Late-Term Abortions: Pro and Con

Late-Term Abortions Should Be Banned


Supporters of abortion, including President Barack Obama, assert that it is a "private family matter," but when it comes to the illegal procedure known as late-term abortion, or "live-birth abortion," it no longer belongs in the family sphere. All abortion is murder, and late-term abortion is a particularly egregious procedure that should not be allowed under any circumstances.

The case of Kermit Gosnell reached the newspapers just a few days before the 38th anniversary of Roe v. Wade [which legalized abortion in 1973]. President [Barack] Obama did not mention Gosnell in his official statement celebrating the anniversary. But the case sheds more light on Roe's import than the statement did.

Obama did not refer to the word "abortion," preferring instead to discuss "reproductive freedom" and the "fundamental principle" that "government should not intrude on private family matters." The stories about Gosnell were a little less abstract. They told of a Philadelphia clinic where dirty instruments spread venereal disease, cats roamed and defecated freely, and some patients died. The state government conducted essentially no oversight; administrations of both parties wanted to keep abortion as free from governmental intrusion as possible.

Abortions Inspired Outrage
The clinic's lack of hygiene is not the detail that has captured the most attention, or inspired the most outrage. It turns out that Gosnell frequently, perhaps hundreds of times, delivered fully intact fetuses and then took scissors to the newborn's spine. In his words, he engaged in "snipping" to "ensure fetal demise." In many cases, the fetuses were in the third trimester.

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This procedure, sometimes called a "live-birth abortion," is illegal. But not thanks to President Obama. As a state legislator in Illinois, he argued that the law should offer no protection to neonates if they had been delivered before viability. He said that protecting them would violate Roe v. Wade and undermine the right to abortion. What looked like infanticide to most people was for him, it must be inferred, a "private family matter." When Gosnell applied his scissors to pre-viable children, he was, on Obama's terms, merely exercising a cherished freedom.

Credit Obama with a real insight: The physical location of a human being conceived five months ago may mark the difference between whether he is considered a "fetus" or an "infant," but it cannot mark a moral difference. Nor can it make a moral difference whether this being is partly inside the womb. When Congress moved to ban partial-birth abortion, most liberals took the view that any prohibition had to include a health exception: If in the judgment of the abortionist the safest method of ... ensuring fetal demise ... was to partly deliver the fetus, crush its skull, vacuum its brains, and then deliver the rest, then he had to be free to do so—at any stage of pregnancy. President Obama favored this health "exception."

A few liberals—notably Supreme Court justices John Paul Stevens and Ruth Bader...
Ginsburg [and] also the celebrated intellectual Richard Posner in his role as a judge—made the moral point as well: What difference could it possibly make whether the fetus was partly out of the birth canal when its life was ended? Start with the correct view that location does not matter; add the liberal view that partial-birth abortion is justified whenever an abortionist says so; and it is hard to escape the conclusion that a live-birth abortion is justified whenever an abortionist rules it the safest method of killing.

**Fifty Million Deaths**

We don’t know that Gosnell has closely followed the Supreme Court’s opinions or the president’s statements. We can say that his actions perfect the logic of the mainstream of the pro-choice movement. He has followed premises shared by the president and by four Supreme Court justices to their unavoidable conclusion.

Concluding his statement, President Obama said, "I hope that we will recommit ourselves more broadly to ensuring that our daughters have the same rights, the same freedoms, and the same opportunities as our sons to fulfill their dreams." Let us commit ourselves to ensuring that our sons and daughters have the opportunity to live; an opportunity cruelly snatched away from more than 50 million human beings since the day the president commemorated.
Restricting access to second- or third-trimester abortions as a way of finding common ground between abortion supporters and opponents is problematic and threatens women's health. Women who are in their second or third trimester often have a compelling need for an abortion. They are often young children who are victims of incest or who are too young to bear children, or women who desperately want a child, but discover their baby has a fetal anomaly. Abortions are becoming increasingly difficult to obtain for women in all stages of their pregnancies. Reproductive justice supports the rights of women to have children they want, when they want them.

I am intrigued by some reproductive rights advocates' increasing willingness to search for "common ground" with abortion opponents, evidenced by a recent conference convened with this purpose at a major university. Prior to the conference, one of its organizers, long-time reproductive rights supporter and former Catholics for Choice president Frances Kissling, expressed sentiments representative of this disturbingly conciliatory tone:

"As long as women have an adequate amount of time to make a decision, and there are provisions for unusual circumstances that occur after that time, I would be satisfied [with early gestational age limits to abortion].... Women have an obligation to make this decision as soon as they possibly can."

A Problematic and Dangerous Trend

In short, the abortion debate has come to include abortion supporters and opponents bargaining about restricting second-trimester abortion as a means of seeking common ground. While I applaud efforts towards a more civil public discourse in principle, as a provider of second-trimester abortion services, I find this trend problematic and dangerous to the health interests of women. I am also troubled by the question—to whom, other than themselves, are women obligated "to make their decision as soon as they possibly can"?

Apparently recognizing that termination of pregnancy won't be outlawed any time soon, abortion opponents are willing to engage in dialogues that—while appearing to progress towards a more civil exchange with abortion supporters—unwittingly enlist the energies of abortion rights activists for the restriction of those rights. These conversations subtly endorse the parsing away of this fundamental human right, ironically beginning with women in their second trimester, who often have the most compelling need to have an abortion in the first place. As is common in discussions of abortion, absent from these dialogues are the voices of the women and families that are affected—the very women who are and will be denied access to what is oftentimes a health-related decision.

The lives of these women and their families are what compelled me to add abortion care to my practice, mid-career, when I was no longer able to weigh the life of a pre-viable or lethally-flawed, viable fetus equally.
with the life of the woman sitting before me. My intent here is to share why I provide abortions. The times in which we live call for a thoughtful, compassionate, evidence-based approach to women’s healthcare that should empower healthcare providers to include abortion in their practice—second-trimester abortions included—because of the women who, in the absence of these services, would die unnecessarily.

Approximately one in three women in the US will terminate a pregnancy in her lifetime.

I did not provide abortions for the first 12 years of my career as an obstetrician and gynecologist, even though my work allowed me to see first-hand the reproductive dilemmas and outcomes that women and families face. While recognizing that abortion was a need in my patients’ lives, I grappled with the morality of providing them, as I came from a traditional religious background that considered abortion to be wrong. It is said that when you grapple with your conscience and lose—you actually win. I “lost” that 12-year battle about whether or not to provide abortions while listening to a sermon by [civil rights leader] Dr. Martin Luther King, Jr.

Dr. King related the story of the Good Samaritan to encourage compassionate action on behalf of others. The story tells of an injured traveler who was ignored by passersby until one person, the Samaritan, stopped to help.

**If Not Me, Who?**

According to Dr. King, what made the Good Samaritan "good" was his refusal to place himself first, asking instead, "What will happen to this person if I don’t stop to help him?" Similarly, I asked the simple question of myself, "What happens to women who seek abortion if I don’t serve them?" This radicalized me, leaving me more concerned about the unnecessary peril to women when safe abortion services are not available than about what would happen to me if I helped women in this way. It was at that point—some eight years ago—that I began to perform abortions, compelled by women’s situations and moved to action by their need, and by my respect for their moral agency to make such a decision.

The stories of the women who come to me are what move me to overlook the well-established danger of antiabortion violence to do this work. Approximately one in three women in the US will terminate a pregnancy in her lifetime. While the epidemiology of women who have abortions gives a general impression of who they are—40 percent of US pregnancies are unplanned, with about half of this number unwanted—it is the specific realities of women who seek abortion, especially in the second trimester, that best inform us. The stories of the following women and girls that I have cared for provide a small glimpse into their reality of unplanned, unwanted or wanted but lethally-flawed pregnancies:

An 11-year-old was discovered by her grandmother to be 19 weeks pregnant the day before she was to start sixth grade. A trip to an emergency room confirmed the pregnancy, leading the family to seek abortion services. While the young lady refused to name who impregnated her, our best judgment was that it did not indicate incest. In talking to her to determine "who" desired the termination, she did not want to be pregnant and was not being coerced, but the stark reality of just how young she was became explicit when she expressed her chief concern: she had missed three days of school and wanted to be with her friends. I safely terminated her pregnancy and restored her childhood by allowing her to have the only concerns an 11-year-old should have.

A 13-year-old girl was a victim of incest by her uncle who had lived with the family for six months. By the time the girl’s mother discovered her pregnancy, she was 17 weeks along. Her quiet demeanor,
interpreted by her mother as ideal behavior, unfortunately delayed the detection of her pregnancy. We performed her abortion, but the family was understandably deeply shocked by the circumstances of the abortion. A 32-year-old attorney, senior staff for a prominent US senator, came in with a desired pregnancy at 20 weeks, complicated by a lethal fetal anomaly. By the time diagnosis was confirmed, she was 23 1/2 weeks. She and her husband were distraught, as this was their first child, but resolute that this was the right decision for them. Compounding the horror of their situation were the delay and struggle they experienced when her federally-funded health insurance initially refused to cover her abortion. I performed her procedure without complication, for which they were effusively grateful.

The reality is that some women have pregnancies that they did not plan and have no desire to continue and, therefore, they seek abortion—legal or not, safe or not. The difficult circumstances described above are typical for second-trimester abortions, with pregnancy detection and decision making often occurring late. The women I see in these situations are pregnant and they can’t be or don’t want to be. They are resolving dilemmas created by circumstances unique to their private lives, and certainly unknown to their critics who judge from afar. I define a dilemma as a situation in which one has to decide between nondesirable options without the luxury of foregoing the decision.

Lack of Access to Abortion Care
It is in this context that I understand the abortion care that I provide—in the first or second trimester. While their stories might differ, what all pregnant women have in common is the increasing difficulty in abortion access, especially for later abortions. Ironically, it is the lack of access to abortion care that oftentimes delays abortion to the second trimester. A pregnancy in this timeframe is troublesome to those who are in what a friend calls the “mushy middle”—people who approve of abortion access abstractly, but who become conflicted about its specifics, e.g., termination beyond the first trimester. Eighty-five percent of women in the US live in a county where there is no access to abortion and, if later gestational age is taken into account, that access is even more limited. That reality, along with my patients’ compelling individual stories, compels me to provide the abortion care that I do, moved to help women in these crisis moments and to prevent the unnecessary health consequences that occur when safe abortion is not available.

The reality is that some women have pregnancies that they did not plan and have no desire to continue and, therefore, they seek abortion—legal or not, safe or not. I believe that it is their right to do so, in the second trimester or the first, that right being rooted in their moral agency as human beings. Thus, I advocate for reproductive justice (RJ).

Reproductive Choice
The RJ movement, as distinct from "reproductive choice," places reproductive health and rights within a social justice and human rights framework. RJ supports the right of individuals to have the children they want, raise the children they have and plan their families through safe, legal access to abortion and contraception. In order to make these rights a reality, the movement recognizes that RJ will only be achieved when all people have the economic, social and political power to make healthy decisions about their bodies, sexuality and reproduction. To be certain, when reproductive justice is present, abortion is available as a choice, but in the RJ framework all reproductive decisions are valued equally. When RJ is a reality, women are empowered to maintain their dignity.
I endeavor to move our world to a place where women have the space and power to make these tough decisions without judgment, coercion or restriction thrust upon them, and are able to do so in a setting of safety and uniform access to all possible reproductive options. It is in this context that I gladly provide first- and second-trimester abortion access for women in support of their humanity, dignity and health. I challenge my peers to do the same.