The Ethics of Late-term

If any woman truly desires an abortion, I imagine it must be rare. As I went to research this article, I could not imagine why a woman would request a late term abortion, in the third trimester of pregnancy, when we now have had premature newborns survive when born as early as 22 weeks gestation. However, before we can make moral decisions in medical matters we need the unbiased facts. What do we know about the reasons why late-term abortions are performed?

Protagonists have suggested that late-term abortions are sometimes necessary to preserve a woman’s life and health.1 Former abortionist Dr Mary Davenport MD, FACC1G, of the American Association of Pro-Life Obstetricians and Gynaecologists, questions the necessity of late abortion on grounds of risk to maternal health. ‘The very fact that the baby of an ill mother is viable raises the question of why, indeed, it is necessary to perform an abortion to end the pregnancy. With any serious maternal health problem, termination of pregnancy can be accomplished by inducing labor or performing a caesarian section, saving both mother and baby.’2

She writes that most abortions are performed late because of delayed diagnosis of pregnancy and are done for similar reasons to early abortions: relationship problems, young or old maternal age, education or financial concerns. T. Murphy Goodwin, a maternal-fetal medicine specialist, lists only four very rare conditions where maternal mortality is greater than 20% in the setting of late pregnancy: pulmonary hypertension (Eisenmenger’s syndrome), Marfan’s syndrome with aortic root involvement, complicated coarctation of the aorta, and possibly, peripartum cardiomyopathy with residual dysfunction.3 Even in these conditions it may be possible to delay delivery until foetal viability if the mother so desires. Davenport describes the need for late-term abortion on grounds of maternal health, particularly after viability, as a great deception.4

Another reason given for late abortion is foetal abnormality. The routine 18-week ultrasound has meant that abortions performed as a result of these scans are often late-term. This suggests that a decision has been made that, regardless of whether the parents want a baby, they don’t want this baby. The reasons for the decision will range from ignorance combined with the prompting of the ultrasound technician, to concern for the child who is born to a life of disability, to reluctance to take on the burden of caring for that disabled child, to postmodern determination to have a child who is, ostensibly, perfect. Possibly a combination of these will co-exist.

We do well to hesitate in judging the motives of those who choose late-term abortion. Aborting a previously desired child because of birth defects is a difficult decision.

In evaluating the rightness or wrongness of our behaviour, we need to consider our motives, intentions, actions and consequences. The most common approach in our society is to judge our actions solely on their consequences, that is, whether something is right or wrong depends on the outcome. Good outcomes mean you made good choices. This ethical theory is called consequentialism. Christians have a moral compass which aids us in our decision making, the Bible. While the Bible teaches that we should consider the consequences of our actions (implicit in instructions such as 1 Cor 10:24 ‘Nobody should seek his own good, but the good of others’), it does not support the idea in consequentialism that they are the only things that matter. It teaches that our motives, intentions, actions and consequences are all important.

Christian motivation is grounded in the summary of the commandments given by Jesus in Matthew 22:37-40, ‘Love the Lord your God with all your heart and with all your soul and with all your mind’ and ‘Love your neighbour as yourself’. Christians will act with compassion towards those who suffer, which is the motivation shared by those who support and oppose late-term abortion. Motivation will prompt us to act, but it will not inform the content of our actions. In the medical profession, Christians will usually find that their motivation is similar to their non-Christian colleagues.

Jesus taught that God sees our intentions and our actions as overlapping. They are both to be judged according to God’s law. Secular law will differentiate between intention and act – for example the killing of an innocent human will be judged as murder when the intention was to bring about death, but as the lesser charge of manslaughter when it was not. In the case of late-term abortion, where we are considering deliberate killing of an unborn child who is close to if not at the point of viability, God demands both good intentions and good actions for our choices. It is not enough to have good intentions with wrong actions; Paul refutes the notion that we would do evil with the intention of a good outcome in Rom 3:8. Similarly it is not enough to have good intentions and do nothing; James rejects this notion in Jas 2:16. Both intentions and actions have individual significance. The Bible teaches us in Exodus 20:13 that killing an innocent human is wrong (one of the ten commandments – ‘Do not murder’). Biblical commands represent absolute values – there are some things we should never do, whatever the consequences. By this argument late-term abortion, by definition, will always be wrong.5

Performing an abortion as well as participating in one will be included. The classic argument for abortion – a woman’s ‘right to choose’ is not relevant in the third trimester if the mother does not have to choose between carrying a pregnancy to
viability and abortion. However, as Christians loving
their neighbours we will be more interested in our
responsibilities to others than claiming rights for
ourselves (1 Cor 10:24).

In light of the recent legislation in Victoria, we also
need to consider whether referring a patient for
late-term abortion is morally wrong for the Christian.
To determine whether we are morally complicit in
an action will depend on several factors. Firstly,
have you any role in the causation of the act? Is the
desire of the woman requesting abortion influenced
by your role? Secondly, are you facilitating the
morally wrong act directly? Are you making the
abortion happen? And thirdly, does your action
perpetuate the moral wrong? Does your referral
increase the likelihood of it happening again?

It would be easy to make sure you have not had
a role in causing the wrong by making sure you
counsel the woman involved against this path
of action. This would obviously need to be done
with gentleness and respect. The second point
is interesting – by referring a woman for abortion
are you helping her achieve her morally wrong
aim? What about if you refer her to a colleague
who you know will refer her for the procedure? I
would suggest that the latter is just an indirect way
of doing the former. But is it morally the same as
actually performing the abortion? In biblical terms
I would say that it is, as the intention (to kill the
unborn child) is the same. Just because someone
else is prepared to do a morally wrong act does not
excuse us from doing the same act. The third point,
whether our action would perpetuate the process is
difficult to determine. If you were the only possible
referrer you might end the practice by stopping
referrals, but this is not the case here. It is possible
that by making a stand and sensitively explaining
your point of view to the woman involved and
others, you may persuade them to think differently
about late-term abortion in future. This may alter
future behaviour. By going ahead and referring a
patient for late-term abortion at her request, you
infer that this is a legitimate therapeutic pathway
to take. This may also impact on future behaviour.

But what if we induce early labour in attempts to
save the life of both mother and child, and the
baby dies because of complications of premature
delivery? In this case the intention was morally good
– to save both lives – and the action was morally
acceptable – an appropriate medical intervention.
In this case it is the outcome which troubles us.

Before we begin a discussion of good and bad
consequences, we need to acknowledge that all
things are in God’s hands and that as humans
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we cannot foresee all consequences. God knows this and we are judged according to those things for which we are responsible, not those things which are out of our control. This is not to say that we should not make the best prediction we can regarding the outcome — in medical scenarios we can usually make an educated guess regarding the impact of our intervention — but as humans we have limited foresight. If we aim for a good outcome (in this case, a premature but live infant) but a bad outcome intervenes, we are not morally liable. I know that philosophers have spent time discussing whether we can know if good or bad outcomes are intended with various medical procedures, but in my experience, clinicians know what they are intending to achieve when they put a specific therapeutic strategy in place. And God certainly knows our hearts.

Christians will judge consequences in light of gospel values. If we are aiming to love our neighbour we will measure ourselves against values such as relief of suffering, social justice, and respect for human dignity. Sometimes this means we will need to be creative in considering what therapeutic options are available to us.

Let us consider the possible scenarios where late-term abortion may arise:

1. Elective abortion with delayed diagnosis of pregnancy. In this case there is no medical indication for terminating the pregnancy. If Christians are going to urge a woman to continue what may be an unwanted pregnancy, they will need to provide practical alternatives — emotional and financial support for those women who see abortion as their only option. There are church-run hostels for women who want to avoid abortion but not enough of them to meet demand.

2. Abortion on grounds of maternal health. As mentioned above, according to Godwin, in reality this is a very small group. He suggests that closer study of the facts will reveal that most medical ‘indications’ for abortion (he discusses cancer, cardiac disease and severe autoimmune disease amongst others) can be managed during pregnancy. If the unborn child is viable, early induction of pregnancy or caesarean section is appropriate. Should the foetus’ viability be in question and the mother’s life is at risk, it is still ethically appropriate to attempt early delivery as it means the mother’s life will be saved, and an attempt is being made to save the baby. If the mother dies, the baby will not survive anyway.

3. Abortion for foetal abnormality. I will divide this group into fatal and non-fatal birth defects.

For both groups it is worth mentioning that the eugenics agenda developing as we are able to screen for ever more disorders is not consistent with the Biblical claim that all human beings are valuable as they are made in the image of God, even after the fall (Genesis 9:6).

Fatal defects Abortion is sometimes presented as the only options when a foetus is diagnosed with conditions such as Potter’s syndrome (kidney disease with no amniotic fluid) or anencephaly. I would suggest (with Davenport) that perinatal hospice is a better option. A pregnancy is continued (with the required emotional support) until labour begins and birth occurs normally in a supportive and comfortable setting. The family is given time together until death occurs. In my experience, parents who pursue this option have had the comfort of knowing they did all they could for their child as long as they were able, and the subsequent funerals have been a powerful witness to the value of human life. The alternative can be associated with profound guilt and complicated grief.

Non-fatal defects These parents have the challenge of facing life with a disabled child. My first reaction, as a mother who was advised to have an abortion on grounds of foetal abnormality for a daughter who was subsequently born healthy, is that the false-positive rate should be considered. Second, we know that some birth defects considered as indications for abortion can be treated with intrauterine surgery (eg spina bifida) or surgery after birth (eg omphalocele) with success. Third, we know that many families faced with a disabled child have indeed been able to manage and they, and many disabled adults, would assert that these lives can be worthwhile and satisfying. Education may be needed to help parents understand what the disability entails. For example, Down’s syndrome is considered an indication for abortion, but many parents are not aware that these children may attend school and live semi-independent lives. Sadly it remains that often these families struggle to get the help they need in terms of community support and Christians should be alert to the need to improve services available to these families.

I have been discussing right and wrong from a Christian perspective. As we live in a secular society there will be many around us who make choices with which we will not agree. Particularly in the case of encouraging a couple to keep a child with known birth defects I am conscious that this is an heroic act that one cannot demand of another. And so my last suggestion is that, whatever our patients and friends may decide, we endeavour to maintain our relationships with them, so that we may be able to support them in the grief that ensues, witnesses to a loving God who forgives the repentant sinner.

References

1. This is the justification for abortion in the third trimester given by the US Supreme Court in Roe v Wade, 1973.
4. Ibid.
6. Godwin, Ibid.
7. In some cases labour may need to be induced for medical reasons.