The background of the cover features a large, stylized graphic. It consists of a white hand pointing downwards towards a silhouette of a fetus. The fetus is depicted in a curled position. A large, thick black 'X' is drawn over the entire graphic, symbolizing opposition or a negative stance towards the subject.

ABORTION IN PERSPECTIVE

A Report of the
Commission on Theology
and Church Relations of
The Lutheran Church—
Missouri Synod
as prepared by its
Social Concerns
Committee
May 1984

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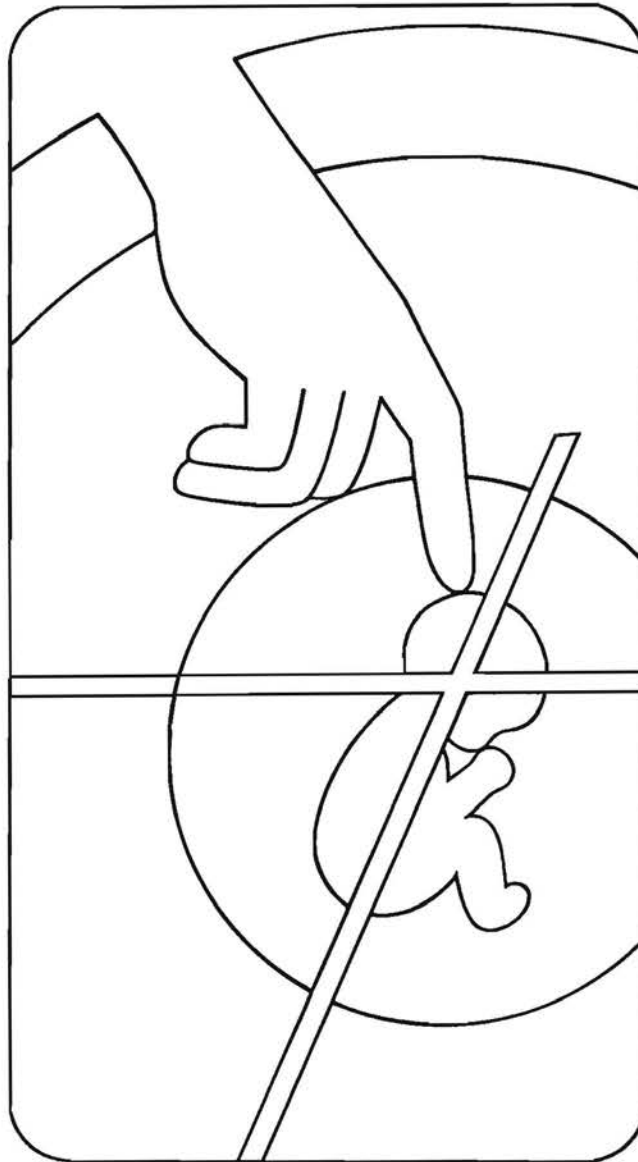
INTRODUCTION

More than a decade has passed since the Commission on Theology and Church Relations issued its report, "Abortion: Theological, Legal, and Medical Aspects." Much has happened since then. While the principles and warnings issued in that document are still valid today, it would at that time have been difficult to anticipate the 1973 Supreme Court decisions which, by striking down many of the legal restrictions which surrounded abortion, made possible a dramatic increase in the number of abortions performed in this country. Since then abortion has been and continues to be an issue creating deep divisions within our society.

As groups supporting and opposing a right to abortion emerge within our nation, as the number of abortions performed yearly grows astonishingly, and as courts consider cases which may involve all citizens in the public funding of abortion, the Christian community must struggle with the moral and spiritual issues raised by such a rapid transformation of our public policy with respect to abortion. Controversy over abortion will probably continue in our country. As Lutheran citizens we seek to participate in this national debate—a participation which should be informed by the discoveries of medicine and science, be familiar with the legal situation which now exists in our country, and be guided by a vision of human life which is grounded in God's Word.

This report—intended as an aid to such informed participation—results from a request by the Commission on Theology and Church Relations that its Social Concerns Committee prepare a resource document for use by members of The Lutheran Church—Missouri Synod. While drawing on the theological principles presented in the Commission's 1971 document, this new report seeks to respond in greater detail to the changed political situation we face and to the moral problem which abortion continues to present.

I. THE MEDICAL PERSPECTIVE



I. THE MEDICAL PERSPECTIVE

A. THE BEGINNING AND DEVELOPMENT OF A NEW HUMAN LIFE

Christian vision, even in a prescientific age, has always been shaped by words like those of Psalm 139:

For thou didst form my inward parts,
thou didst knit me together in my mother's womb.
I praise thee, for thou art fearful and wonderful.
Wonderful are thy works!
Thou knowest me right well;
my frame was not hidden from thee,
when I was being made in secret,
intricately wrought in the depths of the earth.
Thy eyes beheld my unformed substance;
in thy book were written, every one of them,
the days that were formed for me,
when as yet there was none of them.

Such words have not only moved us to wonder at the marvel of new life; they have persuaded us that the dignity and value of human lives depend on no special achievement, for God has set His hand upon us and taken care for our days even "when as yet there was none of them."

We are prepared, therefore, to accept with continuing wonder and delight what medical researchers have begun to learn about the formation of a human being. The development of a new individual begins with fertilization. Sperm and ovum, in themselves incapable of growth, unite to form something new: a cell which carries the genetic characteristics of both parents and which establishes many characteristics of a new human being (e.g., sex, color of the eyes, blood type, facial features, some elements of intelligence and temperament). Given time and the proper environment this new cell will undergo constantly changing yet continuous development marked by the terms embryo, fetus,¹ infant, child, adolescent, adult. If the fertilized ovum, already

¹ In the medical and legal sections of this report the biological terms "embryo" and "fetus" are often used in referring to the unborn child, while in the remaining sections care is exercised to speak of the unborn in terms more indicative of a new human being.

undergoing cell division, successfully implants itself in the spongy lining of the mother's womb, a "bag of waters" will begin to form in which the embryo will float freely within the womb. Around 14 days after the time of fertilization this new cell—now multiplied to thousands of cells—may mysteriously "segment" or "twin" into two or more individuals with identical genetic inheritances. After this happens or fails to happen, the individuality of the new life (or lives) is clearly established.

The rate and magnitude of change and development which follow are astonishing. After a mere three and a half weeks the tiny heart begins to beat. Backbone, spinal column, and nervous systems are taking form—as are the kidneys, liver, and digestive tract. When the embryo is four weeks old, though he/she is only the size of an apple seed, his/her² head and body are clearly distinguishable. By the end of six to eight weeks of gestational development electrical activity from the developing brain can be detected (a fact of some significance, since it is now common to use cessation of brain activity as a criterion for determining death). By the end of two months of development the limbs (including fingers and toes) have begun to appear and the unborn child—now technically called a fetus—can hear, respond to touch, and make his first movements (though the mother will probably not feel such movement for several more months). By the end of the first trimester of a pregnancy the baby is fully formed. He can change his position, respond to light, noise, and pain, and even experience an attack of hiccups. In possession of his own set of fingerprints, the child now need only continue to develop size and strength until he is born.

B. ABORTION

Abortion may occur spontaneously or may be induced. Not every fertilized ovum develops and matures according to the schedule outlined above. Pregnancies may end at many points in this course of development. Spontaneous abortions occur most frequently at the time when implantation must take place if the new life is to survive. For any of a number of possible reasons—improper hormone levels in the mother, some abnormality in the uterus caused by infection or scar tissue, an incapacity due to genetic defect of the fertilized ovum to sustain itself, an incomplete process of fertilization—abortion will often occur at this point. Spontaneous abortions, usually referred to as miscarriages, are less likely after the first three months of gestational development.

² For stylistic reasons the masculine pronoun will generally be used from this point when reference is made to the unborn child.

Today, however, the word "abortion" is used most often to refer to action aimed at bringing pregnancy to an end. During the first trimester of pregnancy an induced abortion will usually be done by means of dilatation and curettage (D & C). The cervix opening is forcibly dilated, and the embryo and placenta are cut and scraped, or vacuum suctioned and scraped, in order to empty the uterus.

After the first trimester induced abortion is more difficult and less safe for the mother. Dilatation and extractions may be used—which requires dilating the cervix, inserting a forceps to dismember and remove the fetus, followed by curettage to be certain the uterus is emptied. A different method—known as saline abortion—is also used for second trimester abortions. A needle is inserted through the woman's abdomen into the amniotic sac ("bag of waters"), and some amniotic fluid is drawn off and replaced with a concentrated salt solution. This poisoned solution asphyxiates the fetus. Normally the mother will then go into labor and deliver a (usually) dead fetus. A more recent version of a similar method involves the injection of prostaglandins, which also induce labor and delivery. This method is considerably more likely than the saline method to result in the delivery of a living (and if the pregnancy is advanced enough, possibly viable) child.

An induced abortion beyond the second trimester will often require a surgical procedure called hysterotomy. The procedure is technically similar to a Caesarian section—except that the intent here is abortion rather than delivery of a child. It is complicated by the fact that a fetus aborted by hysterotomy may possibly still be viable when he or she is removed from the womb and the placenta is severed. Hence, this procedure raises serious legal questions about the physician's responsibility not just to the mother but to the possibly viable infant.

While some abortion procedures involve less risk than others, any abortion may involve complications. Immediate complications may include infection, hemorrhage, cervical damage, perforation of the uterus—any of which could endanger the life of the mother or prevent future pregnancies. Delayed complications may include sterility, greater chance of premature delivery in subsequent pregnancies (which may, in turn, cause physical or mental defects in the prematurely born child), and an increased incidence of ectopic (tubal) pregnancies. Finally, we should note that complications are not merely medical or physiological; they may also be emotional and psychological, for even a carefully considered decision for abortion can later be cause for intense guilt and deep regret.

C. AMNIOCENTESIS

Amniocentesis is a medical procedure in which amniotic fluid is withdrawn from the amniotic sac by means of a needle inserted through the abdominal

wall of the mother. Fetal cells within this fluid can then be studied, and from such study much can be learned about the condition of the developing fetus. The procedure is not without some risks, chief among them an increase in the rate of miscarriage. (The risk of fetal death from infection or puncture is one in 200. If miscarriages are included, then the fetal death rate is at least 3 percent.)³

Amniocentesis was first developed in the 1950s with the intent of detecting and treating problem pregnancies (e.g., when the mother's blood was Rh negative and the fetus's Rh positive). However, from amniocentesis we can also learn the sex of the fetus and information about chromosomal abnormalities and neural tube defects (spina bifida). As a result, the most common use of amniocentesis today is in the second trimester to detect defects, especially the possibility of chromosomal abnormalities such as Down's Syndrome when the mother is in her late childbearing years. Abnormalities are very rarely found—on an average, fewer than 0.5 percent⁴—but if an abnormality is found, such pregnancies will often, then, end in induced abortion. Since amniocentesis cannot be successfully done before about 14 weeks gestational age, any abortion which is determined upon because of information gained through amniocentesis will necessarily be a relatively late second trimester abortion (perhaps, even, of a possibly viable fetus).

D. THE IUD

The intrauterine device, discovered and developed in the late 1950s, calls for brief comment here. There has been disagreement about the precise way in which it prevents pregnancy. Some have held that the IUD prevents fertilization of the ovum, others that it prevents a fertilized ovum from implanting in the uterine lining, still others that either may be the case on different occasions. It is generally agreed, however, that the IUD's effectiveness is due mainly to prevention of implantation. Of course, precise determination of what an IUD does solves no moral problems. If an IUD prevents fertilization, the moral issue raised by its use would be that of contraception. If an IUD prevents implantation, the moral problem raised by its use would be abortion, even if it could be shown that *individual* human life does not begin until the time of implantation or before the possibility of "twinning" has passed.⁵

³ Hymie Gordon, M.D., Mayo Clinic, Rochester, Minn., Personal Memorandum on file in CTCR office.

⁴ Ibid.

⁵ C. Everett Koop, now U.S. Surgeon General, has written the following regarding the IUD: "You should know that when

E. FETAL THERAPY

In California surgeons have successfully operated on a fetus (by inserting a catheter through the mother's uterus in order to drain fetal urine) to treat a congenital defect that prevents normal growth of the ureter, obstructs the passage of urine, and can lead to serious brain damage. In Colorado physicians have inserted a brain shunt in a fetus to relieve pressure from accumulating fluid, a condition which could have resulted in brain damage and abnormalities of head and face. Even more remarkable is the case of a 21-week-old fetus partially removed from the uterus while congenital defects in both ureters were repaired and then returned to the uterus to be carried to term. (In this case the child died after birth, but from cause unrelated to the surgery.)

The fetus, bearer of an uncertain legal status at best, has suddenly become visible through fetoscopy (using instruments to see the fetus *in utero*) and sonography (the "picturing" of fetal size and shape by sound waves). Fetuses have become patients, some of whose illnesses can be diagnosed and treated even while they remain within the womb. Increasing recognition of such possibilities will make more glaring the difficulties raised by medical advances for our society's attitude toward abortion.

the IUD first came on the market, it was known as the IUCD, which stood for 'Intrauterine contraceptive device.' However, it was recognized even then that the IUD was not a contraceptive device, but an abortifacient. It prevented the implantation of the already fertilized egg on the prepared wall of the womb (uterus).

Early in the use of the IUD, women were not mentally comfortable with it because many felt it was producing an abortion every time a fertilized egg attempted implantation on the wall of the uterus. Then one of the unthinkable happened: The American College of Obstetricians and Gynecologists changed the definition of pregnancy! Whereas formally all textbooks of obstetrics in this country properly defined pregnancy as 'that period of time between conception and delivery,' the definition was changed to 'that time from implantation to delivery.' You can see, therefore, that the effect of the IUD took place before pregnancy by the new definition, and this avoided any possible controversy. The IUD is not a contraceptive device; it is an abortifacient."—Francis A. Schaeffer, C. Everett Koop, John Buchfuehrer, and Franky Schaeffer V, *Plan of Action - An Action Alternative Handbook for Whatever Happened to the Human Race* (Old Tappan, N. J.: Fleming H. Revell Company, 1980), p. 80.

The basic moral principle of justice is that we should treat similar cases similarly. But we now face the possibility that one fetus could be given therapy while *in utero* and another fetus, with similar problems in similar circumstances, could be aborted—the only difference being that in one case the mother would choose to sustain fetal life and in the other she would choose to end it. Indeed, we find ourselves in circumstances in which the legal right to abortion recognized in *Roe v. Wade* means that a woman has no legal duty to ensure that a fetus is born alive but, if she intends to carry the fetus to term, the law might in some circumstances impose upon her a duty to assure that the fetus receives the therapy needed to be born as healthy as possible.⁶ Not only a moral but an emotional juggling act is required when in one moment we consider the most advanced medical techniques for fetal therapy and in the next moment, in a similar case, regard the status of another fetus as wholly dependent upon the will and choice of his mother. These difficulties will have to be faced, however, if we consider what the medical perspective has to teach us.

F. THE DOCTOR'S DILEMMA: MEDICAL ETHICS AND ABORTION

In almost all professions, ethical standards frequently—perhaps usually—exceed those laid down by law. It is not unusual, for example, for physicians who are found not guilty or are exonerated in criminal or civil proceedings to be disciplined for precisely the same act because the act is deemed unethical by their professional colleagues. One may well despair of defining “medical ethics” with any precision; but in ordinary usage the term refers, albeit somewhat loosely, to the *moral*, as opposed to the *legal*, obligations of a physician in his/her professional practice. The difference is not, admittedly, always clear; some standards which are commonly regarded as being in the province of medical ethics in fact have legal effect. Physicians may, for instance, be barred from practice if found guilty of “infamous conduct,” i.e., some sort of professional behavior which can, by professional associates of good repute and recognized competence, be reasonably regarded as being disgraceful or dishonorable. Indeed, when there is a code of ethics and an association of physicians who recognize it as “approved,” any violation of such a code may be regarded as infamous conduct, as decided in 1955 in the Supreme Court

⁶ John S. Robertson, “The Right to Procreate and In Utero Fetal Therapy,” *The Journal of Legal Medicine*, 3 (1982), p. 352.

of Massachusetts.⁷ But disputes arise when medical ethics and the law do not coincide, especially when rules in the former are very widely recognized and accepted. Then the question arises: what should take precedence, the rules of ethics or of domestic legislation and judicial pronouncements?

Professional consensus is at present inclined to regard abortion as a borderline case. Or, to say the least, it is, in the context of profoundly and rapidly changing attitudes in the religious, legal, and scientific communities—and in the “public philosophy” as well—under relentless pressure to minimize the purely ethical component in decisions relating to abortion.

Much recent domestic legislation and a sizable number of judicial determinations now permit abortions upon request of the mother; and medical practitioners in growing numbers perform the procedure simply by virtue of the permission that is now granted by law. While it remains true that significant numbers of physicians still decline, out of professional, religious, or personal scruples, to perform or assist at abortions—except in very extraordinary circumstances—and many others participate with varying degrees of reluctance rooted in mental and moral reservations, we are nearing the day when a majority of physicians regard abortion from a neutral ethical perspective. Or many, preferring not to face it at all, relegate these agonizing ambiguities to others for resolution.

A surprising symbol of the reversal of older attitudes and usages is the steady abandonment of the Hippocratic Oath and the Declaration of Geneva (both of which explicitly prohibit abortion) as an incident in the life of the physician at the moment he takes up his profession.⁸ There is, moreover, the

⁷ *Forziatti v. Board of Regulation*. 12E 2d 789. This and the two following paragraphs follow closely the argument and language of David A. Frenkel (Ministry of Health, Jerusalem, Israel), in *Journal of Medical Ethics* (London), V (June 1979), pp. 53-56.

⁸ The Hippocratic Oath reads in part: “I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortions” (*Encyclopaedia Britannica*, 15th ed., s.v. “Medicine, History of,” by John Walford Todd, *Macropaedia*, Vol. 11, p. 827). The “Declaration of Geneva,” adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September 1948, states in part: “I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use any medical knowledge contrary to the laws of humanity.” — *Ethics of Medicine*, eds. Stanley Joel Keiser, Arthur J. Dyck, and William Curran (Cambridge and London: The MIT Press, 1977), p. 5.

related dilemma of those physicians, surely still a majority of those now practicing in the United States, who took the oath before the current retreat from it began. May the pledge-bound physician violate the Oath? The problem is more poignant when it is recalled that the Oath has always been taken by individual physicians, not corporately or in their behalf by an agent or agency.

Indeed, in reviewing the literature bearing upon this sensitive issue, it is difficult to overcome the feeling—or to rebut the evidence—that in the everyday practice of medicine physicians spend little time in systematic, deep, and critical reflection upon their work. They evidently take for granted a few moral principles, writes the distinguished medical scholar John Walford Todd in the current *Encyclopedia Britannica*,

whether they believe these are derived from Hippocrates, from the natural law, from the divine law, or just from plain common sense. They do their best to benefit their patients, by curative methods, if possible, and otherwise by relieving symptoms and by kindness or reassurance; they tell the truth (except when the truth is too wounding); and they do not reveal their patients' confidences.⁹

But there persists, even among those physicians who profess no religion (except perhaps the "civil religion" of secular sanctions for "human decency"), as well as among committed Christians, a deeply troubled pathos haunted by the sense that the startling increase in abortion in our time involves special and unique considerations. *A profession whose peculiar function has always been the fostering and preservation of life is increasingly applying its skills to the termination of life*; so much so that abortion is fast becoming a leading cause or form of death. The bearing of medical ethics upon such considerations is, one would suppose, decisive. But many physicians, whose number it is impossible to guess, find uneasy reassurance in the consoling premise that they are, after all, only technicians, laboring in a field clouded by agonizing uncertainties and imperfect knowledge, whose shadows it is the responsibility of others—theologians, theoretical scientists, philosophers, ethicists, mystics, and justices of the Supreme Court—to dispel.

The relatively sudden introduction of so large a number of respectable physicians into a field so lately served almost exclusively, and more or less clandestinely (to say nothing of illegally), by a small number of physicians looked upon by their colleagues as pariahs,¹⁰ is still of too recent development to have permitted the accumulation of substantial studies of the ethical im-

⁹ Fifteenth ed., *Macropaedia*, Vol. 11, p. 849.

¹⁰ In 1859 the American Medical Association called abortion

plications for the medical profession itself. Evidence on the point is not wholly wanting, however.

An example is the pioneer study of Nathanson and Becker, published in 1977. The paper, heavily statistical in form and based on telephone interviews with 473 obstetrician/gynecologists, is introduced by a summary:

Although religion is the most powerful predictor of whether a doctor will perform any abortions, satisfaction with his or her patients and emotional reaction to the abortion procedure powerfully affect the physician's practice. Doctors who are most satisfied with their patients are less likely to ask unmarried teens for parental consent and to charge lower fees. Physicians who are severely disturbed over abortion perform terminations less frequently and more often ask spousal or parental consent—but charge lower fees and are more likely to accept Medicaid patients.¹¹

The paper, like others which have canvassed American physicians more generally, also notes that inquiries of this sort demonstrate “substantial support” among physicians for “a liberal abortion policy once that policy has been enacted into law.” The studies emphasize, moreover, that the “liberal” physicians are found to be “younger, non-Catholic, and from specialties other than ob/gyn.”

“the slaughter of countless children; no mere misdemeanor, no attempt upon the life of the mother, but the wanton and murderous destruction of her child; such unwarrantable destruction of human life . . .” In 1871 the AMA said concerning doctors who performed abortions: “The members of the profession should shrink with horror from all intercourse with them, professionally or otherwise; these men should be marked as Cain was marked; they should be made the outcasts of society; it becomes the duty of every physician in the United States . . . to resort to every honorable and legal means in his power to crush out from among us this pest of society.”—Quoted in William Brennan’s *Medical Holocausts I: Exterminative Medicine in Nazi Germany and Contemporary America*, eds. Richard S. Haugh and Eva M. Hirsch (New York: Nordland Publishing International, Inc., 1980), pp. 331—32.

¹¹ Constance A. Nathanson and Marshall H. Becker, “The Influence of Physicians’ Attitudes on Abortion Performance, Patient Management and Professional Fees,” *Family Planning Perspectives*, IX (July/August, 1977), p. 158; cf. pp 158 and 163 for the brief quotations that follow from this source.

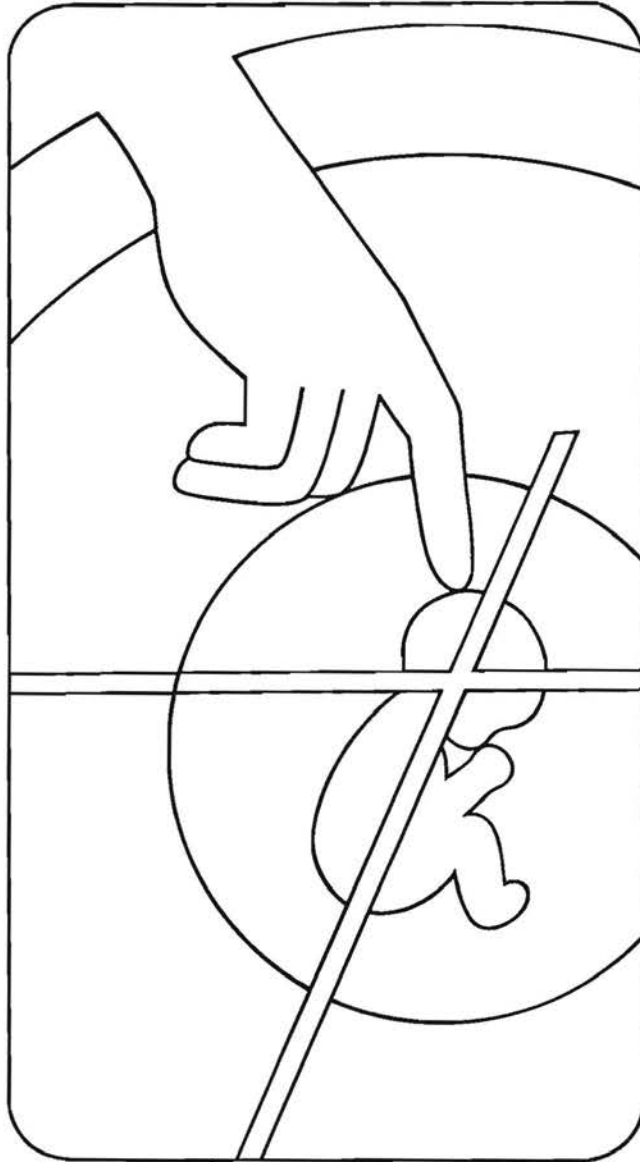
Religion aside, Nathanson and Becker found that few responses were expressed primarily, or even incidentally, in explicitly ethical/moral terms; and they concluded that "obstetrician-gynecologists . . . remain ambivalent about various related legal and moral issues." Thus it is not surprising to find that physicians' personal feelings about the patient and the procedure become major determinants of their response to women seeking abortion. And, given the high degree of control and influence physicians have over whether, how, and where abortion services are performed, it is also not surprising that the structure of abortion services in this country appears to have developed largely in accommodation to these doctors' feelings.¹²

Many doctors appear to have accepted as at least a provisional answer for themselves the view that a living (i.e., *post partum*) human being is in a crucially significant way more fully human than any fetus, that a fetus's right to life is in some important sense minimal at conception but becomes progressively stronger as birth approaches, and that the morality of a particular abortion is determined by weighing the various rights of the mother against the fetus's right to life. Especially since *Roe v. Wade* brought doctors a measure of peace of mind, questions which probe more deeply have uneasily, and perhaps understandably, been tacitly referred by physicians to others for resolution, while they themselves go about their business as technicians primarily, and, more diffidently, as friends and counselors of their patients, in a social context which lawmakers and judges have altered drastically in recent years.

¹² The American College of Obstetricians and Gynecologists, the professional association of those physicians who are most frequently called upon to deal with questions relating to abortion, sends out to its membership an occasional newsletter release under the title "Statement of Policy as Issued by the Executive Board of ACOG." Perusal of these mailings more than suggests a cautious reticence on the part of ACOG in dealing directly and intensively with the *ethics* of abortion itself. For example, the statements dealing with abortion, even when labeled "ethical considerations," are characteristically devoted to matters many of which are only peripherally germane to ethics: due care in verifying diagnoses of pregnancy; adequate facilities, equipment, and personnel "to assure the highest standards of patient care"; problems of conflict between the pregnant woman's health interests and the welfare of the fetus; the special problem of unanticipated delivery of live infants by abortion; the careful consideration of alternatives to abortion, and the suggestion that the fetus has a qualitatively

different nature and value from that of other human tissue and organs because of its potential for developing into "an obvious human being." The policy statements acknowledge that "prognoses often involve medical, social, and economic factors which impact adversely on the health of the woman; and while abortion may be one option . . . other alternatives may, in fact, be equally or more appropriate in solving these problems." Alternative options which the policy statements recommend, without explicitly pronouncing upon the ethical considerations involved in abortion, include: education in family life, contraception, reproductive responsibility, and parenting skills; provision of supportive counsel; job protection for pregnant women; changes in employment practices whose present effect is to punish women for being or becoming pregnant; more supportive attitudes toward those who elect abortion or out-of-wedlock birth; improved adoption services; accumulation and evaluation of data concerning experience with abortion and its alternatives.

II. THE LEGAL PERSPECTIVE



II. THE LEGAL PERSPECTIVE

A. THE LEGAL STATUS OF ABORTION

In this section we offer a brief overview of the legal status of abortion and the legal problems it continues to raise in the United States.¹³ We recognize, of course, that Christians often differ in their political judgments, and, since moral principles cannot always be translated into legal requirements, such differences are not ordinarily a matter for concern. However, on issues of great moral significance like abortion, it is imperative that we take more than the usual amount of care to understand and reflect upon what the law permits and prohibits.

Certainly the most important legal decisions in the matter of abortion have been the 1973 decisions of the Supreme Court in *Roe v. Wade* and *Doe v. Bolton*.¹⁴ Although it is incorrect to say that these decisions permit abortion-on-demand, their practical effect has approached that. In the case of *Roe v. Wade*, the structure of the Court's decision can be outlined fairly simply. The Court held that abortion could not simply be prohibited, such prohibition being a violation of the woman's constitutionally guaranteed right of personal privacy. The Court also held, however, that this right was not unqualified but was limited by other important interests of the states, if such could be shown to be pertinent here. The question then arises, are there such compelling state interests which should limit the woman's right to abortion?

The Court found two compelling state interests which might justify regulation of and restrictions on abortion: (1) the states' interest in protecting the health of the pregnant woman; and (2) the states' interest in protecting the potentiality of human life.

With respect to (1) the Court, maintaining that in the first trimester of pregnancy mortality rates in abortion are less than in normal childbirth,¹⁵ held that the states' interest in safeguarding maternal health could justify no reg-

¹³ As in its 1971 report on "Abortion: Theological, Legal, and Medical Aspects," the Commission has here limited its discussion to legal developments in the United States.

¹⁴ See footnote 16.

¹⁵ Recent evidence presents a serious challenge to the Court's premise and also raises questions about the validity of comparing two entirely different classes of pregnant women: healthy and diseased. The death of a healthy woman from a legal abortion is totally preventable simply by not aborting. The death from child-bearing of a woman with a disorder is most often unpreventable

ulation of abortion during the first trimester. After that point the Court permitted states to establish regulations designed to protect the health of the pregnant woman—e.g., a requirement that abortions be performed only in licensed medical facilities.

With respect to (2) the Court held that states could have no compelling interest in protecting the potentiality of human life prior to the time of viability (when the fetus can exist outside the uterus of the mother). The Court set the time of viability at 24 to 28 weeks of gestational development—that is, approximately the end of the second trimester of pregnancy.

Thus, the force of the Court's decision was to divide a pregnancy into trimesters and to see the potential for regulating abortion grow as each trimester passed. In the first trimester of pregnancy the Court held, in effect, that no restrictions could be placed on a woman's right to procure an abortion (assuming she could find a doctor willing to perform it). In the second three months states could pass regulations designed to protect the health of the pregnant woman but not to protect fetal life. And in the last trimester of pregnancy the states could, *if they wished*, protect fetal life by going "so far as to proscribe abortion during that period except when it is necessary to preserve the life or health of the mother." (However, *Doe v. Bolton* [1973] at the same time extended the term "health" far beyond the mere physical well-being of the mother.¹⁶) Hence, the Court's decision in *Roe v. Wade* did

because of medical inability to understand or control the disease process which takes her life.—M. J. Bulfin, "Deaths and Near Deaths with Legal Abortions," presented at the Oct. 28, 1975, convention of the American College of Obstetricians and Gynecologists. "Abortion and Maternal Deaths," *British Medical Journal* 2 (July 10, 1976), p. 70. "Most Mother, Child Mortality Seen in Small High-Risk Groups," *O. B. Gyn News* 16 (May 15, 1981), p. 13.

¹⁶ The word "health" as defined by the Court was not limited to the usual understanding of the word (i.e., the absence of sickness or disease). Rather, the Court defined "health" in terms so broad as to encompass a woman's preferred life-style and social well-being. Factors which relate to health, said the Court, are "physical, emotional, psychological, familial, and the woman's age"—all of which are "relevant to the well-being of the patient" (*Doe v. Bolton*, IV-C). Health also includes "distress associated with the unwanted child," "continuing difficulties and stigma of unwed motherhood"; when pregnancy "will tax mental and physical health of child care" or will "force upon a woman a distressful life and future" (*Roe v. Wade*, VIII).

not require that the unborn child be given protection at any time during pregnancy. It merely permitted such protection to be given during the final three months of pregnancy.

In the decade since *Roe v. Wade* state legislatures have passed laws regulating abortion, the federal government has been involved in questions concerning the funding of abortion, and new cases have made their way to the Supreme Court. New issues of substantial significance have arisen, issues which had not been specifically addressed in *Roe v. Wade*.

In *Colautti v. Franklin* (1979) the Court appeared to modify one determination made in *Roe v. Wade*. The Court now recognized that the time when the fetus is viable outside the womb is relative to the progress of medical science and cannot be set forever at 24 to 28 weeks gestational development. Hence, in *Colautti v. Franklin* the Court specifically recognized that relativity and left the determination of viability to the judgment of physicians. The potentially explosive force of this seemingly minor modification becomes apparent when we consider the likelihood that development of an artificial placenta will, in the near future, permit fetuses to live outside the womb earlier even than 20 weeks of gestational development. When that becomes possible, the Court's division according to trimesters will seem increasingly untenable. The question as to whether a physician has an obligation only to the pregnant woman or whether the well-being of the fetus (when it is viable) must also be considered has not yet been resolved.

This issue quickly arose in one of the most important decisions to follow *Roe v. Wade*. In *Planned Parenthood of Central Missouri v. Danforth* (1976) the Court considered and rejected a Missouri statute which prohibited use of the saline method after the first trimester and required, instead, the newer method of prostaglandin injection. The Court overturned this, holding that it was a requirement not reasonably related to maternal health. Of interest, however, is the fact that the Missouri law clearly sought to view abortion primarily as a "severance procedure" intended to permit the woman to be relieved of carrying the child, but not necessarily intended to result in a dead child. If, especially in the second trimester, some methods of abortion offer greater hope that the fetus may survive the abortion procedure, and if medical advance increasingly makes such fetuses possibly viable, it may be possible to seek legal ways to encourage the use of these methods and to stress the responsibilities of physicians and other medical personnel toward possibly viable infants who may survive an abortion.

The Court has not, however, been eager to face such questions. In *Akron v. Akron Center for Reproductive Health* (1983) the Court took note of the increasing safety of second trimester abortions and overturned an Akron ordinance which—seemingly in accord with the *Roe v. Wade* schema—required that second trimester abortions be done in hospitals. The Court held that, because these abortions could now be safely done in abortion clinics, an interest in maternal health could no longer justify a requirement that they be

done in hospitals. The Court did not, however, take notice of the other side of medical advance: namely, that viability has been pushed back into the second trimester and that, therefore, greater regulation to protect potential life might be needed. In a related decision, *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft* (1983), the Court did uphold a Missouri statute which required the presence of a second physician—to protect the interests of a possibly viable fetus—in third trimester abortions. The day is surely at hand, however, when clear thinking will force the Court to ask whether a similar requirement is not appropriate also in the second trimester.

Another important issue which has arisen in the years since *Roe v. Wade* concerns government responsibility to fund abortions just as it funds other medical procedures (in particular, childbirth) for people receiving government assistance. In *Maher v. Roe* (1977) the Supreme Court upheld a decision by the Welfare Department of the state of Connecticut not to fund an elective abortion unless it was medically necessary to safeguard the mother's life or health. In a related case, *Poelker v. Doe* (1977), the Court upheld the city of St. Louis' decision that its municipal hospitals were not required to provide nontherapeutic abortions, even though they provided care for childbirth. Three years later, in *Harris v. McRae* (1980), the Court upheld the constitutionality of the "Hyde Amendment" and, in doing so, extended its ruling in *Maher v. Roe*. The Court now held that the federal and state governments had no obligation to pay even for certain medically necessary abortions. And the Court reiterated its view, first expressed in *Maher v. Roe*, that the issue of funding was a political question to be settled in the legislatures of the several states and that it was even within the power of the states to seek to make childbirth a more attractive option than abortion. In its decisions about funding, therefore, the Court has made clear that the right of a woman to seek an abortion—a right enunciated in *Roe v. Wade*—is a liberty, not an entitlement. The distinction is important and is one we should affirm and support. It says nothing, however, about the many abortions which are not publicly funded.

In *Roe v. Wade* a woman's liberty to seek an abortion was grounded in her right to privacy. The Court began, therefore, by viewing the woman as an isolated individual. It was inevitable that this starting point should raise difficult questions about the relation of a pregnant woman to her husband or (if she is a minor) to her parents. In the decade since *Roe v. Wade* the Court has also struggled with this issue. In *Planned Parenthood of Central Missouri v. Danforth* (1976) the Court ruled unconstitutional any attempt to require consent of the pregnant woman's husband to an abortion. Given the starting point of *Roe v. Wade*, with an individual right to privacy made central, it was no surprise that the Court refused to permit the husband what, from its perspective, would appear to be veto power over a woman's constitutionally guaranteed right. At the same time, we cannot avoid noting that the Court's starting point undercuts the sharing and mutual responsibility inherent

in the "one flesh" bond of marriage as enunciated in Scripture.

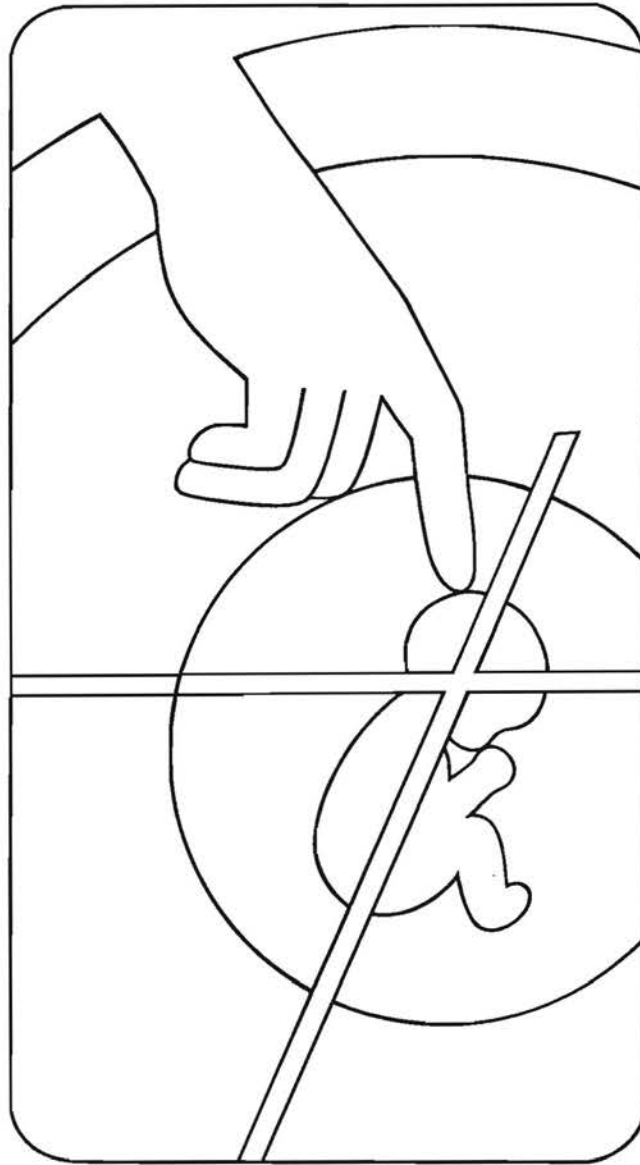
The issue of parental consent for a minor daughter to have an abortion has proved intractable. In *Planned Parenthood* . . . the Court overturned a Missouri statute which had required the consent of one parent before an abortion could be performed upon an unmarried woman under 18 years of age (unless the abortion was necessary to preserve her life). In *Bellotti v. Baird* (1977) the Court considered a slightly more complicated Massachusetts law—which required parental consent for a minor's abortion but also provided for judicial recourse if the parents refused their consent. This too the Court found unconstitutional, holding that it still too nearly granted the parents a veto power. However, in *H. L. v. Matheson* (1981) the Court upheld a Utah statute which required physicians to notify (not to seek the consent of) parents before performing an abortion on a pregnant minor. The Court held, in addition, that the minor must always have the option of going directly to court to argue that she is mature enough to make the decision herself and that parental notification is unnecessary or damaging. This issue has proved so intractable precisely because the Court has been unable to deny the importance placed upon the family bond in our society. Yet the Court's original decision in *Roe v. Wade* had recognized the importance only of a woman's right to privacy and of the states' interests in protecting maternal life and the potential life of the fetus. Given that starting point in an ideology of individualism, it has been difficult to find ways to support the family bond within the bounds set down in *Roe v. Wade*. There may, in fact, be no way to offer such support, short of constitutional amendment.

B. POSSIBILITIES WORTHY OF CHRISTIAN SUPPORT

The legal decisions discussed above, of course, are not to be viewed as providing moral determinations for decisions regarding abortion. However, the legal struggles of the past decade have suggested several possibilities for reducing the impact of these decisions. (1) We should stress the fact that the Court in *Roe v. Wade* does not in any way attempt to justify abortion morally. The Court only speaks to the issue of whether a *state* can constitutionally interfere with or impose restrictions on abortion. (2) We should emphasize that the Court has specifically held in *Roe v. Wade* that abortion on demand is *not* a protected constitutional right. (3) We should affirm that the grant of power to the woman recognized in *Roe v. Wade* is a liberty, not an entitlement, and that the government has no obligation to fund abortion. (4) We should work toward recognition of an earlier date for viability, since *Roe v. Wade* recognizes the power of the state to give some protection to the fetus from the date of viability. (5) We should learn to think of a woman's court-established ability to obtain an abortion as the right to a "severance procedure"

aimed not at procuring a dead infant but at relieving her of the burden, perceived or otherwise, of carrying a child she does not wish to carry. That is, even if a woman may have the ability to terminate a pregnancy, she may well not have the right to terminate the life of a child. Thus, a state may impose obligations on all concerned to do all in their power to enable the fetus to survive. (6) We should encourage legislative and administrative attempts to involve parents in abortion decisions made by a minor daughter. The moral requirements of the Fourth Commandment apply here as well as the prohibition given in the Fifth Commandment. (7) We should strive for greater change in the structure of *Roe v. Wade*, recognizing that such change may be accomplished by means of constitutional amendment, by change in the views of the membership of the Supreme Court, by legislative actions, or by changes in medical knowledge, e.g. earlier viability dates.

III. THE THEOLOGICAL PERSPECTIVE



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Christians in this country have been blessed with a political heritage and system which acknowledges their need and right to shape their lives in accordance with their religious convictions. Such a blessing is not without its dangers, however, one of which is the tendency to regard religious belief as restricted to the private realm. A proper theological perspective will never acquiesce in the notion that Christian faith can be that narrow. Christian love shapes our understanding of what care and concern, justice and equity, for the neighbor must mean. Christian love moves us to serve the needs of neighbors, and sometimes those needs can be served only in the public sphere. Moreover, the properties protected under the First Amendment, sometimes called the preferred freedoms, are an invitation to speak out in exercise of the privileges these freedoms confer. Thus, the expression of Christian judgment is not only countenanced but invited in a society which believes that public policy should emerge from the clash of opposing views in the public sphere. The framework of this service to the neighbor in society must, of course, be the distinction between the two kingdoms (AC and Ap. XVI), which reflects the distinction between Law and Gospel.

The Bible is not a code book which enables us to dispense with theological and ethical reflection, but Christian belief and action are decisively shaped and governed by Scriptural teaching and narrative. The great Christian truths of creation and redemption, and the dark shadow cast by sin, inform everything Christians say and believe about God's will for human life and the meaning of human personhood. Naturally, these truths remain somewhat abstract as they are stated below in the form of theological principles. They become more concrete as they lead, also below, to ethical reflection. And when they influence the values we share in our families and use in the nurturing of our children, the policies we espouse in the public sphere, and our common life within a worshiping congregation, they cease to be abstract and begin to form Christian character. We offer here four Scriptural principles, with accompanying brief discussion, to assist in the shaping of Christian belief, character, and action.

A. THEOLOGICAL PRINCIPLES

1. *Human life, at every stage of its development, is valued by God.*

The Scriptures do not specify the moment at which a new individual human being comes into existence—we have already indicated what science and medicine have taught us, namely, that the development of a new individual begins at fertilization—but the Scriptures do make clear that every

human being is valuable because valued by God. It is truly an act of *procreation* when a man and woman, participating in the blessing of God spoken to the creation, conceive a child. This unborn child, like all human beings at every stage of their development, is made in God's image—made for life with God, made to respond in love and obedience to the mercy and grace of God.¹⁷

The God in whose continuing creative activity parents are given a share is no respecter of persons. He values the weak and the lowly, and with Him achievement does not count for more than potential. Human dignity is therefore bestowed by God, not achieved or earned. The psalmist's poetic language

¹⁷ We refer to the child in the womb as a *human being* but refrain from referring to that child as a *person* though we have no objection to the use of personal language in that context. We do this simply for the sake of clarity and to avoid unnecessary and futile disputes. In the contemporary meaning used by some, a person is a being aware of itself as a self-conscious self, capable of relating to other selves and envisioning for itself a future. On the basis of such an understanding, some would deny that the life of the unborn child is *personal* life. The more traditional sense given by Christian theologians to the term "person" would predicate it of any member of the human species, any individual sharing our common nature—whether or not that nature is at any moment developed to its fruition in the life of that individual. Human nature has a capacity to know, love, desire, and relate to others. We share in that human nature even though we do not exercise all the functions of which it is capable. Thus, the contemporary understanding adopted by some will designate as a person only one presently exercising certain characteristic human capacities; it understands personal life in functional terms. The more traditional understanding of Christian theologians regards personhood as an endowment which comes with our nature, even if at some stages of life we are unable to exercise characteristic human capacities. Obviously, some important philosophical disputes—chiefly, the debate between nominalists and realists—are involved here. We bypass these arguments and simply refer to the unborn child as a *human being*. Whatever we may say of personal qualities, human beings do not come into existence part by part as do the artifacts we make. Human beings come into existence and then gradually unfold what they already are. It is human beings who are made in God's image and valued by God—and whose inherent dignity ought also to be valued by us.

witnesses to God's marvelous creativity, but also to God's concern for the weak and still-developing: "Thou didst knit me together in my mother's womb" (Ps. 139:13). The God who from all the mighty peoples of the ancient world could set His hand on Israel is not likely to judge worth in the comparative terms of our world (cf. Deut. 7:6-8). Indeed, the God of Israel was identified as One who had shown steadfast love to a weak and enslaved people. Hence, Israel could say:

Who is like the Lord our God . . . ?
He raises the poor from the dust,
and lifts the needy from the ash heap (Ps. 113:5, 7).

From the conviction that God has vindicated Israel in her weakness an ethical imperative arose:

Open your mouth for the dumb,
for the rights of all who are left desolate.
Open your mouth, judge righteously,
maintain the rights of the poor and needy (Prov. 31:8-9).

Christians, belonging to the new Israel, reason in precisely the same way. They confess that Christ has died for the weak and the ungodly (Rom. 5:6) and that God has chosen what is weak in this world (1 Cor. 1:27). Such knowledge gives content to Christ's command that we are to love as He has loved us (John 15:12). We too must value the poor and the weak, those too powerless to speak for themselves, those easily disposed of because they seem to contribute little. This suggests a second principle.

2. Human lives are entrusted by God to our care.

The Christian belief that human life is not to be taken rests not only on our conviction that human lives are valuable (because valued by God) but also on the truth that life is not ours to take. In the Decalog is a command which calls upon us to respect the lives of our fellow human beings: "You shall not kill" (Ex. 20:13). As Luther's explanation of this commandment in his Small Catechism makes clear, the command requires not only respect for the neighbor's life ("that we may not hurt nor harm our neighbor in his body") but also care and concern that the neighbor's life be preserved ("help and befriend him in every bodily need"). Similarly, in his Large Catechism Luther explains that this commandment means that God

wishes to have all people defended, delivered, and protected from the wickedness and violence of others, and he has set up this commandment as a wall, fortress, and refuge about our neighbor so that no one may do him bodily harm or injury (LC I, 185).

To this Luther adds:

Not only is murder forbidden, but also everything that may lead to murder. . . . we should neither use nor sanction any means or methods whereby anyone may be harmed . . . (LC I, 186, 188).

To be sure, the mainstream of Christian tradition has, in its understanding of just war and justice in war, permitted the soldier in service to legitimate government to harm and even kill an enemy soldier. This has been understood as a permitted exercise of government's God-given right to use force to preserve ordered peace and justice within human society. (Also given to government is the right to take the life of the evildoer as retributive justice; cf. Rom. 13:4.¹⁸) The received Christian tradition has, however, placed limits upon what may be done even in a just war. Most important, it has insisted that the enemy, when he lays down his arms and surrenders—when, that is, he ceases any longer to threaten other human lives—cannot be harmed. Ceasing to be an aggressor, he can be neither harmed nor killed. Of course, throughout the church's history some Christians have felt that only a pacifist stance and witness was compatible with Christian teaching and Christian love—a feeling which is again present within our own day. These Christians will refuse to take human lives under any circumstances. But granted the legitimacy of warfare in certain situations, the use of force is warranted only by a threat to life or some value equal to life. In all other circumstances the strict prohibition of the Fifth Commandment applies.

It has become increasingly common in our society to speak as if taking life—whether of the unborn through abortion, of the handicapped or retarded child through benign neglect or infanticide, or of the suffering and the senile through euthanasia—were a way of serving the well-being of those whose lives we take. Against all such misuse of language Christians insist that the task entrusted us by God is to help and befriend our neighbor in every bodily need, not to rush the neighbor out of existence and beyond the realm of bodily need. This leads quite naturally to a third principle.

3. *There are limits to human freedom.*

It is the same apostle Paul who exhorts us that "as we have opportunity let us do good to all men" (Gal. 6:10) who in another context indignantly rejects the suggestion that he might have taught that we should do evil that good may come of it (Rom. 3:8). The juxtaposition of these two passages

¹⁸ Cf. CTCR's 1976 "Report on Capital Punishment."

sets before us a perennial difficulty of the moral life. We ought to serve the well-being of our neighbors—as often as possible, as many neighbors as possible. But we are also forbidden to engage in certain activities (as when, for example, the Fifth Commandment forbids unjustified killing). Yet, there may be occasions in life when it seems that serving the greater good of our neighbors requires the use of a forbidden means to that good.

It is important, when contemplating such possibilities, to retain a firm grasp on our creatureliness. Ours is not the role of a deity, but the limited role of a creature. We are indeed to do all the good we can for as many neighbors as possible, but this means all the good we *morally* can do within the limits set by God's law. We are not, even if our motives are praiseworthy, to do evil that good may come of it.

This means, we recognize, that some good and desirable ends cannot be achieved, because the means to those ends are forbidden us. It may also mean on some occasions that a good end must be achieved more slowly and less directly in order to remain within the limits set by God's will. Certainly the prohibition of unjustified killing constitutes a strict limit on the ways in which we may attempt to do good. Recognizing that our capacity to accomplish the good we desire is limited not only by our abilities but also by moral precept, we are driven to be and become a people of hope, who trust that God can bring good out of evil and may accomplish what we are unable to do. This suggests a final theological principle.

4. *Moved by their hope in God, Christians must be a people glad to receive children into the human family.*

It may be through our children—and sometimes only through our children—that God finds a way to teach us how to love those who are not what we wish them to be and whose presence is neither convenient nor timely. In our society, however, a different attitude has become commonplace. The child is often perceived as a burden, as a threat to our plans and purposes, a danger to our chances for self-fulfillment. We can, of course, understand the experiences which may underlie that perception. The presence of children may sap our energy, deplete our resources, and tax our patience.

Nevertheless, as Christians we understand the presence of children among us in a special way. The divine blessing—"be fruitful and multiply"—spoken at the creation continues to be effective in our world (Gen. 1:28). And the presence of children is a sign of God's continuing "yes" to His creation, a manifestation of God's unwillingness to abandon us or to withdraw from the time and history in which we live (1 Sam. 1:1-2:11). Moreover, this God who through our sexual powers continues to create new human beings is One who has demonstrated in Jesus Christ His indefectible love toward us. In Him, as St. Paul writes, God's Word to us is always "yes" (2 Cor. 1:19). We welcome children into our midst, therefore, as a renewed act of

trust in the God who has taken the dangers and problems of human life upon Himself and shared our suffering (Mark 10:13-16).

This means that our willingness to welcome children—to help and befriend these small neighbors in their every bodily need—is one way in which we express our confidence in God's goodness and mercy, and our hope that in the future His promises will continue to find their "yes" in Jesus. In welcoming a child we testify that our hope for fulfillment rests in God, and we express our trust that He is not powerless in the face of life's difficulties and dangers. We value the lives of children because God values them; we refrain from harming them because God forbids such harm; but more important still, we seek to become people who receive them with joy and thanksgiving (Ps. 127).

The Scriptural principles offered here compel us to regard abortion on demand not only as a sin against the Fifth Commandment forbidding the destruction of human life, but also as a grievous offense against the First—that we worship the one true God and cling to Him alone. The act of abortion clearly manifests a refusal to honor God as the Creator and to seek Him above all else in time of need. It, too, belongs in the list of those offenses that illustrate man's rebellion against the Creator (Rom. 1:26-32), summoning wrath from which only God Himself can—and does—deliver us.¹⁹

¹⁹ Early Christian writers specifically condemned abortion as a violation of the Biblical prohibition against killing. The first century *Epistle of Barnabas* states: "You shall not murder a child by abortion, or kill it when it is born" (19:5 Goodspeed Translation). Similarly, the *Didache* (about A.D. 100–20) says: "Do not murder a child by abortion or kill a newborn infant" (2:2 LCC Translation). The ancient church father Tertullian (about A.D. 160–220) wrote in his *Apologeticum* (about 197): "For us, since homicide is forbidden, it is not even permitted while the blood is being formed into a man to dissolve the conceptus in the uterus. For to prevent its being born is an acceleration of homicide, and there is no difference whether one snuffs out a life already born or disturbs one that is in the process of being born" (IX, 8.)

B. ETHICAL REFLECTIONS

Though it cannot deal in advance with every imaginable case, ethical reflection seeks to bridge the gap between general statements of Biblical principle and particular actions. As such, it performs a vital and necessary role in Christian theology. The attempt to make precise judgments about right and wrong behavior will always be regarded by some as an unwarranted limiting of Christian freedom. But it is, in fact, the necessary charting of the course of the Christian life, within which course Christians are free to serve their neighbors in the countless ways which love discerns but law can never specify. In that spirit we offer the following ethical reflections with respect to abortion.

1. The unborn child developing within the mother's body²⁰ is clearly a human being entitled to our care and protection. We now know so much about this developmental process that a refusal to grant that the child is an individual human being must amount almost to willful self-deception. When we consider that within eight weeks of gestational development electrical activity of the brain can be detected and that within the first twelve weeks of pregnancy all major organ systems have begun to develop, we should be at least as awestruck as was the psalmist who marveled that God knit us together in our mother's womb. This young human being may be weak and unable to speak in his own behalf. He may as yet have achieved nothing as we ordinarily measure achievement. But the lives of these small human beings are valued by God and entrusted to our care. This moral judgment gains in precision when we consider the following related points:

a. We know too much about the unique identity of the unborn child to imagine that he can properly be called "a part" of his mother's body. He has his own genotype, his own developing body. The unborn child can and does respond to stimuli and is already beginning to relate to his mother. He is simply an unborn human being undergoing a period of development in the environment natural to him at this stage of his life. He is neither an aggressor nor a usurper.

b. Naturally, the unborn child's life is dependent upon his mother. But so is the newborn baby dependent upon others for

²⁰ Here we have set aside the medical/legal designations "embryo/fetus" and emphasize the creation of a new human being within the womb of the mother.

care; so are we all dependent on each other; so may we all be dependent upon others for care when we are ill and dying. Moreover, the ideal of "independent" life is one which ought to be seriously questioned by us. Our society has seen and experienced some of the dangers which an ideology of isolated individualism can bring. It is mistaken, therefore, to regard viability (the time at which the unborn child is able to live outside the uterus) as a morally significant dividing line. Aside from the fact that the time of viability is relative to the present state of medical science and will change as medical progress continues, the supposed importance of viability depends on imagining that only the lives of human beings who can live independently of others' help are entitled to protection. That is, we think, a supposition which will be rejected by those who think through its possible consequences, and it is surely no part of a Christian ideal for human existence.

c. The unborn child does not become entitled to our care and protection only if he is "wanted." His dignity rests in his creation for life with God. That dignity does not come into or fade out of existence according to the wants of others. Moreover, we cannot be a people who welcome children into our midst if they must always be "wanted." The ethical task is not to welcome only those children whom we want, but to discipline and shape our wants so that we care for those given us. And finally, it must simply be said with candor: A willingness to abort the unborn on the grounds that they are "unwanted" by adult society is a raw exercise of power by the strong over the weak. Both the requirements of justice and the claims of Christian love compel such a judgment.

d. The fact that a child will be born retarded and/or disabled cannot justify withdrawing our protection for his life. To hold otherwise would require that we also justify infanticide of retarded and disabled newborns—a conclusion from which some at least will still shrink. The glaring weaknesses of this justification for abortion will become increasingly apparent as our ability increases to operate on the unborn within the womb to correct some defects. It will then be apparent that, if we choose to abort some and provide therapy for others, we consider the value of their lives to depend entirely on our own choosing. If, however, instead of looking for value in the lives of such children by comparing them with others who are "normal," we will instead learn to value the lives they have—even as God values them—we will be renewed in our commitment to care for them.

e. There are circumstances in life in which an abortion might

be considered a means toward achieving some good end. For example, abortions are often sought to assist family planning goals, to minimize instances in which children may suffer abuse, to control the costs of caring for an increasing poor population, to make it possible for women to continue pursuing careers, to ease the burden on women or families with problems—all, quite probably, desirable goals. But however desirable such goals may be, they cannot justify killing a human being in order to attain them. These are instances in which the means to an admittedly good end is prohibited us. Naturally, we can and should try to achieve these goals by other means. Certainly there are other ways to try to deal with family planning, with poverty and unwanted children, with opportunities for women to pursue vocations—if only we have the will to seek those other ways. Our long-term aim should be to move toward a society in which the choice for abortion is a choice no one feels compelled or drawn to make.

2. We have emphasized as strongly as possible the protection to which the unborn child is entitled. We do not overlook, however, the fact that in the gestation and birth of children mothers bear by far the greatest burdens. The child's life is dependent upon his mother in a unique manner, a manner which calls for an act of self-sacrificing on her part. Indeed, we may even say that in the manner of human gestation and birth we see a deeper truth than our attachment to independence and individualism can reach. The life-giving burden carried by mothers, and only by mothers, must be kept clearly in view throughout our ethical reflection. This fact alone gives the mother's claims a certain preeminence in those cases where the life of the unborn child and the equal life of the mother come into conflict.

In the rare situations of conflict we must recognize the permissibility of abortion. Despite the progress of medical science, there are still unusual circumstances in which a mother will die if an abortion is not performed. There are also cases (e.g., some instances of chronic heart or kidney disease in which pregnancy increases the strain on heart or kidneys) in which the danger to the mother's life is greatly increased if no abortion is performed. Even in such circumstances a mother may choose to risk her own life as an act of love, but such an act of self-giving cannot be required. It must be freely given, not imposed.

Very difficult and painful situations arise in cases of pregnancies which result from rape or incest. Even if such wrongful acts do not result in pregnancy, the most sensitive kind of pastoral counseling is required. Christian love manifests itself in deep compassion for those who are the unwilling victims of exploitation and violation. Guilt, fear, anger, hatred, self-loathing, and other emotional and spiritual upheavals must be dealt

with wisely and mercifully. Although conception almost never occurs as a result of forcible intercourse, when it does, the life of the new human being is as valuable and as worthy of protection as any other newly begun life. Thus, the evil and violent circumstances in which a child is conceived do not in and of themselves constitute valid grounds for recommending or approving an abortion. There is a necessity for a concentrated and sustained ministry to the woman who finds herself in such tragic circumstances. There must be concern for her physical, spiritual, and emotional needs as well as for the life and future of the child. Comfort can be taken from St. Paul's exhortation that God promises to bring good out of even the greatest evils that befall us (Rom. 8:28).

3. Ethical reflection must always pay attention to the possible *consequences* of actions we endorse. One possible result of permissive abortion becomes evident when we set out in simple syllogistic form the argument which underlies opposition to abortion.

Major premise: The lives of human beings—whatever their stage of development or achievement—are entitled to equal care and protection.

Minor premise: The unborn child is a human being.

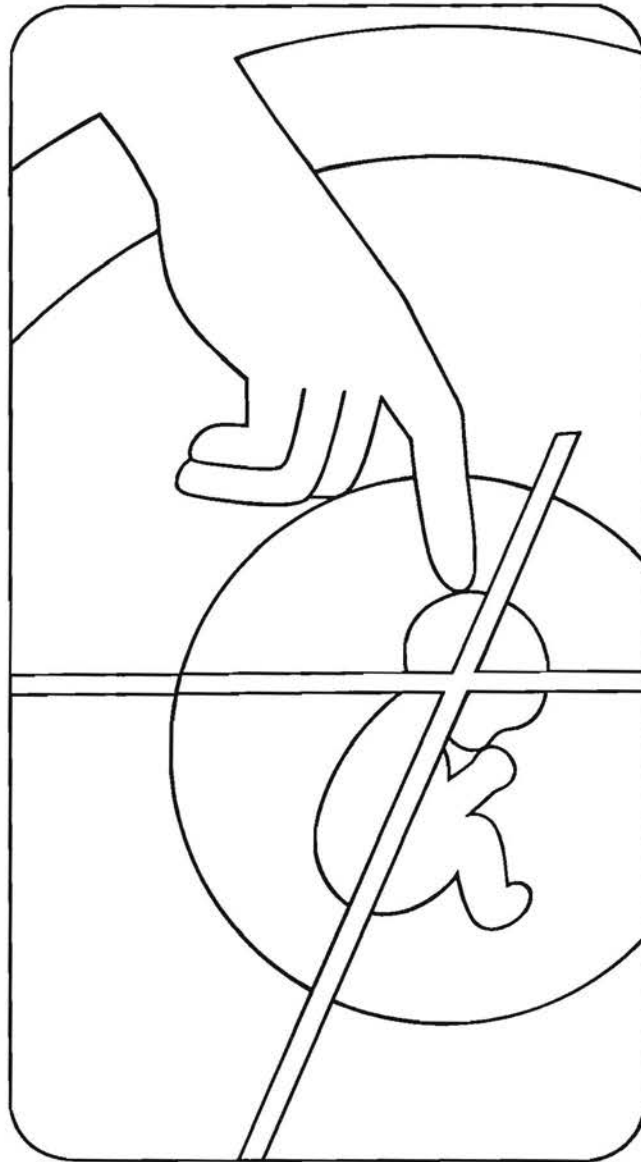
Conclusion: The life of the unborn child is entitled to equal care and protection.

It is a commonplace of logic that, if we change the conclusion, one of the premises of an argument must also be changed. If, as is certainly the case in our society, the conclusion is no longer affirmed, our commitment to one of the premises is likely to erode. However much some may at present deny the minor premise, it is difficult to believe that it will in the long run be rejected. The more we know of fetal development, and the greater the possibilities become for fetal therapy, the more difficult it will be to deny the persuasive force of the minor premise. We are more likely to see an erosion of our commitment to the major premise. In short, we might predict that our society would begin to abandon the view that entitles all human beings to equal care and protection of their lives—that we would abandon this and replace it with judgments of comparative worth. When we consider decisions presently being made about infants born with defects and decisions made about care for the retarded and senile, it is hard not to believe that some of those consequences are already upon us. People who are untroubled by permissive abortion are not likely forever to resist other judgments of the comparative worth of lives.

4. Finally, we must emphasize the proper use of these ethical reflections within the theological task, the life of the church, and the life

of the individual Christian. In the delicate administration of Law and Gospel to those troubled by decisions related to abortion, the Christian pastor in particular should realize that his task does not consist in the mere articulation of moral judgments. Nor ought he to announce God's forgiveness to those who are impenitent. The Law in all its severity and the Gospel in all its sweetness are to be applied with sensitivity to all those who are crying for help through a personal crisis. It is important to understand that a request for an abortion is, in a sense, the mother's serious plea for her life. A Christian woman may wish to be freed from a burden she feels she cannot bear and still live. However, the means by which she seeks to affirm her own life is wrong. The Christian pastor must try to help her see and face this painful contradiction in her feelings and affirmations, and finally lead her, under the blessing of God, to accept her burden in the faith that all things work together for good with those who love God and who are called according to His purpose (Rom. 8:28-30).

IV. CONCLUSION



IV. CONCLUSION

A. REFLECTIONS FOR THOSE GIVING SPIRITUAL CARE

The task of ethical reflection and the application of moral judgments to the life of the individual Christian falls not only to Christian pastors but also to Christian counselors, physicians, and—perhaps in some cases more so—to others closely associated with the person seeking help. With the promotion and growing acceptance of abortion as a matter of private choice and constitutional right, fewer women are seeking professional or ministerial counseling in their deliberations about abortion. Today, advice and guidance concerning abortion decisions come primarily from peers, friends, and family—if, indeed, the pregnant woman consults anyone at all. Certainly, any serious counseling that is done is likely to have been done before a woman goes to an abortion clinic. The remarks that follow, therefore, are addressed not only to pastors and to Christian physicians and counselors, but also to anyone who may suddenly be faced with the challenge and opportunity of counseling with a woman or a couple contemplating abortion.

1. *The Contemporary Setting*

a. Women are being conditioned to want and feel the need for abortions. Data from many countries indicates that a change from restrictive to permissive abortion laws gives rise to a group of women who seek abortions when they would not previously have done so. The subjectively felt stress which leads many women to seek an abortion can be understood correctly only if this social influence is recognized and taken into account.

b. Overlooked in the abortion dilemma is the distress often experienced by the father of the child to be aborted. Numerous studies have reported that men may have difficulties with an abortion experience and may suffer painful role conflict. Since abortion is legally the choice of the woman alone, she may, in effect, choose motherhood, while he may not choose fatherhood. Some men, thwarted in their desire and need to protect their offspring, report persistent dreams about the destroyed child and considerable guilt and sadness.²¹

²¹ Vincent M. Rue, Testimony before Senate Subcommittee (November 4, 1981). Cf. "Sharing the Pain of Abortion," *Time* (Sept. 26, 1983), p. 78.

c. A near constant which must be remembered in counseling women who are considering (or have had) an abortion is their low self-esteem. Many have difficulty appreciating the dignity and value of their own lives. They may have a poor self-image or may have experienced rejection at a crucial moment in their lives. It is understandable, then, that they may have difficulty affirming the dignity and value of the child within them. The pain they know takes precedence over the unseen child they do not know. For such women an abortion may only reinforce their negative feelings about themselves.²²

2. Counseling Considerations

a. Abortion counseling should be crisis counseling. Abortion is an irreversible action often chosen at a time when careful, unhurried reflection is difficult. In such circumstances all of us may make decisions which are not best for us and which we may later regret. The distressed woman or frightened teenager facing pressures of time, economics, and even coercion from those with vested interests may be ill-suited to make a constructive and wise decision. It is imperative, therefore, that she be involved in an exploration of her situation and her alternatives.

b. It is important to identify accurately the real reason or reasons an abortion is being considered. For example, is it the *condition* of pregnancy or the *result* of pregnancy (the child) which is the source of anxiety? If the pregnancy itself is at issue, this may be because of lack of money for medical care, an existing health problem complicated by pregnancy, loss of employment, other inconveniences due to pregnancy, embarrassment, or rejection by one's spouse or partner when he becomes aware of the pregnancy. If the child to be born is the issue, this may be because of the woman's inability (financially, socially, or emotionally) to care for him, due to fear of single parenthood or fear of a child with mental or motor disabilities. Only by isolating the real problem, exploring its dimensions, and considering its possible resolutions will the woman's interests, as well as the child's, be fostered and protected.

c. Be aware of potential risks. Those who stand to benefit financially from an abortion are least likely to inform the distressed woman of possible physical problems which can result. Medical risks include more than immediate dangers. An abortion increases a woman's chances of having

²² David Mall and Walter F. Watts, M.D., eds., *The Psychological Aspects of Abortion* (Washington, D. C.: University Publications of America, 1979), p. 121.

in the future an ectopic pregnancy, a spontaneous miscarriage, or a premature delivery. Hence, it is important to remember that more than a present crisis is at stake.

d. Know about available resources. Experiencing the limits to our ability to help women facing the stress of untimely pregnancy, we may be quickly drawn to assume that abortion is the only possible or reasonable solution. But a variety of agencies, organizations, and volunteer groups are available to offer a pregnant woman the support system needed to meet her personal, medical, and legal needs. These options can become possibilities for choice only as she is made aware of others who want to help her.

e. Be sensitive to the problem of guilt. Since abortion has become legally and socially acceptable, problems of guilt may be dismissed by some as part of an outmoded value system. Such dismissal is not likely to be a real service, however. When many women experience depression, nightmares, and difficulties in relationships following abortion, it will do little good to suggest that such guilt is irrational or unjustified because abortion was their legal right.²³ The problem is the guilt itself, and the verdict of conscience on these occasions is to be taken seriously. Such a woman needs counseling which will lead her to sincere confession and to the renewal of hope offered by the powerful word of the Gospel.

B. RESPONSE IN THE POLITICAL SPHERE

We should not underestimate the depth of division on the issue of abortion which exists within our country, nor should we imagine that any quick and easy solution to that division is possible. While we may grieve over the drastic relaxation of legal restraints on abortion, we cannot, upon serious reflection, be surprised by it. We find in it yet one more example of the growing disposition of an increasingly secular society to resolve moral dilemmas through pragmatic considerations of public policy and one more instance of the perennial tendency of the strong to oppress the weak. The judgments courts make about legality or illegality do not settle moral issues and are not determinative for Christian conscience. If abortion was sinful before 1973, it

²³ R. Illsey and M. Hall, "Psychosocial Research in Abortion: Selected Issues," in *Abortion in Psychosocial Perspective: Trends in Transnational Research*, ed. H. David et al. (New York: Springer, 1978), pp. 11—34.

continues to be sinful in the decade that has followed *Roe v. Wade*. And even if abortion were made illegal tomorrow, the divisions among our people would still need healing and the moral issues would need to be addressed. It is to the moral issues that Christians can and should speak.

We should not acquiesce in the notion that defenders of abortion are merely "pro-choice." There are some issues with respect to which it is not sufficient to be "pro-choice." Just as the Kansas-Nebraska Act of 1854—permitting new states entering the Union the choice whether to be slave or free—was not a tenable solution to the problem of slavery, so also a so-called "pro-choice" position on abortion is not adequate; for it does not recognize the justified claims of the unborn child upon us.

There is also no reason to acquiesce in the notion that abortion opponents are illegitimately attempting to foist a private, religiously grounded view upon the whole of a society which does not share these religious beliefs. Much Christian opposition to abortion is based upon (1) our increasing knowledge about the facts of fetal development, and (2) a commitment to justice and an unwillingness to make comparative judgments assessing the relative value of human lives. These aspects of our viewpoint are certainly held by many who do not share our religious commitments. Beyond this, however, we reject the prevailing view in our society that considers religion good only as long as it remains a purely private matter. This is a distorted notion of the function of religious faith in the believer's life, and we ought not permit others to define for us the nature and extent of our religious commitment. However one arrives at the view that the unborn are, in fact, human beings deserving of protection, it is difficult to see how such a view could possibly be responsibly held as a purely private opinion.

We do not, of course, imagine that all matters of morality are fit subjects for legislation. Lust and gluttony are among the seven deadly sins; yet we would not suppose that they should be prohibited by statute. But those matters of morality which impinge upon civic order, which touch the common good, are appropriate subjects of legislation. In such matters we can, do, and ought to legislate morality. Just as we believe that racial discrimination ought to be opposed not merely in private but also in the public sphere, even so we believe that laws to provide protection for all human lives are appropriate and necessary. When the common good is involved, law and morality must join hands.

For what should we labor in the public sphere? We have seen in our discussion of "The Legal Perspective" that court decisions following *Roe v. Wade*, although clarifying some questions in helpful ways, have left little room for limitation of abortion. It is probably true that any large gains will have to await either a different membership of the Supreme Court or a constitutional amendment. There have been within Congress attempts to settle the problem legislatively by passing a law which defines the legal meaning of "person."

(The advantage of such an approach is that, as ordinary legislation, it would require only a simple majority.) The legality of this attempt is greatly disputed, however, and there is no doubt that a constitutional amendment would offer a more lasting resolution.

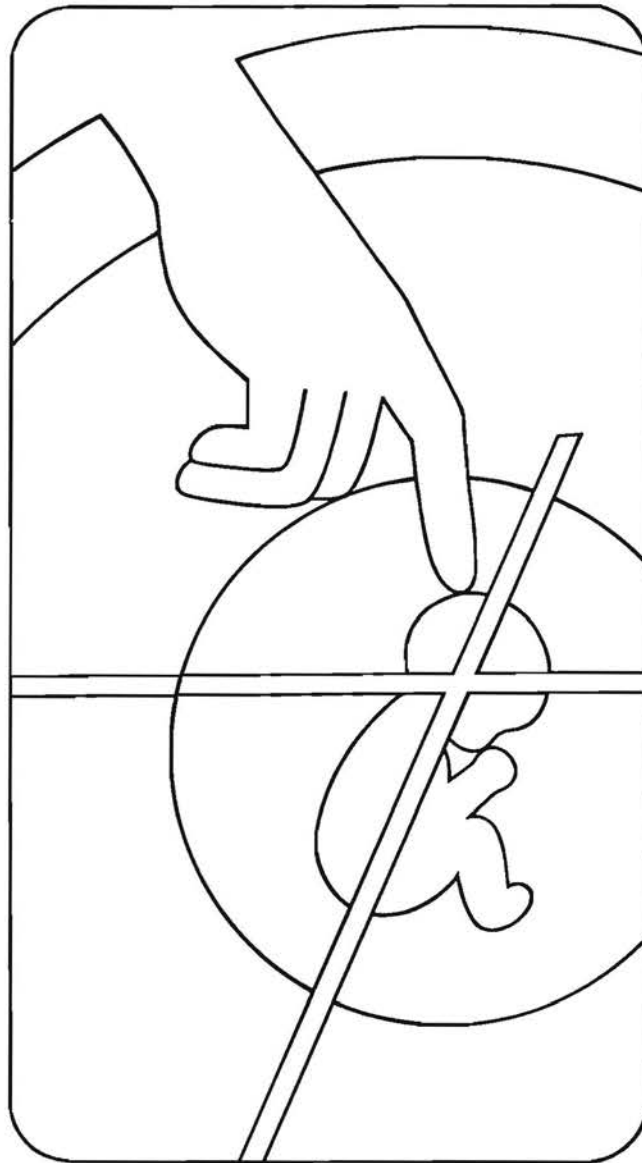
Proposals for such an amendment have come in several forms. Some propose amendments which specify when individual human life begins and thereby offer protection for the rights of the unborn. Others propose an amendment which states simply that the Constitution does not secure a right to an abortion—hereby returning us to the situation which prevailed prior to *Roe v. Wade* and permitting the several states to regulate abortion to whatever degree they wish. The advantage of the first kind of amendment is that it would provide a more uniform and sweeping solution. In our current political climate, however, it would likely be viewed by many as imposed rather than agreed upon, and might well be the source of new divisions. The second kind of proposed amendment, which would return the abortion issue to the states, would permit the people through their legislatures to debate at length what their policy with respect to abortion should be. Undoubtedly, however, it would make for a less uniform and less restrictive policy.

In truth, our greatest hope may lie in the possibility that the Supreme Court, perhaps with some new justices, perhaps impelled by medical advance, will find it necessary to extend greater protection to unborn human beings. The way in which this may occur was, in fact, suggested by Justice Sandra O'Connor in her dissenting opinion in the 1983 decision, *Akron v. Akron Center for Reproductive Health*. She noted that "the Roe framework . . . is clearly on a collision course with itself." As abortion becomes a safer procedure, states will be less justified in claiming to limit abortion in ways that protect maternal health. But at the same time, medical progress will move farther back into pregnancy the time at which the fetus is viable, the point at which *Roe v. Wade* had permitted the states to legitimate interest in protecting fetal life. We can hope that the direction pointed to in Justice O'Connor's dissent, which takes seriously the need for more stringent protection of fetal life, will in the future be taken by a majority of the Court.

There is currently a "great debate" concerning whose good shall count in the common good. Shall the good of the unborn child count in the common life we share? Shall the rights and protections we all claim flow back evenly upon all, also upon the unborn child? We are, in fact, determining what the outer limits of the human community among us shall be. When such issues are being debated in our public life, Christians ought to be first to speak on behalf of those who are weak and unable to speak for themselves. We confess as a cardinal tenet of our faith that "God chose what is weak in the world to shame the strong" (1 Cor. 1:27). If that "religious" belief does not shape the whole of our life, including also our life in the political sphere, we have not begun to fathom either its power or its depth.

APPENDIX

SUGGESTIONS FOR RESPONSE AT THE CONGREGATIONAL AND INDIVIDUAL LEVELS



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The Christian response to the problem of abortion cannot be limited to public protest; Christians must also commit themselves to an ongoing ministry of supportive care for those who are faced with the kind of burdens that often prompt women to contemplate an abortion. Congregations and individuals interested in pursuing such commitment may wish to consider the following avenues of support for human life:

1. Designate a pro-life resource and contact person within the congregation to coordinate pro-life activity and education. Such a person may be responsible for informing the congregation on pro-life issues through bulletin inserts, a column in the congregational newsletter, pamphlets and tracts available, books for the church and/or school libraries.
2. Address the life issues from the pulpit and in Bible classes.
3. Make information available to all members of the congregation on the needs of pro-life organizations.
4. Organize a "care" group within the congregation to help mothers after the birth of the baby. Sensitize members to the plight of the woman who must try to raise a child in poverty, without a husband, often without help or support from family. Teenagers ostracized from peer groups need a listening ear from a friend. Some need parenting skills, assistance to obtain medical care, and other basic necessities. Provide infant and maternity clothes for mothers, as well as for organizations that provide supportive services for crisis pregnancies.
5. Discover ways to be supportive of parents whose teenage daughter becomes pregnant. Elders and spiritual care committees in particular need training for dealing with this situation.
6. Form prayer circles to pray for the unborn, mothers with a troubled conscience, children with handicaps and burdens in the home, the elderly and senile, and others whose value is viewed as diminished because they are unwanted or imperfect.
7. Conduct or sponsor youth workshops on life issues and sexuality for the community. Provide for sex education in the congregation for parents, youth, and children.
8. Establish a local "Lutherans for Life" chapter.
9. Celebrate a "Life Sunday" during the year to develop a Christian concern for mothers and unborn children.

10. Include a pro-life unit in confirmation classes and premarital counseling sessions.
11. Enlist the Christian day school in projects such as compositions, posters, poetry, and drama that convey a pro-life message.
12. Inquire about governmental and community sources of funding for the support of single mothers.
13. Establish contacts with pro-life leaders in your area and discuss ways of carrying out cooperative programs regarding pro-life issues.
14. Invite pro-life professionals (medical, legal, theological) to address groups within the congregation.
15. Provide home care for unwed mothers seeking temporary assistance during moments of crisis.
16. Write to congressmen and senators expressing the pro-life position on life issues.