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Hard Cases do not Justify Partial Birth Abortion

by

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Some suggest that pro-life doctors should be excluded from perinatology (maternal-fetal medicine, which deals with extra high-risk pregnancies and the care of babies with birth defects before delivery). This is because pro-choice doctors sometimes feel compelled to offer abortion to prevent or lessen maternal risks. I argue that the pro-life perinatologist brings a unique and valuable countervailing perspective which women need. To support my thesis, I will provide a pro-life critique of the "hard cases" which were used to justify partial birth abortion (PBA).

In congressional testimony and at the time of the presidential veto of the PBA ban, five women testified about their tragic pregnancies. Since these cases are in the public domain, I breach no confidentiality. My analyses are limited to publicly disseminated information. The facts in these cases and the justifications for abortion presumably comprise the best arguments of proponents of PBA. Therefore, I will be critiquing some of the strongest arguments which these proponents have been able to assemble.

Since PBA has been proposed as necessary for mothers, my analyses are limited to maternal issues. Other reasons to ban PBA will be mentioned in the concluding remarks. In each case my critiques will attempt to demonstrate that 1) PBA was neither necessary nor advisable from a maternal standpoint and 2) the mother would have benefited from the countervailing perspective offered by a pro-life perinatologist. This evidence will support my contention that for truly informed consent to occur, women who are offered termination of pregnancy should also be given a second opinion from a pro-life perinatologist or obstetrician.

Partial Birth Abortion: The Procedure

After the pregnant woman has been anesthetized, the abortionist opens the cervix, the entrance to the womb. A blunt grasping instrument is

passed through the cervix and into the womb. The abortionist pulls the baby's foot down through the cervix, out the vagina, and down between the mother's legs. This turns the baby to a feet-first (breech) position. The baby is then pulled out until only the head remains inside. The head is punctured and a tube is passed into the baby's brain. The brain is suctioned out through the tube. This collapses the baby's head, so it can then be removed. It also prevents live birth for infants past viability.

Partial Birth Abortion: The Risks

PBA entails significant maternal risks. During the second and especially the third trimester, the wall of the womb is soft and thin, with no greater strength than that of a wet paper towel. The blunt grasping instrument can easily tear the womb. Since PBA is largely a blind procedure, puncture of the womb could occur and would often be imperceptible to the abortionist. Tears emanating from a puncture may open the large blood vessels of the womb. If this occurs, substantial bleeding may necessitate removal of the womb to stop the bleeding. Maternal death from excessive bleeding and other lethal complications may also occur (Hilgers, 1972).

Prior induced abortion may have a significant impact on a woman's future fertility and reproductive performance. There is also an increased risk of miscarriage, premature labor and low birth weight, tubal pregnancies, and sterility (Hilgers, 1972).

Studies documenting post-abortion harm have been reviewed by Rue (1994). A meta-analysis suggests a link between abortion and breast cancer.

Case #1: Mary Dorothy Line

M.D. Line's baby was diagnosed at 19 weeks gestation with severe hydrocephalus (water on the brain). She was told that there was "no hope" and that "not only would her son die but [that] complications of the pregnancy put her life in danger as well." These complications included: tears of the womb, cervix and vagina from vaginal delivery, as well as stillbirth. If stillbirth occurred, toxins would be released which could cause bleeding and necessitate hysterectomy.

Pro-Life Critique: Babies with hydrocephalus do not usually suffer stillbirth. In most cases, these babies survive and often with normal intelligence. In fact, normal intelligence can even be found in some cases wherein only a thin rim of brain matter remains and where most of the brain has been replaced by water. Bleeding complications following stillbirth are uncommon and they typically would occur more than a month after fetal death. Delivery and monitoring of clotting parameters prevent

these problems. Furthermore, tears of the womb and vagina could be prevented by caesarian section, a procedure much safer than PBA.

Case #2: Coreen Costello

C. Costello testified that she and her husband "have always been opposed to abortion," and that they consider themselves "very, very much pro-life conservative Republicans." More than anything, they wanted to be able to hold their baby before it died, even if it were only for an hour or so. But Coreen was led to believe that PBA was necessary in managing her pregnancy. When she was seven months pregnant, her doctors informed her that her daughter was dying inside her womb, an excessive amount of fluid was present in the womb, and the baby was breech. The doctors attempted to turn the baby, without success. Since the baby could not be turned to a head-first position, PBA was presented as her only viable choice.

Pro-Life Critique: With excessive fluid, the fetal compartment is enlarged. Rather than cramped quarters, the womb is much larger than the baby. In the case of a breech, this circumstance should make turning easier. But even if turning and vaginal delivery were not possible, caesarian section would have been safer for the mother and the baby than PBA. In addition, the parents could have gotten their one wish: to hold their live baby in their arms before she died.

Case #3: Claudia Crown Ades

C.C. Ades' baby had Dandy-Walker syndrome, a form of hydrocephalus, heart and intestinal defects, widely-spaced eyes, and trisomy 13. Trisomy 13 is a condition where an imbalance of genetic information is caused by the presence of extra genetic material in each cell. This condition is lethal, results in severe mental retardation, and has a life-span of days to months.

Pro-Life Critique: Babies with birth defects rarely pose any risks to their mothers. Given the potential for maternal mortality from PBA and given the fact that vaginal delivery is safe, normal vaginal delivery at term of C.C. Ades would have been her safest option. Certainly, it would be difficult to imagine anything more painful to the child than PBA. Vaginal delivery would have allowed the mother and child to hold the baby before it died.

Case #4: Tammy Watts

T. Watts baby had extra fingers, intestinal and kidney defects, no eyes, and trisomy 13. Termination was recommended by her specialists.

Pro-Life Critique: Spontaneous vaginal delivery at term would be a safer option than PBA. The former does not require blind instrumentation of the womb and does not pose significant risks to future fertility and

reproductive performance, as does PBA. The defects of the baby under consideration do not require caesarian section, but even if one felt compelled to perform a c-section, doing so would still be safer than PBA. During caesarian section, the womb is exposed under direct vision. Tears and torn vessels are immediately evident and can be repaired quickly.

Case #5: Vickie Stella

V. Stella's baby was diagnosed at 32 weeks with nine major birth defects including "no brain." Stella had diabetes and because she does not heal well and has reduced resistance to infection, she was counseled to have a PBA.

Pro-Life Critique: Normal spontaneous vaginal delivery at term would have been safer than PBA. Diabetics do indeed have reduced resistance to infection. PBA could result in a septic abortion. Serious infections after vaginal delivery are rare.

Conclusion

In addition to adverse effects on maternal safety and future maternal fertility, there are other reasons why PBA is not a good solution. It goes without saying that PBA is painful and damaging to the baby. It deprives the baby of its right to be born and the opportunity to experience a parent's love and physical affection. Similarly, the parents are deprived of loving and holding their baby.

With the choice of PBA, the mother's loss of her baby will forever be an immensely unforgettable, personal tragedy. It stands to reason that coupling the death of the baby with the guilt, anger, self-loathing, and desolation of an abortion would compound the tragedy and possibly harm the parents' marriage. Bringing the baby to term and having a live birth, by contrast, allows a tremendous outpouring of love and emotional support from family, hospital staff and friends. In this context, the tragedy of the baby's eventual death could be forever wedded to an unforgettably positive, rewarding and loving experience.

Even in the "hard cases" just analyzed, I have demonstrated that PBA is not the only solution. Some of these women did not want an abortion but felt they were trapped into it by circumstances. For such women, the option of a second opinion from a pro-life perinatologist or obstetrician could be offered. Only such an option guarantees that women with difficult pregnancies will be able to experience true reproductive freedom.

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