctor, and talked about how she had not succeeded in having a baby, but NaPro Technology had worked for her, because it had helped her to come to terms with life without children and to move on. No woman should leave a medical facility broken, humiliated and with a lingering sense of having been violated by procedures intended to help her. The fact that that woman chose to stand with her head held high, supported and respected by the doctor who had guided her through that painful journey, was testament to the importance of truly pro-woman medical care in that most sensitive of fields.

It maybe unhelpful to bring the Blessed Virgin into a discussion in a consulting room, but as Catholic doctors you do know the value of women as God’s daughters, you do know that the mystery of the incarnation began in the fallopian tube of a woman. In my novel We’ll Never Tell Them, I referred to an old saying I heard as a child, that a man should see his wife as Our Lady in his home, and he should treat his wife with the same level of respect and reverence. Perhaps, by the same token, healthcare professionals should get into the habit of seeing their female patients as Our Lady in their consulting room or their hospital ward. If you were treating the Blessed Mother, how careful would you be, how respectful of her dignity! This is not as outrageous a proposition as it may at first appear, since Mother Teresa spoke of seeing the suffering Christ in the face of every poor person she encountered.

Inevitably – if unfortunately – a woman’s understanding of her own dignity and her own place in the history of salvation, will be heavily influenced by those she encounters. And in a society where we are losing any sense that there even is such a thing as womanhood, it is imperative that as Catholics, we do not let women down. Because a key part of our understanding of the complementarity of the sexes, is that we appreciate the extent to which the dignity of women is enriched by men as well as by other women.

Girls learn to be women and they learn to understand that they are God’s creations, God’s daughters, first and foremost in the home, through the example of the mother but also through the behaviour of the father. The fatherless society harms the formation of girls as well as boys, because girls come to understand their own dignity by the way their fathers treat their mothers, they develop expectations about the way they should be treated by men by viewing the relationship between their parents.

But when a girl or a woman goes to see her doctor, she is by definition vulnerable. She’s ill, injured or concerned that something is wrong. And how she is treated will have a profound impact on her. What sets Catholic medical professionals apart is surely that sense of vocation, that sense that you are serving God in the sick and vulnerable. Catholic healthcare should perhaps serve as a reminder that doctors are healers not facilitators servicing clients.

Because in the end, our faith is both a physical and a spiritual reality, and it is through the physical experience of being female that we as women can understand more fully what it means to be daughters of an incarnational God.

I discussed this topic at length with Californian NFP promoter and sister-in-arms Sheila St John and I was particularly struck by her reflection on the connection between the physical and the spiritual within female identity. She writes: “There is a symphony of events that are all so orchestrated to create each month, the best circumstances for a woman to welcome and nurture a new life.

This process is part of me, and who I am as a woman. When I more intimately understand the way God created me, I become more aware that I am a daughter of God, for only a loving God could have imprinted in my body such an intricate process to receive, nurture, and grow love. AND, made it visible to me so I can actively participate in His design. It would seem, HE is inviting us, his daughters, to marvel with him at this amazing process that is so the core of our womanhood, to be part of it, to participate in it, consciously.

 Sheila asks the question, I too ask, which is that if society granted young women an understanding of that amazing symphony being played out in their bodies and taught them that their lives matter down to the tiniest details of their existence, would they perhaps grow up to understand their dignity? Unlike those sad girls sniggering over their aborted babies, would they appreciate their role of beloved daughters of God?

 If the answer is a resounding yes, then we all have a role in bringing women to that understanding, the doctors and nurses who treat women, the educators who mentor girls and above all the parents who, as primary educators of their children, have the first and greatest responsibility in leading their daughters into the presence of God.

 **Designer Babies**

The practice of selecting embryos for implantation who either possess or lack certain genes, is ethically dangerous on many levels. I’m very aware that this is a huge area, it is a very broad field, and that even the term designer babies is emotionally loaded. For the sake of clarity, when I talk about designer babies, I am referring to embryos selected or discarded whether because of the presence of certain genes or because of a lack of certain genes. For example, an embryo may be chosen through preimplantation genetic diagnosis because that embryo lacks a genetic anomaly or an embryo may be chosen because it can provide a tissue match for a sick sibling. You will be very familiar, I suspect, with the traditional objections to designer babies and there are many, but at heart the creation of embryos through IVF, that separation of procreation from the sexual act – from the *marital* act – does not itself cure any genetic anomaly, it does not cure any condition. It does not cure infertility. IVF with or without embryo selection is a means of circumventing a problem. However, preimplantation genetic diagnosis is not so much about selecting healthy embryos; it is about seeking out and destroying the undesirables. I wonder if the idea of designer babies would have caught on as it has, thanks to some very emotive cases such as the Hashmi case, if instead of designer babies or saviour siblings, we spoke about spare part siblings or non-consenting donor siblings.

The Hashmi case which caused a change in the law in Britain to allow so-called saviour siblings was based on the very distressing case of five-year-old Zain Hashmi who suffered from Beta Thallaesaemia and whose parents wished to create a baby who could be a tissue donor for their child. After a highly charged and prolonged legal challenge, the Hashmis were granted their wish, but after six unsuccessful IVF cycles in two years, they were forced to stop treatment.

Another couple successfully created a designer baby, Max, to provide a tissue transplant for their daughter Megan. The article celebrating this event began with the words “It is perhaps the most priceless present a child can give his sibling: the precious gift of life”. The trouble is that the child never gave his sibling a gift, he was simply created to provide for his sibling and had no agency whatsoever in that act. Furthermore, one has to ask, since when was it the duty or the role of an infant to give his sibling anything (leaving aside a risk- and pain-free donation such as perhaps the placenta). As Josephine Quintavalle of Comment on Reproductive Ethics pointed out, a child cannot consent to be a donor. What if it turns out that the sick child needs more than a one-off treatment, and what if the donation is risky or unpleasant for the donor? Is that child obliged to keep giving to the sick sibling indefinitely? What if, at the age of 18, that person decides he doesn’t want to do it anymore? That was of course the premise of Jody Picoult’s novel, My Sister’s Keeper.

The question was asked at the time, but only in a very half-hearted way, ‘what effect does it have on a person to know that they were created to service another?’ It’s very easy in that situation to say that that child will be loved as much as any other child in the family, it makes no difference. But does it really make no difference when the whole purpose of that child’s existence was to provide for another, to the extent that the child would have been discarded if unsuitable to do that? I find it very difficult to believe there can be no psychological or emotional effects there, however little the adults concerned may wish there to be. My fear is that any concerns a young person may have when they discover the purpose behind their creation is that those concerns will simply be swept under the carpet, rather like the concerns voiced by the children of anonymous gamete donors, which were ignored and even ridiculed for years. When a friend of mine wrote an article in The Guardian newspaper about how it felt to know that her daddy’s name was donor, that all she knew about her father was that at some point about 35 years ago, he had masturbated into a bottle in a doctor’s office and disappeared from her life forever, the responses she got to her anguished article were completely unsympathetic. “Are you glad you are alive? Well, shut up then!” Will that be our response to the admittedly small numbers of children who discover that mummy and daddy wanted to “help your brother so much that we got a couple of scientists to make you? But it doesn’t make any difference at all!”

And whereas it has been relatively easy for society to accept the idea of saviour siblings because of emotive cases, there are so many ways in which the creation of designer babies can be misused. Talk of a master race still feels like the stuff of science fiction, the product of Aldous Huxley’s overactive imagination, but should it? IVF - however it is applied – is and will always be a production process and it has thrown up so many ethical questions and ethical nightmares since the birth of Louise Brown that is almost difficult to know where to start. Could the pioneers of Artificial Reproductive Technology have foreseen commercial surrogacy and the commodification of the female body? Could they have imagined a world where a baby could be born with five possible parents and legally none at all? Could they have anticipated a case like the Baby Manji case, in which a baby born to an Indian surrogate on behalf of a Japanese commissioning couple, was left parentless and stateless when the couple divorced? Could they have anticipated the millions of embryos left in storage, discarded or used for experimentation? Perhaps not, but some prophetic voices, prior to the advent of IVF, did imagine a world in which human lives could be created and modified in a laboratory. In other words, the world in which we all live.

 Margaret Atwood, commenting on her novel the Handmaid’s Tale, claimed recently that the world of the HandMaid’s Tale, in which fertile women are enslaved to wealthy, childless couples, is closer to reality than when it was first published. Apparently, with Trump in power, Gilead may be just around the corner for the US. But what angers me about the sudden proliferation of protesters in red dresses and white bonnets, is that we have created the world of the Handmaid’s Tale. Through commercial surrogacy, we have created a system in which women in developing countries, enslaved by poverty, end up acting as handmaids to wealthy western couples. This exploitation of women goes on under the noses of western feminists and is justified and even glorified rather than condemned, even though commercial surrogacy in developing countries holds the lives of women and unborn babies very cheap.

If embryos can be screened out to avoid certain defects, we have to ask ourselves, where do we even draw the line about what counts as a defect? In Britain, the Royal National Institute for the Deaf briefly supported the right of a deaf couple to use IVF and select a deaf baby, because in their opinion it was preferable for the child to be deaf, to share in the parents’ deafness and to be part of the deaf community. The RNID appears to have done an about turn on that position within the space of a couple of months, but the fact that a respected charity supported the deliberate selection of a child with a disability raised many questions. The first of which was surely, what is a disability? Where do we draw the line between an undesirable characteristic and a disabling condition? In many parts of the world, being a girl is regarded as highly undesirable, so much so that hundreds of thousands of baby girls are lost to sex selective abortion every year whilst Western feminists look on. Could we not use the same logic to say that a couple have a right to select a boy over a girl because the boy will get on better in life, whereas a girl is more likely to suffer simply because she is a girl?

 When my son was diagnosed with autism it forced me to reconsider much of what I thought I understood about disability and to appreciate something of the minefield that we have to cross within the prolife movement when it comes to appreciating what it means to have a child with a disability. The need to avoid falling into the sentimentality trap of pretending that children with disabilities are little angels gift-wrapped by Jesus to teach us important life lessons. I promise it doesn’t feel that way when you’re collapsed on the sofa at ten o clock at night after the day from hell, with a glass of wine and a box of tissues. But also to avoid subconsciously writing off people with disabilities. I have never forgotten a devoutly catholic relative phoning me up in flood of tears after my son’s diagnosis, saying; “oh Fiorella, you don’t deserve this!”

And I thought, no I don’t. I don’t deserve by beautiful, innocent, honest, loyal, big-hearted, gentle giant of a son. I don’t deserve the privilege of being his mother. But I knew that was not what she meant.

We have to be careful about the way we even speak about disability. Who decides what constitutes a disability? Who decides what constitutes an ideal or even a normal human body in the first place? My nine-year-old son regards it as a bit of a handicap that he is rather on the short side, I sense his rage every time an old lady pats him on the head and says, “aren’t you just the cutest little thing?” “what an adorable little lad!” Let’s face it, he feels seriously disadvantaged!

Long before IVF was invented, society found ways to manipulate and maim the human body to suit whatever the current trends were, from binding girls’ feet in China to forcing girls as young as eight to wear corsets to give them impossibly small waists. The female body has been particularly affected by social fetishes on the subject of ideal beauty, but ethics is not dictated by what society deems to be the ideal human being. If this sounds sensationalist, I go back to the original question. If we can justify discarding embryos on grounds of disability, can we not justify the discarding of human lives on any grounds? If we’re prepared to cross that moral line than surely the wrong colour hair or eyes, the wrong height, a poor IQ can be added to the kill list if there already is a list.

 As with so many of these issues, a major question is surely “what is healthcare” and “what is the purpose of healthcare?” Some time ago there was a story reported in the British press of a woman who had agreed to be a surrogate for her gay son to provide him with his much-desired child. This was reported in a very positive light, a mother giving her dear boy his heart’s desire, a woman doing what all mothers do – showing love, making sacrifices for her boy, for her beloved son. But a child is not a Christmas present and it was never the purpose of the medical establishment to make people’s dreams come true. There were so many other ways that woman could have shown love to her son.

 I think unfortunately that Catholic healthcare and Catholic ethics for that matter has a reputation for saying no to everything but for every no there must if possible be a yes. I discovered during the Hashmi case and its aftermath that people from my ethnic group – central Mediterranean/North African – are at considerably higher risks of certain blood disorders, but that only a very small minority from my ethnic group are registered bone marrow donors. When I found out about the situation, I tried to encourage friends and relatives to sign up to the Anthony Nolan register and also Britain’s National Health Service bone marrow registry and I did so myself, because I do believe that as Catholics we should be prepared to ‘give until it hurts’ as Mother Teresa famously put it. We should be prepared to give our own bone marrow if necessary to save a small child or to save anyone facing serious illness. If everyone who could be on a bone marrow register was to sign up, we might not have so many heartrending cases of parents demanding the right to create a human being to service another.

 The question though is left which I would like to open to the floor during the discussion time because it is a genuine question. I am concerned to know how Catholic healthcare professionals can best help couples who discover that they are genetic carriers of a serious condition so that there is a high chance that they will give birth to a very sick or even a dead child. We need to think about how healthcare professionals can best help and support couples facing the distress of caring for a very sick child or indeed losing a very sick child. How best can we care for them, what advice should we give them? Everyone in this room would have heard of the Charlie Gard case, it was broadcast all over the world, that most agonising of medical dramas made its way into the sitting rooms of families all over the world. But a detail of the case that was not broadcast so widely, possibly because it was only really discussed after Charlie’s death, was the reason why that situation had occurred in the first place. Both Charlie’s mother and father were carriers of the same genetic defect. It was an extraordinarily tragic coincidence, the likelihood of a couple both being carriers of the same very rare genetic defect was minuscule and yet that is what happened with the parents of Charlie Gard. And they were told, if you ever want to try for a baby again you must have IVF, you must have preimplantation genetic diagnosis. It is the only way we can be sure you will not face another tragedy in 18 months’ time. And I can only imagine what a couple like that must have felt being told that, having gone through the agony of months and months of legal wrangling, of watching their very very sick child die, to be told, if you have another baby, you may go through this all over again, possibly over and over again. And the question I have for you as doctors, as practitioners, is what advice would you give to a couple like that? Would you advise them to trust to Providence and go ahead and try for a baby, or would you advise them against having children, on the grounds that this really would constitute grave reasons for not having a child. In my opinion, it would be better to advise a couple like that to avoid having children and perhaps consider the adoption route as it seems to me that a high risk of serious illness or death very much falls within the boundaries of grave reasons not to have a child. However, I don’t know if any of you would think differently; for example, it might depend how ready and able the parents were to care for a very sick child. What would be your advice?

 Because, if the Charlie Gard case taught us nothing else as Catholics, it was a horrific reminder of the need for parents of babies like Charlie to receive better pastoral support and to be kept more closely involved with the treatment of their children to avoid those sorts of bitter battles from erupting in the first place. There is nothing easy about letting nature take its course and it is certainly not a situation in which families should be left to deal with the consequences alone.

 It is not the role of an innocent child to be another child’s keeper, expected to give until it hurts, but if a sibling should not be burdened with the title of ‘saviour’, it is perhaps the role of the Catholic healthcare professionals to take on some of that burden.