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A THEOLOGICAL-ETHICAL ANALYSIS OF SELECTIVE TERMINATION
OF PREGNANCY AND THE FETUS WITH ANENCEPHALY
IN LIGHT OF CHRISTIAN AGAPE

by

Bridget Campion

A Thesis submitted to the Faculty of Regis College and
the Theology Department of the Toronto School of Theology.
In partial fulfilment of the requirements of the degree of
Doctor of Philosophy
awarded by the University of St. Michael's College

Toronto 1999

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A THEOLOGICAL-ETHICAL ANALYSIS OF SELECTIVE TERMINATION
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IN LIGHT OF CHRISTIAN AGAPE

PH.D. 1999

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Anencephaly is an anomaly which occurs early in pregnancy
leaving the fetus severely impaired neurologically and facing
death either in the womb or shortly after birth. The anomaly
can be detected prenatally and usual medical practice is to
terminate this "futile" pregnancy. It is a practice not
without ethical considerations. In Catholic health care
facilities, the question is whether the pregnancy can be
terminated prior to viability, while, in non-Catholic health
care settings, practitioners are concerned about the moral
permissibility of late pregnancy terminations when fetuses are
normally regarded as having interests. However, many
Clinicians and ethicists believe that in anencephaly the
neurological anomaly is so severe as to render the fetus
incapable of experiencing anything. In their opinion, the
fetus can neither be benefitted by continuation nor harmed by
termination of the pregnancy. In view of the overwhelming
tendency to terminate these pregnancies either through
abortion or early induction of labour, this thesis
nevertheless asks: is pregnancy termination in this case
necessarily "good medicine"? Can a woman who wishes to
continue such a pregnancy be seen as arguing from anything but
emotion and intuition? Can an empirically grounded and
theologically sound argument be made for the continuation of a
pregnancy where the fetus is found to be anencephalic?

By reviewing and recasting conventional perceptions of
the meaning of pregnancy and of the fetus who is anencephalic,
and working within a moral framework informed by a particular
understanding of Christian agape, this thesis attempts to put
forward such an argument. Drawing on research in the life
sciences as well as in theology, the thesis will make the case
that continuation of such a pregnancy can be understood to be
far from futile. Without attempting to put closure on the
debate this thesis will, it is hoped, provide material for
further reflection and dialogue.
ACKNOWLEDGEMENTS

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INTRODUCTION

Background

In April 1992, a group of moral theologians, clinical ethicists, and practitioners met at a Catholic hospital to discuss the permissibility of early induction of labour prior to fetal viability. There was concern that such practice would normally violate Catholic teaching; however, there was also the question as to whether there might be exceptions. In particular was the case where the fetus was discovered to be anencephalic, that is, to suffer from a terminal condition that leaves it apparently without higher-brain function and consciousness. The discovery was usually made during the second trimester of pregnancy and practitioners wondered whether early induction of labour could be undertaken to spare patients the distress of continuing a "futile" pregnancy.

There was also some doubt about the status of this fetus. Even in a setting that professed to value human life from conception, there was speculation that the anencephalic fetus' absence of a higher brain compromised its moral
status. Without consciousness or the potential for it, could the fetus be considered a person or potential person? Under such circumstances, some clinicians believed that they would be morally justified in inducing labour upon diagnosis of the anomaly; indeed, they believed it would be "bad medicine" for them to do otherwise. Other practitioners wondered whether induction of labour in this instance might not constitute an action which could be interpreted in light of Catholic health care directives as a direct abortion.

In the meeting, discussion was dominated by ethical questions: the differences between direct and indirect abortions; whether direct abortions might sometimes be justified; the relevance of viability especially in this case; and how the principle of double effect and proportionate reason might be used to work through the issue.

Much different was a later meeting where practitioners were in the majority. Here, one physician talked about having his hands tied, about knowing what good standards of practice required and being unable to fulfill them because of religious considerations. At that point, conversation turned to an examination of the religious

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1 For a discussion of the differences between direct and indirect abortions, please see chapter 2, pages
position and whether it could be brought into line with conventional medical practice in this very specific case. The same approach had dominated the discussion among moral theologians, that is, the tendency was to examine the intricacies of the religious position to see if it could accommodate prevailing medical opinion. The implicit conclusion was that Catholic health care and good medical practice were incompatible in this case. The task at hand seemed to require concentrating on the religious component with a view to aligning it with current standards of medical practice which saw termination of the pregnancy as the better course.

**The Need for a Response**

Being Church-in-the-world is no easy task, and in issues of social justice it may require taking stances that are decidedly counter-cultural. Catholic women religious took such a stance when they founded Catholic health care in Canada. Whether in Victoria or Montreal, Toronto or St. John's, women religious built hospitals to provide care for the poor, for immigrants, for people who would otherwise not receive medical care. In this they hoped to imitate the healing ministry of Jesus, which meant questioning the "givens" of the practices of their times.
Likewise, health care ethics questions the "givens" of medical practice, in this instance, the practice of terminating pregnancies because the fetus has been discovered to be anencephalic. This practice is becoming more widespread as prenatal diagnosis becomes more readily available. Researchers Charles Limb and Lewis Holmes describe how the management of anencephalic pregnancies changed in just under two decades at a large hospital in Boston:

In the first 3 years of this study (1972 to 1974), before the advent of routine prenatal diagnosis in the second trimester, 47% of the affected infants [infants who were anencephalic] were live-born and 53% were stillborn. By the early 1980s more than half of the pregnancies with affected infants were terminated electively. By 1990 all of the affected infants were detected prenatally and 100% of the pregnancies were terminated . . . .

The average age of the fetus at delivery went from just over thirty-five weeks in the early part of the study to eighteen weeks at the end of the study.¹

The statistics are almost as dramatic for the same period of time in England and Wales, where "the birth prevalence of neural tube defects fell by 95%", a phenomenon


³Ibid.

Jeffrey Botkin believes that "if and when α-fetoprotein screening becomes standard practice in the United States, there may be a rapid decline in the prevalence of anencephaly at birth."\footnote{Jeffrey R. Botkin, \textit{Anencephalic Infants as Organ Donors}," \textit{Pediatrics} 82 (Aug. 1988): 251.} For those hoping to eradicate the incidence of anencephaly, this may be hailed as a victory.

Currently the trend is to terminate pregnancies in which the fetus is discovered to be anencephalic. In the face of such a trend, Catholic health care ethics must be in dialogue with medical theory and practice. While one approach might give precedence to or seek to accommodate current practice, it is nevertheless legitimate to ask: is termination of this pregnancy necessarily good medicine? Is there a way of making intelligible a woman's decision to continue the pregnancy? Can an alternative to termination be offered which takes into account the well-being of the pregnant woman and fetus, and which would be consistent with the spirit of Christ's healing ministry? In other words, can an argument that is both empirically grounded and
theologically sound be put forward to challenge current trends in practice and support the continuation of pregnancy when the fetus is found to be anencephalic? Constructing such an argument is the task of this thesis.

It should be noted that in making the argument, the thesis is not attempting to put closure on the debate or even to engage opposing arguments directly. New pathways for debate may be opened by the thesis, but its task is to construct a very specific response to the dilemma posed by the fetus with anencephaly.

**Method**

In order to make its argument, the thesis will propose an understanding of the fetus with anencephaly and the meaning of pregnancy quite different from those underpinning conventional responses to the dilemma. It will look to literature and research in the life sciences to supply the data for these new perspectives. The thesis will also articulate an overarching ethical viewpoint based on a particular model of Christian agape. To this end, it will draw on literature in systematic and moral theology as well as bioethics. In its use of inductive reasoning arising from the use of empirical data, and deductive reasoning that follows from the belief in the transcendent reality of
Trinitarian love, the thesis will reflect the tension that can characterize theological bioethics. As a creative force, this tension will be largely unresolved; the thesis' position and foundations provide not a definite answer but a further unfolding of thought about the dilemma posed by the fetus with anencephaly.

Literature from the life sciences provides the background for chapter one, which establishes the empirical foundations of the thesis. It sets out the facts of anencephaly -- describing the condition, etiology and prognosis -- and how the condition is detected prenatally. It also distinguishes selective termination of pregnancy from terminations carried out for reasons other than fetal indications. The chapter makes clear that the thesis will limit itself to consideration of selective termination of pregnancy, whether abortion or early induction of labour, undertaken because the fetus is anencephalic.

The literature review of chapter two will be limited to those works which specifically address termination of pregnancy because the fetus is anencephalic. While there are many aspects of the literature worthy of analysis, the chapter will restrict itself to two points only: the authors' underlying assumptions about the meaning of pregnancy and their understanding of the fetus with
anencephaly. The thesis will show that, whether they are arguing for or against termination of the pregnancy, in a Catholic or secular framework, the authors share certain perceptions of the anencephalic fetus and of pregnancy.

Chapter three turns to agape to provide the theological-ethical point of view for the thesis. Having examined the term's background and shown that there is precedence for using agape to inform bioethical discourse, chapter three will discuss interpretations of Christian love. While agape is also a philosophical concept, the thesis will be limited to a discussion of the term as it exists in Christian theology. In order to organize the discussion, the chapter will use categories of agape modelled on the Cross and agape modelled on the Trinity. Recognizing the transcendent and concrete aspects of theological bioethics, the chapter will apply these models to the dilemma posed by the fetus with anencephaly with a view to evaluating their theological soundness and application in the clinical setting. Ultimately the chapter will propose a modified understanding of Trinitarian agape to serve as the ethical viewpoint of the thesis.

Chapter four will return to the question of perceptions about the fetus with anencephaly and the meaning of pregnancy. Drawing on research in prenatal attachment and
fetal psychology, the chapter will provide an alternative, empirically grounded understanding of these key components of the dilemma. The chapter will close by showing how continuing the pregnancy can be understood to be an act of Christian agape.

As an exercise in application and synthesis, chapter five will examine a case where prenatal diagnosis was followed by selective termination of pregnancy. Realizing that the arguments put forward in chapter two are meant to address such cases, chapter five will review them in light of agape and the new understandings of the fetus with anencephaly and the meaning of pregnancy. Returning to the case, the chapter will suggest that Catholic health care could have a contribution to make by actively supporting continuation of the pregnancy where the fetus is anencephalic. The chapter will also address two important considerations. First, that, while the thesis places much emphasis on the dilemma as it exists in Catholic health care, the arguments put forward could appeal to Christian denominational health care and to people of good will generally. Second, that the thesis itself is an exercise in exhortative ethics, an approach to the moral life that the chapter will illustrate in its description of the foundations of Catholic health care in Canada.
After reviewing the progress of the thesis, the conclusion will note that the thesis has raised many more questions than it has answered. It will admit that issues such as the use of the principle of double effect and proportionate reason, the relationship of agape to principles and duties, and the shape and function of an exhortative ethic are among the many points that merit further study but that the thesis must necessarily be limited in what it can pursue. The conclusion will reiterate that at its heart the thesis has aimed only to show that there is a theologically sound and empirically grounded alternative to selective termination of pregnancy when the fetus is anencephalic.
CHAPTER ONE

THE FETUS WITH ANENCEPHALY AND
SELECTIVE TERMINATION OF
PREGNANCY

Introduction

In order to lay the foundations for the arguments which follow, the chapter will begin with an examination of the fetus with anencephaly -- a description of the condition, its prognosis, and possible causes. An appreciation of the severity of the anomaly is essential to understanding why practitioners and ethicists otherwise opposed to termination of pregnancy find the practice acceptable in the case of the fetus with anencephaly.¹ The thesis will revisit the facts of anencephaly in chapter four in order to explore the possible relational abilities of the fetus. However, the conventional understandings of anencephaly as set out in chapter one provide the empirical foundations for the literature reviewed in chapter two.

¹ Recognizing that there are several stages in the development of human life prior to birth and that there are different terms used to describe human life prenatally, for the sake of simplicity, this thesis will nevertheless use one term, fetus, to designate the entity in the womb.
Chapter one will also review methods of detecting anencephaly prenatally and show that the condition can be diagnosed quite reliably. Next, the chapter will define selective termination of pregnancy and distinguish it from elective and therapeutic terminations. The chapter will briefly examine surgical and medical methods of ending pregnancy and note that this thesis will not make a distinction between abortion and early induction of labour. Instead, for the purposes of this thesis, selective termination of pregnancy will be understood to comprise those interventions undertaken to end a pregnancy because of fetal indications, in this case, for anencephaly.

Because of the nature of its subject matter, the chapter will rely on research done in the life sciences. Such an interdisciplinary approach is not inconsistent with moral theology; still, caution is in order. It is important to note that many "facts" of medicine are theories; that is, they are statements conveying what the scientific community and its individuals believe they can say about a matter at this time based on current evidence. Research in medicine is ongoing; theories can be further substantiated or adjusted as new data emerge. There remains much that is uncertain about anencephaly and, in the empirical overview which follows, it would be prudent to think of almost all of the
"factual" statements as being accompanied by the implicit qualification, "as far as is known at this time."

The Fetus with Anencephaly

Physical Characteristics

Literally anencephaly means to be without a brain, although as David Stumpf and his co-authors Ronald Cranford, Sherman Elias, Norman Fost, Michael McQuillen, Edwin Meyer, Ronald Poland and John Queenan (Stumpf et. al.) note, in reality it "does not mean the complete absence of the head or brain" -- as will become clear in the description of the malformation. Until as recently as the 1960s, the fetus with anencephaly was classified as a "monster," a "visually abnormal being, a gargoyle." Another source provides a more clinical description:

The anencephalic exhibits the following anatomy:
The top part of the head flattens out ("toad

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head") and consists of a bloody mass at the skull base underneath which necrotic tissue can be found. The skin and all the skull bones are missing; the eyes bulge; the nose is broad; the tongue is large and protruding; the ears are malformed; the neck short, especially when the malformation has included the back of the neck. Occasionally the brain is completely missing and one can see the base of the skull.

Anencephaly is a neural tube defect. Like spina bifida, another neural tube defect, it occurs early in the first trimester of pregnancy when the neural tube fails to close. While spina bifida affects the spine, anencephaly is an anomaly of the brain and skull. It can range in severity from macroanencephaly, where some forebrain and skull are present, to holoanencephaly, where the forebrain and skull are absent.

Normally the brain comprises three sections: the forebrain, composed of the cerebral hemispheres which are covered by the cerebral cortex; the midbrain which includes the hypothalamus; and the hindbrain in which are found the medulla oblongata, cerebellum and pons. The forebrain, or

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"higher" brain, is responsible for human consciousness, for processing and assimilating sensations and attaching meaning to them, and for performing the functions normally associated with human awareness and reflection. The brain stem, or "lower" brain comprises the midbrain and hindbrain, the latter of which is "the center of control over the body's most basic functions, such as regulating heartbeat, breathing, blood pressure, and other vital activities."  

Here is Alan Shewmon on the subject:

It seems established beyond doubt that in the mature human brain, the content of consciousness is processed in the cerebral cortex, while behavioral arousal and receptivity of the cortex is governed by the reticular activating system of the brainstem.  

The skull protects the brain. In the fetus, it is a barrier between the developing neurological tissue and amniotic fluid which is hostile to such tissue. However:

in the human anencephalic infant, there is usually virtually complete absence of the forebrain and of the skull ... In the place of a forebrain there is a mass of haemorrhagic fibrovascular tissue containing some neural elements ... There are no recognizable anatomical structures, but the brain stem is present, and there are usually normal eyes and optic nerves which end blindly at the base of the skull. The midbrain and cerebellum may be

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8 Shewmon, 14.
9 Kittredge, 29.
intact and normally developed or may be absent. Because it means that the fetus is without a forebrain and skull, anencephaly is "an irreversible, uncorrectable, lethal deformity."

Etiology

The cause of anencephaly is unknown. One current theory links it to a vitamin deficiency in the woman carrying the fetus, another to influenza because of the predominance of fetuses with anencephaly conceived during the "flu season" and still another to mothers eating blighted potatoes. Epidemiological studies confirm that there have been "epidemics" of anencephaly. In the 1930's the United States saw an increase in anencephaly that has since levelled out. Some areas of the world have higher

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"Elwood and Elwood, 16.


"Cuckle and Wald, 277.


"Stumpf and others, 671."
incidences of anencephaly, with Ireland among the highest at a rate of 6.7 per 1000 births.\textsuperscript{17} Within the U.S., where the current birthrate is 0.3 per 1000 births (approximately 1100 per year),\textsuperscript{17} the Northeast has a higher birth rate of afflicted fetuses compared to states in the lower plains and mountain regions.\textsuperscript{17} Thus it is possible that environmental factors play a role in anencephaly. Research into causes and prevention is ongoing.

Progression and Prognosis

In the affected fetus, anencephaly develops quite early, between the third and tenth week of gestation when the neural tube fails to close and the exposed neural tissue degenerates. As Stumpf \textit{et. al.} observe, "in some embryos, before degeneration has occurred, a laminated but abnormal cerebral cortex may exist."\textsuperscript{17} However, without a skull to protect it, the tissue is exposed to the amniotic fluid and deteriorates, so that "by 10 weeks the process is

\textsuperscript{17}Shewmon, "Anencephaly," 12.

\textsuperscript{18}Stumpf and others place the number of births at 1050 annually; Shewmon estimates that 1125 infants are born each year with anencephaly. See Stumpf and others, 671 and Shewmon, "Anencephaly," 12.

\textsuperscript{19}Stumpf and others, 671.

\textsuperscript{20}Ibid., 669.
sufficiently advanced to be characteristic.""  

The brain stem, too, may be affected in anencephaly and be incapable of sustaining life for very long. According to one source, "approximately 65 percent of fetuses with anencephaly die in utero."" For those who survive to term, the picture is very bleak. Birth can be very traumatic for the infant with no skull to protect it. Should the infant be born alive, death will almost surely occur within hours. In one sample, only one-third of the anencephalic infants were live born. Of those, one lived fourteen days; more than half died within twenty-four hours of birth. Another author confirms the statistics:

As many as 75 percent of fetuses with anencephaly are stillborn; over half of the liveborn infants die within the first twenty-four hours of life, and the rest within the first fifteen days.  

Prenatal Diagnosis  

Because it is so physically distinctive, anencephaly

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"Stumpf and others, 670.


"Berkowitz, 18.
can be detected through ultrasonography by the fourteenth week of pregnancy. Indeed, ultrasound is a very reliable test for this condition. As a neural tube defect, anencephaly can also be detected prenatally by measuring alphafetoprotein levels in both maternal serum and amniotic fluid, tests performed in the fifteenth to eighteenth week and sixteenth to twentieth week respectively. One source estimates that raised alpha-fetoprotein levels in maternal blood samples will lead to the detection of anencephaly in 90% of cases while levels in the amniotic fluid accompanied by a test for acetylcholinesterase is almost 100% effective. In other words, there is a high degree of reliability in the detection of anencephaly early in the second trimester of pregnancy.

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26 Stumpf and others, 670; Cuckle and Wald, 257.

27 Rayburn and Barr, 116; Cuckle and Wald, 258.

28 Stumpf and others, 670.

29 Shewmon notes that it is wrong to think that anencephaly is so distinct as to be absolutely free of diagnostic error. He observes that "the least severe forms of mero-anencephaly may involve relatively small skull and scalp defects, thereby forming a continuum with the most extreme forms of microcephaly with encephalocele." Anencephaly may also be confused with amniotic band syndrome. Even so, Shewmon writes that "it is still quite
Selective Termination of Pregnancy

Before the development of reliable diagnostic techniques, anencephaly often went undetected and the fetus would either be born or die in utero. However, a 1972 issue of Lancet contained an article which suggested that anencephaly might be "managed" in a different way. Finding ultrasonic imaging to be a reliable diagnostic test, the authors proposed that women be tested during the fourteenth or fifteenth week of pregnancy and, should anencephaly be discovered, that "urea or prostaglandin termination of pregnancy . . . be carried out at 16-17 weeks." It was, as far as the authors knew, the first time that anyone had formally proposed such management of a fetus with anencephaly.

The practice of terminating a pregnancy because of

true that in the vast majority of cases the diagnosis can be made quite easily and without risk of error" (Alan D. Shewmon, "Anencephaly: Selected Medical Aspects," Hastings Center Report 18 [Oct.-Nov. 1988], 12).

Campbell and others, 1226.

Ibid., 1227. Interestingly, a hospital in Sydney Australia had been managing such pregnancies in a similar fashion for some time. Of the 43 fetuses whose anencephaly was detected through the use of X-rays following a diagnosis of hydramnios, 34 were delivered early based on fetal indications. See Warren R. Jones, "Anencephalus: A 23-year Survey in a Sydney Hospital," The Medical Journal of Australia 54 (1967): 104.
fetal indications is known as selective termination of pregnancy.\(^3\) Harris defines selective terminations as those "abortions carried out specifically because the foetus has been shown to be affected by a particular abnormality, or has a high probability of being affected."\(^3\) In other words, it is a termination carried out because of fetal indications -- as Judith Boss writes, "because of a genetic disorder or some other undesirable characteristic of the fetus."\(^3\)

As Karen Lebacqz points out, selective abortion predates the development of prenatal diagnostic techniques; the fetus' possible exposure to rubella or thalidomide was

\(^3\) The procedure is also known as eugenic or genetic termination; however, because it appears to be a more neutral term, and one commonly found in the medical literature, the term used in this thesis will be "selective termination of pregnancy." It is not to be confused with the procedure known as "selective reduction," which refers to the practice of removing a number of fetuses in a multi-foetus pregnancy in order to improve the likelihood of survival for those remaining in the womb. In selective reduction the choice is determined according to "physical accessibility as opposed to anything intrinsic to the fetuses themselves," and should therefore be distinguished from "selective termination, which is done on targeted fetuses" (Richard L. Berkowitz and Lauren Lynch, "Selective Reduction: An Unfortunate Misnomer," Obstetrics and Gynecology 75 [1990], 873).

\(^3\) Harry Harris, Prenatal Diagnosis and Selective Abortion (Cambridge, Mass.: Harvard University Press, 1975), 3. My emphasis.

regarded by many pregnant women, physicians and legislators as a legitimate reason for terminating a pregnancy. In many areas of the United States, prior to the legalization of abortion in 1973, abortion was allowed for this reason even if it was otherwise prohibited except when the life of the mother was endangered.\footnote{Karen A. Lebacqz, "Prenatal Diagnosis and Selective Abortion," \textit{Linacre Quarterly} 40 (1973): 112.}

Selective and Elective Terminations of Pregnancy

Very often selective termination of pregnancy involves the termination of a \textit{wanted} pregnancy,\footnote{Rita Beck Black, "A 1 and 6 Month Follow-up of Prenatal Diagnosis Patients Who Lost Pregnancies," \textit{Prenatal Diagnosis} 9 (1989): 802; P. Donnai, N. Charles, and R. Harris, "Attitudes of Patients After 'Genetic' Termination of Pregnancy," \textit{British Medical Journal} 282 (1981): 621.} which distinguishes it from an \textit{elective} termination where "the pregnancy itself is unwanted."\footnote{Judith A. Boss, \textit{The Birth Lottery: Prenatal Diagnosis and Selective Abortion}, Values and Ethics Series, vol. 5 (Chicago: Loyola University Press, 1993), 1. My emphasis.} The dynamics of the two types of termination are different, with selective termination often marked by a grief similar to that evoked by the loss of a newborn infant.\footnote{William F. Rayburn and John L. Laferla, "Mid-Gestational Abortion for Medical or Genetic Indications,"} Further, women accessing
prenatal testing are often older and believe that they have fewer chances of having a child. According to researchers, "advanced parental age and previous infertility or pregnancy loss heighten the investment in the present pregnancy and sharpen the grief over its loss."^33

Selective termination is not without an element of choice. As a medical procedure, it cannot be performed without the informed consent of the pregnant woman. That it must be freely chosen does not invalidate the distinction.

Selective termination of pregnancy is undertaken because of fetal traits rather than because the pregnancy itself is unwelcome.

Selective and Therapeutic Terminations of Pregnancy

A distinction is also made between selective and therapeutic terminations of pregnancy, that is, a termination of pregnancy undertaken to safeguard the life or health of the pregnant woman. Thus the termination of an

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^33Kolker and Burke, 520.
ectopic pregnancy, which could lead to the rupturing of the fallopian tube and subsequent hemorrhaging, or the pre-term delivery of a thirty-two week old fetus in a woman experiencing severe eclampsia, could be understood as "therapeutic". In both instances, it is the serious threat to the woman's physical health that motivates the decision to end the pregnancy.

It should be noted that the pregnancy in which the fetus is found to be anencephalic is not without risks. Possibly because of the fetus' impaired swallowing ability or because of its malfunctioning kidneys and lungs, hydramnios (excessive amniotic fluid) is a very common condition in women carrying fetuses with anencephaly. In one sample, 90% of such pregnancies were accompanied by excessive amniotic fluid. In fact, prior to the development of prenatal diagnosis, the presence of hydramnios was considered indicative that the fetus might be anencephalic. As debilitating and uncomfortable as it is, the condition is not normally life-threatening and can be alleviated by amniocentesis, that is, by inserting a needle into the uterus and drawing off excess fluid. Such

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40 Beller and Reeve, 11-12.

management is often used when the woman afflicted is carrying a fetus who is not anencephalic.

Hydramnios carries with it the risk of preterm labour. Approximately half of the fetuses with anencephaly who do not die in utero are born preterm, most commonly around thirty-three weeks' gestation. Where hydramnios is not present, there is the real possibility that the fetus with anencephaly will be born post-term, that is, labour and delivery will occur after forty-two weeks' gestation. In one sample, "Of the 15 patients without hydramnios, 5 had extreme prolongation of pregnancy. They were delivered after 43, 47, 49, 50 and 53 weeks' gestation." Another source reports that "prolonged pregnancies, sometimes as long as 55 weeks p.c. [post conception] have been seen."

Aside from the obvious distress and discomfort that it entails, post-term delivery in the case of the fetus with

42 Beller and Reeve, 11.


44 Comerford, 679.

45 Beller and Reeve, 11.
anencephaly carries with it the danger of dystocia of the shoulders, "a hazardous obstetrical problem." In the course of a normal delivery, the baby's head emerges and is followed by the shoulders. The fetus with anencephaly whose gestation is prolonged risks becoming physically rigid. When this happens, labour may arrest because the shoulders are unyielding, which could have serious consequences for both mother and child. "With fetal shoulder entrapment, the mother may have significant hemorrhage, fourth-degree perineal lacerations and endometritis." There is also the danger that the uterus will rupture. For the fetus, shoulder dystocia poses the risks of "traumatic brachial plexus injury, humeral fracture, clavicular fracture and severe birth asphyxia." To circumvent this, labour is induced as a therapeutic intervention near term in order to avoid the complications associated with post-term delivery. Despite these risks, there is no indication in the literature that the pregnancy in which the fetus is

46 Comerford, 680.


48 Comerford, 680.

49 Carlan, 1307.
discovered to be anencephalic is itself a life-threatening condition for the mother.

Of course no pregnancy is without risk, and it is possible that there may be life-threatening events during a pregnancy where the fetus happens to be anencephalic. Abruptio placentae is a condition in which the placenta separates itself from the uterine wall prior to the delivery of the baby. While in rare instances (i.e., partial separation with little bleeding) it may be possible to manage the condition conservatively, because of the severe hemorrhaging normally associated with the condition "in most cases the pregnancy must be terminated." In other words, the delivery of the fetus must be effected immediately either by cesarean section or vaginally if labour and delivery have already begun. Once the contents of the uterus have been removed the bleeding usually stops and the woman recovers quickly. However, abruptio placentae carries with

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it a mortality rate of 0%-1% for the mother and 50% for the fetus.\(^2\)

The delivery of an anencephalic fetus in such circumstances is a therapeutic rather than selective termination of pregnancy. It is the severe threat to the physical well-being of the mother and fetus rather than the coincidental fetal anomaly that is the motivation behind the procedure.

While there are instances of elective and therapeutic terminations of pregnancy undertaken where the fetus happens to be anencephalic, it must be emphasised that this thesis will be limited to addressing the issue of selective termination of pregnancy, that is, termination undertaken because of fetal indications: in this case, anencephaly.

Methods Used in Selective Termination of Pregnancy

When the discovery is made that the fetus is anencephalic, usually during the second trimester of pregnancy, there are both medical and surgical methods available to terminate the pregnancy. Radical procedures such as a hysterotomy (incision made in the uterus) and hysterectomy (removal of the uterus) are rarely

\(^{2}\) Bruce, 169.
undertaken. The most common surgical procedure is dilatation and evacuation (D&E). This method involves dilatating the cervix over the course of several hours and then extracting the fetus from the uterus. The procedure can be performed under either a local or general anaesthetic. D&E carries with it the risk of any surgery -- blood loss, infection and trauma to the site -- but usually results in a complete abortion, that is, the uterus is emptied of both fetus and placenta. Because the fetus does not emerge intact, it may be necessary to culture tissue in order to verify the anomaly.

Medically, there are two types of methods used to effect a termination. Instillation procedures involve removing some amniotic fluid and replacing it with a quantity of saline or urea in order to induce labour and kill the fetus. The process can take up to forty-eight hours to complete, with an average being thirty-six hours. The placenta is delivered in 50% of cases. If it fails to be

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54 Rayburn and Laferla, 587.

55 Turnbull and MacKenzie, 319.

56 Ibid.
delivered, a general anaesthetic will be administered and
the contents of the uterus surgically removed. Provided that
it results in a complete abortion, instillation is a
relatively inexpensive technique; however, the destruction
of fetal tissue makes culturing almost impossible.

Prostaglandins are also used to induce labour and
are especially effective for terminations after the
sixteenth week of gestation. It is a procedure that can take
from between ten and thirty-six hours and may result in
the fetus being live-born, an outcome which may be avoided
by injecting urea into the uterus. As with instillation
techniques, it is possible that the placenta will have to be
delivered surgically; however, this method does allow the
fetus to be born intact and, possibly, alive.

As methods of pregnancy termination, these surgical
and medical interventions are done with the intention of
ending the pregnancy by removing or initiating a process
which will effect the removal of the fetus from the uterus.
In some cases these interventions will be undertaken with
the intention of not only ending the pregnancy but killing

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37 William F. Rayburn and John L. Laferla, "Mid-
Gestational Abortion for Medical or Genetic Indications,"
Clinics in Obstetrics and Gynaecology 13 (1986): 76;
Turnbull and Mackenzie, 319.

the fetus as well. Thus a distinction is made between those techniques which kill the fetus directly and those which permit (although do not ensure) the fetus to be born alive. In other words, a distinction is made between abortion and early induction of labour.

This thesis, arguing for the continuation of pregnancy as a theologically sound and empirically grounded response, will not make these distinctions. Selective termination of pregnancy will be understood to encompass those interventions undertaken to end the pregnancy because of fetal indications, whether through abortive techniques or early induction of labour.

Conclusion

Anencephaly is a fatal neurological condition that begins to develop in the third week of pregnancy. The cause of anencephaly is as yet unknown, but the condition can be reliably detected in utero in the second trimester. With the discovery of the anomaly, selective termination -- either through abortive techniques or early induction of labour -- is often offered as a way to manage the pregnancy. It is a procedure that raises ethical questions. Chapter two will examine the debate around selective termination of pregnancy and the fetus with anencephaly.
CHAPTER TWO

THE DEBATE AROUND SELECTIVE TERMINATION OF PREGNANCY
AND THE FETUS WITH ANENCEPHALY

Introduction

The fetus with anencephaly presents a challenge within both Catholic and secular health care settings, but for very different reasons. On the one hand, where there is a prohibition against abortions generally, based on a desire to preserve fetal life, there is a reluctance to terminate pregnancies before the fetus is able to live outside of the womb. Thus terminating a pregnancy prior to fetal viability is very problematic. On the other hand, in settings which allow abortions, there is a recognition that the closer a fetus is to birth, the more claims it has. In other words, once the fetus has reached viability, more serious reasons are needed to justify the termination of pregnancy and fetal life.

This chapter will consider the arguments made on both sides of the dilemma. It will begin by considering the debate as it exists within Catholic health care, first by providing an overview of official Catholic teaching on
abortion as a way of establishing the context of the arguments, then by examining the arguments themselves. The argumentation will be subject to further analysis in chapter three. In this chapter, bearing in mind that one of the tasks of the thesis is to arrive at a new understanding of the fetus with anencephaly and of pregnancy, analysis will be restricted to these two aspects of the authors' positions.

The chapter will then consider the arguments as they exist within the secular setting. It will begin by reviewing the legal and bioethical considerations that make late termination of pregnancy problematic. It will then set out the arguments supporting the view that the fetus with anencephaly should be treated as an exception in this case and that second- and third-trimester terminations of pregnancy be permitted. The arguments will be analysed, again with particular notice given to the authors' perceptions of the fetus with anencephaly and the meaning of pregnancy.

The chapter will conclude by showing that, despite their differences, the authors examined share very similar perceptions of the fetus with anencephaly and the meaning of pregnancy.
The Fetus with Anencephaly in Catholic Health Care

The Dilemma

Moral theologian William Daniel writes:

There have always been anencephalic fetuses, and other monstrous births. But the problem is new in so far [sic] as it is now possible to diagnose this condition by the end of the first trimester of pregnancy. If you consult the old moralists, their only interest in monstrous births was how to baptize them . . . . They would deal, too, with the case of the infant already dead in utero. But they had nothing to say about pre-natal diagnosis of a congenital deformity, because there was no such thing:

With prenatal diagnosis, it is possible to detect anencephaly well before birth and even before viability.

This raises the question: if, and under what circumstances, such a pregnancy can be terminated according to Catholic theology and official teaching.

The question is important because, while Catholic health care facilities were established for the most part by congregations of religious women striving to imitate Christ's healing ministry, the facilities function under the authority of Church leadership. 1 As ministries in the

diocese, their work is guided by official Church teaching.\textsuperscript{3} It is within this context that moral theologians are engaged in studying particular issues. This is the origin of many of the articles cited in this chapter.

The authors examined in this section of the thesis frame responses to the question of whether interventions may be undertaken to end the pregnancy prematurely where the fetus is discovered to be anencephalic. Robert P. Craig


\textsuperscript{3}The question of what makes a health care facility Catholic has been variously answered. Ashley and O'Rourke identify four characteristics: that the facility is under the authority of the local bishop; that it is owned and operated by a Catholic religious congregation; that pastoral care is offered to members of the hospital community; that there are outward signs of Catholicity in the form of religious symbols (Ashley and O'Rourke, Health Care Ethics: 134-135). Murphy identifies six components: that such facilities "are to be under the control of the competent ecclesiastical authority, or acknowledged as Catholic;" that "principles of Catholic moral theology and medical ethics must underlie all activity in the healthcare [sic] facility"; that "the competent authority has authorized the recognition as Catholic"; that "pastoral care and practice is subject to the authority of the Church"; that "there is a right of visitation by the local ordinary or his delegate"; and that "the institution's temporal goods are administered according to the applicable canonical principles" (Murphy "Governance," 30). As important as the issue is, particularly in light of the changes in governance occurring in many facilities, it is nevertheless a question beyond the scope of this thesis.
(1991) and Thomas J. O'Donnell (1981) argue that the pregnancy may be terminated after viability for "serious" reasons; James L. Walsh and Moira M. McQueen (1993) and Kevin O'Rourke and Jean deBlois (1994) contending that the pregnancy may be terminated prior to viability for the well-being of the mother; William Daniel (1984), James F. Drane (1992), and Thomas J. Bole III (1992) writing that the pregnancy may be terminated prior to viability on fetal indications alone; and Eugene F. Diamond (1992), Kevin O'Rourke (1996), the U.S. National Conference of Catholic Bishops Doctrine Committee (1996) and Peter J. Cataldo (1997) insist that the pregnancy may not be terminated either before or after viability because of fetal indications or to alleviate the physical or emotional distress of the pregnant woman. Each position will be considered in turn. In order to provide the context for these arguments, a brief review of Catholic teaching on abortion is in order.

Catholic Teaching on Abortion

The *Health Care Ethics Guide* of the Catholic Health Association of Canada states that "Direct abortion, i.e. any deliberate action with the primary purpose of depriving an
embryo or fetus of its life, is immoral." Similarly, the "Ethical and Religious Directives for Catholic Health Care Services" for the United States contains the following directive: "Abortion, that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus, is never permitted." These pastoral guidelines are meant to reflect the conviction that human life is sacred and is worthy of protection, a conviction contained in Christian tradition, in official Catholic teaching, and in moral theology.

This conviction was recognized by the Second Vatican Council. In discussing the duties and responsibilities of married life, the 1965 Constitution on the Church in the Modern World addresses the issue of abortion:

For God, the lord of life, has entrusted to women and men the outstanding service of watching over life and fulfilling this in a manner worthy of human beings. Therefore from the time of conception life is to be safeguarded with the greatest of care; abortion and infanticide are

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abominable crimes.⁶

Human life from its beginning is to be protected.

The teaching is reiterated a decade later in the 1974 Declaration on Abortion. The document, written in a climate that sought the legalization of abortion, sets out to repeat the teaching of the Catholic Church. Human life, a gift from God, is described as a "precious thing." Catholic tradition "has always taught that human life is to be protected and fostered, both in its beginnings and at every stage of its course."⁷ With the fertilization of the ovum, "a life begins that belongs not to the father or mother but to the new living human being who now develops on his own account." The Declaration admits that identifying when a human person comes into existence is not something that can be determined scientifically. Still, it states that:

> From the moral viewpoint . . . it is clear that, even if there be some doubt whether the entity conceived is already a human person, it is an

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⁸Ibid.

⁹Ibid., 413-414.
objectively serious sin to expose oneself to the danger of committing murder . . . .”

In other words, given the humanity of the life that is formed, the Declaration states that one should err on the side of life, and treat it with the respect and protective care due to persons.

While there may be serious reasons for seeking an abortion, including protecting the life and health of the woman, adverse social and economic conditions, and genetic indications, "none of these reasons justifies disposing of the life of another human being, even in its earliest stages." The document also prohibits abortion for the child's sake:

As far as the future unhappiness of the child is concerned, no one, not even its father or mother, can claim to represent the child -- even if it still be in the early embryonic state -- and in its name choose death over life.  

Written to address questions raised by the issue of the new reproductive technologies, the 1987 Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation emphasises the sacredness of human life from its beginnings. Physical life, while not an absolute value,

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10 Ibid, 414.
11 Ibid, 415.
12 Ibid.
nevertheless is important:

because upon this physical life all other values of the person are based and developed . . . . The inviolability of the innocent human being's right to life 'from the moment of conception until death' . . . is a sign and requirement of the very inviolability of the person to whom the Creator has given the gift of life.\textsuperscript{13}

Citing the Declaration on Abortion, the Instruction notes that, with the fertilization of the ovum, a "new" human life comes into existence. The presence of a soul cannot be established scientifically:

nevertheless, the conclusions of science regarding the human embryo provide a valuable indication for discerning by the use of reason a personal presence at the moment of this first appearance of a human life: how could a human individual not be a human person?\textsuperscript{14}

The Instruction states that Church teaching has consistently condemned abortion, a teaching that "has not been changed and is unchangeable."\textsuperscript{15} Thus the document declares that:

the fruit of human generation, from the first moment of its existence, that is to say from the moment the zygote has formed, demands the unconditional respect that is morally due to the


\textsuperscript{14} Ibid., 13.

\textsuperscript{15} Ibid.
human being in his bodily and spiritual totality. The human being is to be respected and treated as a person from the moment of conception; and therefore from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every human being to life.\textsuperscript{14}

Again, there is the conviction that human life is inherently valuable from the beginnings of its existence and the insistence that the rights due to a person be afforded to it from conception, including the right to life.

In the \textit{Gospel of Life} (1995), Pope John Paul II expresses his unequivocal opposition to abortion. Unlike the \textit{Declaration on Abortion} which anticipated the possible legalization of abortion, the \textit{Gospel of Life} was written because of legalization and toleration of abortion in many countries around the world. John Paul II defines a "procured abortion" as "\textit{the deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception until birth.}"\textsuperscript{15} It is the equivalent of "murder," of taking the life of an innocent, defenseless and dependent human life.\textsuperscript{16} While the woman may have serious and selfless

\textsuperscript{14} Ibid., 13-14.

\textsuperscript{15} John Paul II, \textit{The Gospel of Life} (Sherbrooke: Médiaspaul, 1995), 104. Italics in original.

\textsuperscript{16} Ibid.
reasons for seeking an abortion, "such as her own health or a decent standard of living for the other members of the family," they "can never justify the deliberate killing of an innocent human being."\(^{19}\)

Pope John Paul II cites the Declaration on Abortion to show that human life must be protected from conception because it is then that a unique human life comes into existence. He also quotes the Instruction on Respect for Human Life to show that, while it cannot be proven definitively when ensoulment occurs, one must wonder how ensoulment could not occur with the generation of the unique human life.\(^{20}\) At the very least the Pope insists that one err on the side of personhood. He states that:

> the Church has always taught and continues to teach that the result of human procreation, from the first moment of its existence, must be guaranteed that unconditional respect which is morally due to the human being in his or her totality and unity as body and spirit . . . .\(^{21}\)

This includes the right to life. John Paul II notes that Church teaching has consistently condemned abortion, a teaching which Pope Paul VI called "unchanged and

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\(^{19}\)Ibid., 105. Italics in original.

\(^{20}\)Ibid., 107.

\(^{21}\)Ibid., 108.
unchangeable." In this light, John Paul II states that:

Therefore, by the authority which Christ conferred upon Peter and his Successor, in communion with the Bishops -- who on various occasions have condemned abortion and who in the aforementioned consultation, albeit dispersed throughout the world, have shown unanimous agreement concerning this doctrine -- I declare that direct abortion, that is, abortion willed as an end or as a means, always constitutes a grave moral disorder, since it is the deliberate killing of an innocent human being. This doctrine is based upon the natural law and upon the written Word of God, is transmitted by the Church's Tradition and taught by the ordinary and universal Magisterium.  

Within the Catholic tradition, direct abortions are prohibited. This is based on the conviction that the human

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22 Ibid., 112.

23 Ibid.

24 The distinction between direct and indirect abortions has been the subject of study among moral theologians. See, for instance, Germain Grisez, Abortion: The Myths, the Realities, and the Arguments (New York: Corpus Books, 1970), particularly 328-346; Germain Grisez and Joseph M. Boyle, Jr., Life and Death With Liberty and Justice: A Contribution to the Euthanasia Debate (Notre Dame: University of Notre Dame Press, 1979), 402-407; Joseph M. Boyle, Jr., "Double Effect and a Certain Type of Embryotomy," Irish Theological Quarterly 44 (1977): 303-318. See also Nicholson's comments on this distinction: Susan T. Nicholson, "The Roman Catholic Doctrine of Therapeutic Abortion," in Bioethics, ed. Rem B. Edwards and Glenn C. Graber, (San Diego: Harcourt Brace Jovanovich, Publishers, 1988), 603-620. Arguing that pregnancy has meaning regardless of its outcome, this thesis will not enter into the discussion about the criteria distinguishing direct abortions from indirect abortions. For the purposes of this thesis, however, it is important to note that, by making distinctions between direct and indirect abortions, Roman Catholic teaching does not prohibit absolutely and unconditionally all procedures resulting in pregnancy termination.
life generated is a gift from God and that, although it cannot be established empirically when ensoulment occurs, one must treat that life as if it were of a human person. While there may be serious and compelling reasons to have an abortion, the Church teaching nevertheless maintains that nothing can justify direct destruction of innocent human life. This is not to suggest that fetal life has more value than maternal life. Pope Pius XII declares that:

Never and in no case has the Church taught that the life of the child must be preferred to that of the mother . . . . neither the life of the mother nor of the child may be submitted to an act of direct suppression. Both for the one and the other the demand cannot be but this: to use every means to save the life of both the mother and the child.25

However, there is no reason that can justify the direct killing of the fetus.

This prohibition extends to selective abortion.

Referring to eugenic practices, Pius XII states:

The direct destruction of so-called "useless lives," already born or still in the womb, practiced extensively a few years ago, can in no way be justified. Therefore, when this practice was initiated, the Church expressly declared that it was against the natural law and the divine positive law, and consequently that it was unlawful to kill, even by order of the public authorities, those who were innocent, even if, on

account of some physical or mental defect, they were useless to the State and a burden upon it . . . The life of an innocent person is sacrosanct. 26

With the development and use of prenatal diagnostic tests, the prohibition becomes more specific. While it is permissible to use such tests for the benefit of mother and fetus, their use:

is gravely opposed to the moral law when . . . done with the thought of possibly inducing an abortion depending on the results: a diagnosis which shows the existence of a malformation of hereditary illness must not be the equivalent of a death sentence. [The use of prenatal tests in this way] is to be condemned as a violation of the unborn child's right to life. 27

Implicit is a condemnation of abortion based on fetal indications.

The condemnation is more explicit in The Gospel of Life. Like the Instruction, The Gospel of Life finds prenatal diagnosis acceptable when done for the benefit of the fetus and the mother; however, it notes that prenatal tests are often followed by selective termination of


pregnancy. In light of this, John Paul II writes:

Such an attitude [which accepts selective abortion in order to prevent the birth of children affected by various types of anomalies] is shameful and utterly reprehensible, since it presumes to measure the value of human life only within the parameters of 'normality' and physical well-being, thus opening the way to legitimizing infanticide and euthanasia as well.25

The Gospel of Life clearly values persons with disabilities and those who care for them29 and is critical of those who are intolerant of fetal anomalies. The detection of malformations in utero cannot justify the termination of fetal life.

This is not to say that indirect abortions are not allowed. For instance, it is possible that therapeutic interventions to save the mother's life but which coincidentally result in the demise of the fetus may be permissible in some cases:

if, for example, the safety of the life of the future mother, independent of her state of pregnancy, might call for an urgent surgical operation, or any other therapeutic application, which would have as an accessory consequence, in no way desired nor intended, but inevitable, the death of the foetus, such an act could not be called a direct attempt on the innocent life. In these conditions the operation can be lawful, as can other similar medical interventions, provided that it be a matter of great importance, such as

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28 John Paul II, 114.

29 Ibid., 114-115.
the life, and that it is not possible to postpone it till the birth of the child, or to have recourse to any other efficacious remedy."

While official Catholic teaching prohibits interventions that result in the direct killing of the fetus, not all interventions are absolutely prohibited nor does official Catholic teaching addresses each case. As the Declaration on Abortion states, the document does not cover:

all questions pertaining to abortion; it is up to theologians to examine and discuss these. Only certain basic principles are recalled here; these will be a guide and rule for the theologians and help all Christians deepen their certainty concerning some important points of Catholic teaching."

While the Church teaches that direct abortions cannot be justified by even the most serious reasons, clearly there is room for discernment since not all abortions are direct. Furthermore, a document such as the Declaration on Abortion cannot address every situation but instead sets out principles to be used as guides when working through particular cases. One such case is the dilemma posed by the fetus with anencephaly.

It is important to note that, no matter what their positions, moralists making the arguments that follow are

30 Pius XII, "All . . . large families," 440.
31 Sacred Congregation, "Declaration," 409.
all seeking to work through the dilemma in light of and faithful to Catholic teaching and theology. As well, it should be noted that what follows, given the constraints of this thesis, is no more than a review of the literature. While the salient points will be covered, each article is deserving of a far more nuanced examination. In keeping with the tasks of the thesis, the purpose of the review is to bring to light the arguments and, ultimately, to probe them for the underlying presuppositions about the meanings assigned to the fetus with anencephaly and to pregnancy.

Position: That This Pregnancy May Be Terminated After Viability for Serious Reasons

Thomas J. O'Donnell

The 1981 article, "Catholic Doctors, Catholic Hospitals and the Prenatal Diagnosis of Anencephaly," written by moral theologian Thomas J. O'Donnell, was prompted by the growing use of prenatal diagnosis and the

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32 The concept of viability is the subject of much interest and some debate. See, for instance, Norman Post, David Chudwin and Daniel Winkler, "The Limited Moral Significance of 'Fetal Viability'," The Hastings Center Report 10 Dec. 1980): 10-13. Unless otherwise stated, in this thesis "viability" refers to gestational age, usually 22-24 weeks when a non-afflicted fetus would survive ex utero with medical support.

possibility that, should anencephaly be detected, the woman carrying the fetus might ask to have the pregnancy terminated. This could be especially problematic in Catholic health care institutions where "early clinical direct abortion . . . is obviously not a morally acceptable option within the context of Catholic teaching."

O'Donnell rejects the argument justifying abortion based on the contention that, because of the severity of the deformity, the fetus with anencephaly is somehow less than human. He believes that one must err on the side of humanhood: "abortion of an even doubtfully human conceptus would include the willingness to destroy it even if it is human." As well, he notes that, within the Catholic tradition, the fetus with anencephaly would be baptised rather in the same way that a comatose adult would receive the final sacraments. He dismisses any attempt to use proportionate reason or the principle of double effect to legitimize aborting a fetus with anencephaly.

Having made his objections to abortion even in the case of the fetus with anencephaly, O'Donnell then goes on

34 Ibid., 37.
36 Ibid., 38.
to distinguish between direct abortion and "inducing labor in instances of obstetric difficulties when the fetus is presumed to have attained viability." 37 It would seem that the procedure may be carried out only for very serious reasons, during the last two months of gestation when the fetus has achieved "whatever restricted viability it is ever going to attain." 38

For the fetus with anencephaly, it is "morally acceptable," O'Donnell argues, to induce labor early in order "to mitigate considerable emotional trauma to the mother." 39

In trying to discern what this might mean to fetal well-being, O'Donnell observes that, while the fetus' in-utero lifespan may be shortened, early induction will make little difference to its ex-utero existence. 40 On the issue of baptism he writes:

If induction of labor would be judged to not make any difference with regard to conferring the sacrament while the fetus was alive, it would seem that the shortening of the uterine occupancy would not be, in these circumstances, a real damage to

37 Ibid.
38 Ibid.
39 Ibid.
40 Ibid., 39.
the achievable good of the fetus."

Of course, one must also take into consideration the possible risks to the woman undergoing induction of labour. O'Donnell notes that not all physicians regard the intervention as completely benign and that, physically, continuation of the pregnancy presents "no obstetric danger to the mother.""

O'Donnell's brief and early piece on the issue leaves some questions unanswered. For instance, would a pregnant woman's psychological trauma also justify the early delivery of a fetus not afflicted with anencephaly? If not, why not? What is the moral status of the fetus with anencephaly beyond the insistence that it must be given the benefit of the doubt in the matter of personhood? What meaning has the term "viability" in the case of this fetus? Later authors address these questions as they work through the dilemma.

Robert P. Craig

In his 1991 article, "Ethics Consultation: Induction of Labor for a Woman With an Anencephalic

"Ibid.

"Ibid.
Fetus," Professor Robert P. Craig considers:

whether or not it is ethically permissible to induce labor for a woman with a viable anencephalic fetus, who is experiencing severe abdominal pressure, discomfort and shortness of breath due to polyhydramnios, and severe emotional trauma caused by the diagnosis."

He notes that the presence of excess amniotic fluid, while the cause of great discomfort, is not on its own "life threatening." Thus it would seem that the question is whether the emotional distress of the woman can justify early induction of labour in this instance.

Noting that the condition can be detected prenatally, Craig wonders whether induction of labour can be initiated without delay. He considers the risks of the procedure, observing that it is not always easy to induce labour in a woman carrying a fetus with anencephaly. Indeed, he believes that "waiting for spontaneous labor is, of course, the most judicious plan, since it provides a

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44 Craig, 44. I am presuming that Craig's use of the term, "viable" refers solely to length of gestation.

45 Ibid, 44.

46 Ibid, 44-45.
greater degree of safety to the mother."^{47}

In working through the question of the permissibility of deliberately inducing labour, Craig turns his attention to the moral status of the anencephalic fetus, whom he regards as a "human individual" with the same right to life as its mother.^{48} He reiterates the Catholic position that pregnancies are not to be terminated prior to fetal viability or in order to end the life of the fetus. Further, he states that only serious reasons can justify the procedure.

The question, then, is whether the severe emotional distress of the mother justifies termination of pregnancy. According to Craig:

only the most serious physical or mental distress on the mother's part would justify a pre-term delivery, and then only after viability. This serious condition of the mother would then outweigh in a proportionate manner the risks to the fetus and herself and would ethically justify an early delivery.^{49}

It is unclear whether, in Craig's view, emotional distress experienced by the mother is sufficient reason to justify the termination of a pregnancy where the fetus is not anencephalic. His use of proportionate reason, however,

^{47} Ibid., 44.

^{48} Ibid., 46.

^{49} Ibid., 46.
indicates that the fact of anencephaly, while not sufficient in itself to justify early induction, carries significant weight.

**Position: That This Pregnancy May Be Terminated Prior to Viability for the Well-Being of the Pregnant Woman**

James L. Walsh and Moira M. McQueen

In their article, "The Morality of Induced Delivery of the Anencephalic Fetus Prior to Viability," moral theologians James L. Walsh and Moira M. McQueen address the question of whether early delivery of the fetus with anencephaly can be undertaken when the health or even "comfort" of the mother is at stake. They observe that within the Catholic tradition a distinction is made between direct killing, where the death of the person is the intention of the act, and indirect killing, where the death of a person, while anticipated, is not the intended outcome of the act. The question, then, is whether early induction of labour is to be understood as indirect or direct killing and, if the latter, whether it is morally prohibited in this

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51 Ibid., 357.
case.

Walsh and McQueen begin by reviewing two treatments of the problem. They start with Craig's article, "Ethics Consultation: Induction of Labor for a Woman with an Anencephalic Fetus," and review his arguments that allow preterm delivery after viability. It is an act which, in Craig's view, is a case of indirect killing. As Walsh and McQueen interpret it: "For serious reasons connected with its own or the mother's health, the fetus is simply removed from its site within the womb, unharmed but for this removal."\(^5\) According to Walsh and McQueen, the fact that the fetus will surely die does not change the moral character of the act.

Walsh and McQueen agree with Craig that the fetus with anencephaly "must be treated as a person" and that induction of labour of the pre-viable fetus in this case "is truly direct killing."\(^6\) To induce labour early is to shorten this fetus' lifespan by taking the fetus from the womb which sustains it.\(^7\) Induction of labour is, therefore, a case of direct killing.

\(^5\) Ibid., 359.
\(^6\) Ibid.
\(^7\) Ibid., 360.
Walsh and McQueen take issue with Craig, however, over the issue of viability, questioning "whether it is legitimate to divide the anencephalic's earthly existence into pre- and postviable phases."

They view this distinction as an attempt to preserve the prohibition against taking innocent life directly while allowing early induction of labour. Ultimately Walsh and McQueen question the prohibition itself as it applies to "a fetus who is dying inevitably, who will never experience consciousness, and whose continued existence may pose a serious threat to the mother's health."

They then turn their attention to the position set out by Grisez and Boyle in their book, *Life and Death with Liberty and Justice*. Grisez and Boyle's arguments justify early induction of labour for the fetus with anencephaly based on the intention of the act. According to Walsh and McQueen's reading of Grisez and Boyle:

"even the removal of a nonviable fetus from the womb is not "killing in the strict sense" [i.e., direct killing] when one's intention pertains to the mother's life rather than the death of the fetus and where her life is preserved through the removal of the fetus."

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55 Ibid., 359.
56 Ibid., 360.
57 Ibid., 361.
In other words, the death of the fetus is neither the intended outcome of the procedure nor is it the cause of the woman's well-being. While the distinction between direct and indirect killing is an important one, Walsh and McQueen note that cases of indirect killing are not automatically permissible but require careful consideration.

For their part, Walsh and McQueen wonder:

how the removal of a fetus from its natural means of life support [they also refer to the womb as the fetus' "only life support''] can be described as not 'killing in the strict sense' and the death of the fetus can be seen as outside one's proposal."

The fact that the fetus' death is inevitable and imminent no matter when it is delivered does not, in the authors' view, change the situation. Another problem is the link between the woman's well-being and the death of the fetus. While Walsh and McQueen admit that maternal relief does not depend on feticide, they nevertheless conclude that "the goal can only be achieved through an action that is directed at the death of the fetus."

Intention, it seems, is not the sole determinant of the moral character of the act.

In order to resolve the dilemma, Walsh and McQueen review the differences between direct and indirect

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58 Ibid.
59 Ibid.
consequences. They point out that within Catholic tradition the distinction is most relevant in the taking of innocent life: "Killing of the innocent seems to be the one type of action that is considered to be intrinsically evil when it is direct, but may be morally justified when it is indirect." However, they also believe that there is such a thing as culpability even for unintended evils of acts because the evil would not have occurred had the agent not decided to "permit" them. They argue that the agent should be regarded as the "co-cause" of the unintended evil, and that one must look to the good achieved in light of the evil that occurs in order to determine the morality of the act. While moralists have turned to proportionate reason as a way of judging the moral permissibility of an act of indirect killing, Catholic tradition holds that direct killing, an intrinsic evil, cannot be justified in this manner. It is with this point that Walsh and McQueen take issue.

They contend that an examination of proportionality can lead one to distinguish between permissible and prohibited acts of direct killing. Walsh and McQueen contend that there are instances when the killing of an innocent

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60 Ibid., 364.

61 Ibid.
human being is not simply coincidental but an intrinsic component of the action to be undertaken, as in the case "of a difficult pregnancy, where the fetus is inherently part of the problem." Walsh and McQueen write:

It seems to be pushing the direct/indirect distinction too far to distinguish between killing the fetus indirectly to save the mother's life and killing it directly for the same reason, given that both will die otherwise. The proportionality judgement seems to be the same in both cases, and if it is sufficient to justify the first, it also should be sufficient to justify the second.  

After naming proportionality as a decisive factor in working through the dilemma of taking the lives of innocents, Walsh and McQueen turn their attention to the concept of human dignity. They note that, while we act morally when treating a person "in such a way that his or her personal dignity is always respected," it would be wrong to think of every harm done to a person as an assault on dignity: "Such harm, if truly proportionate, does not constitute an attack on personal dignity."

Because of the worth and dignity of each person, only very serious reasons can justify the taking of life.  

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62 Ibid., 365.
63 Ibid.
64 Ibid.
65 Ibid., 366.
Furthermore, there must not be the misunderstanding that one person has more worth than another when a life is taken. While asserting this equality of persons, Walsh and McQueen nevertheless maintain that not every life is of equal value:

A life that can never support uniquely human activity is not of the same worth as one that either supports such activity now or will do so in the future, though it remains true that the persons who live these unequal lives are themselves equal as persons.¹⁶

They make the distinction between persons and the lives they lead, pointing out that, while persons have dignity, such dignity is not necessarily attached to life itself.

With the foundations in place, Walsh and McQueen are able to state their position:

Since (1) life is not an absolute value, (2) the 'weighing of values' takes place in permitted indirect killings, (3) not all lives are of equal worth, and (4) the taking of life is not necessarily an attack on personal dignity, it follows that not all direct killing of the innocent is necessarily wrong.¹⁷

One of the "extremely rare" instances of a morally permitted direct killing, according to them, is the early delivery of the fetus with anencephaly before "viability."

While the fetus with anencephaly is human and a person with all of the dignity and value which this entails, its

¹⁶ Ibid.

¹⁷ Ibid., 366-367.
anomalies make it capable of a "physical life" only, which "may be sacrificed to save the mother's life or to prevent grave harm to her health, including psychological health." Without denying the personal dignity of the fetus, Walsh and McQueen assert that it is the lives of the fetus and mother that are of unequal value. Aware of the dangers of the slippery slope, they propose that the procedure be limited to those cases "where there is grave danger to the mother's life or health, or where there is good reason to suspect that there will be future danger.”

Kevin O'Rourke and Jean deBlois

In their 1994 "Induced Delivery of Anencephalic Fetuses: A Response to James L. Walsh and Moira M. McQueen," health care ethicists Kevin O'Rourke and Jean deBlois agree with the position taken by Walsh and McQueen but take issue with their moral reasoning. Because the anencephalic fetus' neurological deformity makes it incapable of developing a "cognitive-affective function," O'Rourke and deBlois contend that "it is a seriously

68 Ibid., 367.
69 Ibid., 368.

impaired human being, deprived of any potential to think, love, and relate to other human beings because of its anomaly."

According to O'Rourke and deBlois view, gestation is a time when the fetus grows and develops towards independent human existence. If the pregnancy cannot be continued to term, it must be continued at least until the fetus has reached "viability", that is, until the fetus has developed sufficiently so that it can continue this growth and development ex utero, albeit usually with the assistance of medical technology, a point reached around the twenty-fifth week of pregnancy.\textsuperscript{72} The authors observe that the development which occurs in utero is not simply biological but includes achieving "the physiological capacities that will serve as the substratum for future social and creative (cognitive-affective) functions."\textsuperscript{73} These are capacities that the fetus with anencephaly will never have.

Like Walsh and McQueen, O'Rourke and deBlois believe that the fetus with anencephaly is a "human person" but one whose anomalies prevent it from ever realizing "specifically

\begin{itemize}
\item[\textsuperscript{71}] Ibid., 48.
\item[\textsuperscript{72}] Ibid.
\item[\textsuperscript{73}] Ibid., 49.
\end{itemize}
human functions." Because the continuation of pregnancy, meant to benefit the developing fetus, will not help in this case, O'Rourke and deBlois conclude that the prohibition of termination of pregnancy does not apply to the fetus with anencephaly. However, they believe that it is wrong to initiate the procedure in order to kill the fetus; rather, the goal behind early induction of labour must be to safeguard the woman's well-being.

O'Rourke and deBlois note that "serious" complications often attend these pregnancies. These complications might not justify termination of a pregnancy where the fetus is not anencephalic, but:

Because the death of an anencephalic fetus in utero does not represent the same degree of evil as the death of a fetus who has the potential for developing human function, a less serious reason will be proportionate to the physical evil resulting from inducing labor to protect the mother's health.

Position: That This Pregnancy May Be Terminated Prior to Viability Based on Fetal Indications Alone

William Daniel

In his 1984 article, "The Anencephalic Fetus and

\[74 \text{Ibid.}\]
\[75 \text{Ibid.}\]
\[76 \text{Ibid., 50.}\]
Termination of Pregnancy," moral theologian William Daniel notes that moralists have in the past been interested in the infant with anencephaly because of questions concerning its baptism. Moralists' guidance on the question of termination is, in his words, "coy and unhelpful." Especially problematic for him is the lack of consensus about the personhood of the anencephalic fetus.

Daniel begins by noting the "intuitive reaction ... that there is no purpose to be served in persevering with this pregnancy once anencephaly has been diagnosed." For him the dilemma is whether terminating the pregnancy violates the prohibition against the direct killing of innocent life. He considers, first, whether the fetus with anencephaly counts as "human life"; second, the importance of the concept of "viability" in determining the meaning of pregnancy termination; and, third, whether termination of pregnancy can be seen as "allowing" the fetus to die rather than "intending" its death and, if so, whether this makes

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78 Ibid., 65.

79 Ibid., 66.
any difference in determining the morality of the act.  

Daniel sees no reason to tie personhood to genetic indications or to the presence or absence of a cerebral cortex. Because a fetus with anencephaly is dependent but alive in much the same way as any other fetus (though he notes that the brain is not developing in a "normal" way), Daniel concludes "that we must give it the benefit of the same probabilities as lead us to accord the early embryo and fetus status and respect."  

Viability, for Daniel, "supposes a basic capacity in the fetus itself eventually to attain independence."  
Pregnancy is meant to be continued so that the fetus may develop this capacity.  The fetus with anencephaly will never develop the neurological basis to sustain life outside of the womb beyond a few days, which leads Daniel to this position:

To induce labor at forty weeks (and it often has to be induced) is just as truly bringing a non-viable fetus into the world as it would be if one had induced at sixteen weeks. . . . [Labour] may as properly be induced, or the fetus removed surgically, then as at the later stage"  

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80 Ibid.  
81 Ibid., 68-69.  
82 Ibid., 69.  
83 Ibid., 70.
Because such a procedure shortens the lifespan of a fetus which ought to be given the benefit of the doubt regarding its human worth, Daniel wonders whether the procedure can be understood as anything but a "direct" killing. At this point, he turns to the principle of double effect, suggesting that early induction of labor could be regarded:

as the withholding of a life-support system, the provision of which has become a matter of irrational striving, of grave burden to the mother, and therefore 'extraordinary' in the technical sense.¹⁴

He notes that, within the Catholic tradition, the insistence that a pregnancy not be terminated rests not simply on a prohibition against killing but on a sense of obligation "to sustain and give aid to the one who is in extreme necessity." Abortion, then, is seen not only as a direct and intentional killing, an act of commission, but also an act of omission, a failure to provide what is needed for the fetus.¹⁵

Working by analogy, Daniel notes that, in the case of the terminally ill patient whose death is imminent, there is a duty to support the patient by providing "whatever help

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¹⁴ Ibid.

¹⁵ Ibid.
we can that (a) is of real benefit to the patient, and (b) does not impose intolerable burden on him or others." In the case of the fetus with anencephaly, our "inability to help" leads Daniel to this conclusion:

the woman who is bearing an anencephalus is no more obliged to go on providing the help of gestation . . . than the pediatrician is obliged to institute artificial life-support measures after it is born."

Daniel goes on to confront the problem of value. First, he notes that early induction for this fetus "is a lethal act" whether it is done at sixteen or forty weeks. Using the analogy of the permanently comatose adult patient, Daniel observes: "There is no value seen in simply prolonging the vegetative processes in the dying when there is no prospect of recovery." This is not to say that the fetus with anencephaly has no value, but that existence has little or no value for the fetus:

I cannot see that any extra twenty or so weeks of intrauterine existence has any value for the anencephalus. And there is no prospect of independent existence at whatever level, waiting for it at the end of its gestation. . . . Termination of the pregnancy would therefore not

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86 Ibid., 71.
87 Ibid.
88 Ibid. Italics in original.
89 Ibid., 72.
deprive it of any real present benefit or of any possible future prospects."

Daniel also addresses the issue of means. For him, the pregnancy must be terminated by early induction of labour rather than abortion:

termination of pregnancy should not involve the physical destruction of the fetus, but simply its physical separation from the mother. To allow someone to die, when there is nothing we can do to save his life, is not the same as killing him; nor does the reasonableness of the decision to do no more to try to sustain life authorize a decision to put an end to it."

James F. Drane

In his 1992 article, "Anencephaly and the Interruption of Pregnancy: Policy Proposals for HECs," ethicist James F. Drane addresses hospital practice. His goal "is to justify liberalization of restrictive hospital policies on abortion," including the policies of Catholic hospitals."

After noting the reliability of the prenatal diagnosis of anencephaly, Drane observes that there are

90 Ibid., 72-73.

91 Ibid., 74.


93 Ibid., 105.
anomalies very similar to the condition although they are not as severe. A functioning brain stem will allow the anencephalic infant to behave in many ways like a non-affected infant; though without functioning cerebral hemispheres the anencephalic is, apparently, unconscious and unable to feel pain.

In light of these data, Drane suggests a policy for hospitals which normally do not practise termination of pregnancy. He stresses the importance of accuracy in the diagnosis of the condition, stating that termination should not be undertaken if the diagnosis is in any way doubtful. His own position is clear: "Abortion of an anencephalic pregnancy is appropriate when the diagnosis is firm and the woman makes a free choice." Furthermore, waiting until viability does nothing to help the fetus with anencephaly, who is beyond harm or benefit, and is unduly burdensome to the pregnant woman.

Drane presents the reasoning behind his proposal, beginning with his understanding of the meaning and function

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94 Ibid., 106.
95 Ibid.
96 Ibid., 107.
97 Ibid., 108.
of pregnancy:

to bring an emerging human person to viability and independent existence. But in the case of anencephaly this structure and purpose is [sic] frustrated, creating a tragic separation between the appearances and reality in the pregnancy... the anencephalic pregnancy can be understood and experienced as an extended funeral. ³⁵

This understanding has moral implications. With the pregnancy undermined, there is no need to continue it; early induction of labour "means only relief from a fatally flawed and futile process."³⁶

Drane compares early induction of labour to withdrawing life support for a dying patient. While he notes that the fetus would continue to live if left in the womb, he sees little value in the prolongation of that life. The severity of the neurological defect sets the fetus with anencephaly apart from fetuses with other anomalies. The anencephalic has "no capacity for human life in the sense of a personal history from which an individual existence derives meaning."³⁷ He interprets selective termination of pregnancy as "aiding nature in doing what nature does when functioning normally: i.e., terminate a fatally flawed

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³⁵ Ibid., 109.
³⁶ Ibid.
³⁷ Ibid., 110.
One of the consequences of being without consciousness is that the fetus cannot be benefited or harmed; it cannot suffer. The compelling interests belong to the pregnant woman who, according to Drane, has no obligation to carry the pregnancy to term. Viability is a meaningless term in this context; the infant will die shortly following its delivery whenever it should occur. Further, it is not the induction of labour that causes the fetus' death but "the severe and unremediable fetal defects." Indeed, the aim of the procedure is not the death of the fetus but its removal from the woman's womb -- a distinction in intent which, Drane argues, takes the act out of the realm of direct killing: "Death of the fetus is not the defining characteristic of the act." Drane's understanding of the Catholic tradition leads him to observe that the prohibition against abortion is not meant to preserve simple biological existence. He notes that the tradition does not hold life as an absolute value. Killing in the course of defending oneself or another

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101 Ibid.
102 Ibid.
103 Ibid., 111.
from an unjust attack can be justified. Within this framework, Drane believes that "making vegetative fetal life an absolute value is inconsistent."  

Drane applies the principle of double effect to early induction, observing that the relief to the mother caused by the termination of the pregnancy is the intended outcome of the act. The fetus' death, while expected, is not the intended outcome. The mother is meant to benefit significantly while any harm to the fetus will be slight, given its neurological inability to appreciate harm or benefit. 

Finally, Drane considers objections to his proposal. He is hesitant to deny the "humanness" of the fetus with anencephaly, focussing instead on the futility of the pregnancy, the imminent and unavoidable death of the fetus, and the terrible burden to the mother. He is confident that his proposal will not lead to the slippery slope; pregnancies are terminated in Catholic hospitals under very specific circumstances and his proposal will simply add one more category of pregnancies that can be ended without violating Catholic teaching.

\^104 Ibid., 112.

\^105 Ibid.
Drane's proposals elicit a response from ethicist Thomas J. Bole III in his article, "The Licitness (According to Roman Catholic Premises) of Inducing the Non-Viable Anencephalic Fetus: Reflections on Professor Drane's Policy Proposals." Bole agrees with Drane's position that early induction is permissible; however, for Bole, the justification for the procedure rests on the status of the fetus. As he notes, the Catholic prohibition of abortion is broad and "applies to humans who are, or might be, persons or potential persons." His contention is that the neurological deficits of anencephaly leave the fetus without the capacity to be a person or even a "potential person", thus making termination of pregnancy permissible even before the fetus has reached viability.

Bole notes that Drane regards early delivery of the fetus as an instance of withdrawal of treatment rather than intentional feticide. Bole takes issue with this, comparing early induction of labour to euthanasia practised on a


107 Ibid., 121.

108 Ibid., 121-122.
terminally ill patient: "In the case of early induction, we are also causing death to occur earlier than it otherwise would." The harm that comes to the comatose patient and to the fetus with anencephaly does not depend on their ability to "experience" it; the shortening of their lives, given that life is a good, is itself the harm.

Bole anticipates Drane's use of the principle of double effect to object to this view. Drane could, he says, point out that the intention of the act is not the fetus' death but the mother's well being and that the method, early induction of labour, is not an abortive technique; it ends the pregnancy but is not an act of feticide. The flaw in Drane's reasoning, for Bole, is the inconsistent view of the personhood of the fetus with anencephaly:

If the anencephalic either is or must be presumed to be a potential person, it has the same right to life as a fetus that is capable of conscious experience, and the proportionate reason necessary to justify by DDE ['"doctrine of double effect"] bringing about its death, albeit indirectly by induction prior to its viability, must be far more serious than whatever might motivate the mother's request that the pregnancy be terminated. Proportionate reason would indeed be "only the most serious physical or mental distress on the

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109 Ibid., 124.

110 Ibid.
mother's part."

The principle of double effect does not, for Bole, provide justification for the action, because it does not separate the fetus with anencephaly from the fetus not so afflicted. In other words, if the principle of double effect would not allow induction for the unaffected fetus, neither should it justify the procedure for the fetus with anencephaly because it is a principle that must be applied consistently to these two fetuses presumed to have equal value. For Bole, the pivotal question is: "Is the anencephalic a person or a potential person?"

Here he turns to Catholic teaching, interpreting personhood or potential personhood as having the ability "to become a human who can manifest a rational soul." But a rational soul, which for Bole is necessary in order to have "the capacity for minimal thought," itself depends on having "a non-rational animal soul, i.e., the capacities for the conscious integration of sensation and motor function."

Bole notes that in questions of an individual's

\[1^{11}\] Ibid., 126. Bole gives no references for his own citations.

\[1^{12}\] Ibid.

\[1^{13}\] Ibid.

\[1^{14}\] Ibid, 126-127.
capacity, the Catholic Church errs on the side of personhood. However, he does not believe that this deference is appropriate in the case of the fetus with anencephaly:

The anencephalic is almost unique among members of the biologically human species in lacking the capacity to develop the biological substrate -- a functioning neocortex -- for thinking, or for any kind of conscious experience. By the logic of the Church's position, therefore, the anencephalic is not, and cannot come to be a person; it cannot have, or develop so as to have, a rational or spiritual soul.\textsuperscript{115}

Because of this, Bole feels that it is morally permissible to end the pregnancy at the mother's request.

\textbf{Position: That This Pregnancy May Not Be Terminated Either Before or After Viability for Either Fetal or Maternal Indications}

\textbf{Eugene F. Diamond}

In "Management of a Pregnancy With an Anencephalic Baby"\textsuperscript{116} Eugene F. Diamond, a professor of pediatrics, suggests a possible rationale behind the practice of termination in order to preserve the woman's well being:

Presumably the closeness of the Mother-infant bond occasioned by the maintenance of the pregnancy would intensify the mourning associated with being

\textsuperscript{115} Ibid., 127.

the parent of a child with defects.

Diamond points out that this is an untested theory. His own feeling is that the "mourning process when acted out rather than suppressed may be an integral part of ultimate acceptance and healing." He believes that parents may have a much wider support system (at least within the formal health care system) when the baby is allowed to be born than when selective termination is undertaken.

Diamond moves from these practical considerations to the theological arguments supporting continuation of the pregnancy. His position is that to terminate the pregnancy before the anencephalic fetus has reached viability is, according to the Catholic tradition, "a direct abortion." To determine whether early induction of labour might be permissible after viability, Diamond turns to the analogy of the dilemma facing practitioners in a Catholic health care facility when a woman's membranes rupture, leaving her and the fetus susceptible to sepsis. Diamond's view is that, provided the procedure is meant and likely to benefit the fetus, early induction of labour would be justified. The

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117 Ibid., 19.
118 Ibid., 20.
119 Ibid.
question is whether inducing labour upon the discovery of anencephaly is meant and likely to benefit the afflicted fetus.

Diamond is not convinced that an appeal to the principle of double effect can justify the procedure. He observes that the relief of the mother's distress, which is the intended outcome of the procedure, follows directly from the termination of the pregnancy, which is not an indifferent action but one with fatal consequences for the fetus.

Diamond closes with practical considerations. He cites the slippery slope, suggesting that the detection of fetuses with other anomalies of the central nervous system will automatically lead to pregnancy termination. As well, he contends that "direct interventions against anencephalic infants [i.e. anencephalic fetuses] may aggravate rather than ameliorate the long range adjustment problems of parents."120

For Diamond, the anencephalic fetus is as much a person (he often refers to the anencephalic fetus as an "anencephalic child") as the pregnant woman, and the pregnancy is valuable to both individuals. This somewhat utilitarian point of view (insofar as the pregnancy is meant

120 Ibid., 22.
to be beneficial) is used by Diamond to bolster the Catholic position which prohibits direct abortion, and to show that an indirect abortion would not be morally justified in this case.

Kevin O'Rourke

Revising his earlier position, health care ethicist Kevin O'Rourke, in "Ethical Opinions in Regard to the Question of Early Delivery of Anencephalic Infants," 1996, concludes that within a Catholic framework the pregnancy cannot be terminated solely on the grounds of the fetal anomaly. To induce labour early would mean aborting an "innocent human being." Prepared for a multidisciplinary group within a Catholic health care setting, his article begins by laying the theological and philosophical groundwork.

O'Rourke makes a distinction between actus humanus, which he describes as "acts of intellect and will," and actus hominis, which are "acts of the autonomic nervous system." This is an important distinction in end-of-life


122 Ibid., 58.

123 Ibid., 55.
care. When persons are no longer capable of *actus humanus*, there is no obligation to take measures to preserve their lives. According to this view, when the anencephalic infant is born it is appropriate to provide palliation rather than initiate life support measures. O'Rourke acknowledges that the "anencephalic infant is a human being; a human person," but that it is "severely impaired . . . because its bodily development does not allow it ever to perform human acts."\(^{124}\)

In the case of early induction, O'Rourke makes the assumption that the agent's intention is good. However, there remains the question of the act itself. O'Rourke examines the differences between direct and indirect abortion, noting that the Church "has not declared that early delivery of anencephalic infants constitutes direct abortion."\(^{125}\) Classifying the procedure as an indirect abortion would mean appealing to the principle of double effect, defining the purpose of the act to be maternal relief and treating the death of the infant as unintended and coincidental.

With this groundwork in place, O'Rourke works his way through the dilemma. He believes that the anencephalic

\(^{124}\) Ibid.

\(^{125}\) Ibid., 56.
fetus must be treated as a person and must be allowed to remain in the womb. To deliver the fetus either before or after viability would result in its death because it is incapable of life outside of the womb.\textsuperscript{126} The anticipation of complications in labour and delivery at term are not sufficient to justify early induction of labour. O'Rourke is not persuaded by arguments invoking the principle of double effect:

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early delivery must be an \textit{indirect} effect of a physical procedure to avoid potential pathologies, i.e. direct killing of fetus cannot be a means to avoiding pathologies.\textsuperscript{127}
\end{quote}

In other words, the treatment of a possible pathology cannot comprise or follow directly from the termination of the pregnancy which leads to the death of the fetus.

O'Rourke observes that there are those who would call the pregnancy futile because its purpose -- to produce a baby who will one day be capable of "human acts" -- is frustrated. While O'Rourke does not question this understanding of pregnancy, he is concerned that allowing direct killing for this reason may open the door to permitting euthanasia of permanently unconscious patients.\textsuperscript{128}

\textsuperscript{126}Ibid., 57.
\textsuperscript{127}Ibid.
\textsuperscript{128}Ibid., 58.
He does not believe that that termination would be justified in order to assuage the trauma experienced by the parents of the fetus, declaring that "Therapy for emotional harm (finis operantis) does not allow direct killing of infants (finis operis)."\(^{129}\) Nor does he agree with the argument that compares the womb to a life support system:

> Natural organs may not be excised or rendered inoperative unless they threaten the life of a person. Anencephaly may threaten the life of the infant but does not threaten the life of the mother.\(^{130}\)

In other words, the womb is working as it ought and should not be interrupted in its function. The anomaly directly affects the fetus rather than the woman.

O'Rourke's position is unequivocal:

> Because intervention in the pregnancy of an anencephalic infant results in a direct killing of an innocent human being, the only suitable, ethical opinion seems to be to allow the pregnancy to go to term, baptizing the infant and allowing parents to hold the infant as it is allowed to die. . . . This seems to be the only conclusion in accord with traditional Catholic teaching.\(^{131}\)

**NCCB Committee on Doctrine**

In 1996, The Committee on Doctrine of the National Conference of Catholic Bishops (U.S.) published a paper on

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\(^{129}\) Ibid.

\(^{130}\) Ibid.

\(^{131}\) Ibid.
the care of anencephalic infants, in which the authors argue against the early induction of labour.

The diagnosis of anencephaly leads many practitioners to suggest terminating the pregnancy, when, other things being equal, they prohibit the procedure for fetuses suffering from less severe anomalies. Such treatment implies that fetuses with anencephaly have "lives of less meaning or purpose than others," a prejudice the Committee finds unjustifiable.

The Committee treats the anomaly as a physical deformity which does not diminish the human dignity of the fetus. In the eyes of the Committee, the anencephalic fetus is "an innocent human person." The Committee notes the prohibition of direct abortion and the conditions governing an indirect abortion based on the principle of double effect, and observes that, while termination might be allowed to treat the woman's pathology (a pathology that affects the welfare of both the woman and the fetus), the death of the fetus must not be the means of saving the woman's life. Anencephaly "is not a pathology of the mother, 

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133 Ibid.
but of the child, and terminating her pregnancy cannot be a treatment of a pathology she does not have."\textsuperscript{134}

Neither the fetus' short lifespan nor its severe physical impairment justifies early delivery. In the event of a live birth, the baby "should be given the comfort and palliative care appropriate to all the dying."\textsuperscript{135} The Committee believes that "in the face of every human being" -- even, that is, in the severely deformed countenance of the anencephalic -- "is an encounter with God."

Peter J. Cataldo

In his 1997 article, "The NCCB on Anencephaly,"\textsuperscript{136} Peter J. Cataldo, director of research at the Pope John Center, expresses his support of the Committee's position. He too believes it is wrong to induce labour either before or after viability solely because the fetus is anencephalic. Such a fetus is "an innocent human being," conceived by human parents, carrying human genetic material and operating "as an integrated organism."\textsuperscript{137}

Cataldo takes issue with those who contend that

\textsuperscript{134} Ibid.

\textsuperscript{135} Ibid.


\textsuperscript{137} Ibid., 3.
viability has no application to the anencephalic fetus, charging that they are trying to justify termination at any stage of the pregnancy. He believes that it is a mistake to divide human existence into physical or biological capability and "integrated or true existence." According to this view, it is possible to acknowledge the anencephalic fetus' limited capacity for physical life and yet deny it full human status. Cataldo finds this very problematic. In his view, one cannot be partially human.

Furthermore, human status is not dependent upon actual physical ability. It means:

that an individual by reason of being a member of the human species possesses a nature that includes the potential for actual operations, even though this potential may never actually be actualized due to some anomaly. Cataldo believes that the anencephalic fetus possesses this nature and, with it, dignity and the right to life.

Cataldo makes the analogy between the womb and artificial life support, but rejects the notion that the uterus provides futile treatment when its occupant is an anencephalic fetus:

Given the inestimable human dignity of the anencephalic child, the uterine enviroment in

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138 Ibid.
139 Ibid.
which he or she lives is not useless since it is supporting nothing other than a fully human individual.\textsuperscript{131}

Cataldo supports the NCCB Committee's commitment to protecting the life of the fetus, condemning any procedure that would put that life at risk unless it is "a direct treatment of a life-threatening maternal pathology, which, it should be also be mentioned, puts the life of the child at risk as well." Even in such a case, Cataldo urges that treatment not comprise procedures which directly result in the fetus' death.\textsuperscript{132}

The psychological or emotional trauma associated with the pregnancy does not, for Cataldo, constitute sufficient reason for early delivery. This is not to belittle the suffering of the woman; rather, it is to insist that the woman and fetus not be confused:

\textit{The emotional trauma of the mother is in response to the condition of anencephaly, but the [NCCB] statement shows that the act of terminating the pregnancy is in itself directed at the infant not the mother . . . .} \textsuperscript{133}

The woman's suffering must be addressed and treated through counselling and support. Cataldo suggests that bringing the

\begin{footnotes}
\item[130] Ibid.
\item[131] Ibid.
\item[132] Ibid., 4.
\end{footnotes}
pregnancy to term and treating the infant as a dying individual, providing baptism and palliative care, may have some therapeutic benefit for the parents.

Analysis of the Positions

Meanings Attached to the Fetus with Anencephaly

The preceding section contains a great deal of material for critical analysis. Particularly interesting are the interpretations and applications of the principle of double effect, of which an in-depth study -- worthwhile as it would be -- is beyond the scope of this thesis, as stated previously. In this chapter, analysis of the foregoing arguments will be restricted to two fundamental issues: the authors' understanding of the fetus with anencephaly and the meanings they attach to pregnancy. The perceptions uncovered here may be so conventional as to seem unremarkable; however, they warrant examination if the dilemma posed by the fetus with anencephaly is to be cast in a new light.

The authors consulted presume that fetuses, generally, are human and to be treated as persons. The question, then, is whether anencephaly changes this presumption. Of the authors examined here, Bole alone is unreserved in his refusal to treat the anencephalic fetus as a human person or potential person: its anomaly, leaving it
without "the biological substrate necessary to have . . . a [rational] soul, and thus to become a person," makes it "almost unique among members of the biologically human species."^^

The other authors believe either that the anencephalic fetus is a person despite its anomaly or must be treated as such. O'Rourke and Cataldo describe the fetus as an "innocent human being."'^ Craig attaches a great deal of importance to the brain stem, insisting that "physicians must assume that an anencephalic fetus is a human person."'^ The NCCB Committee likewise contends that this "innocent human person" must be treated like any other fetus.^^

Daniel is not convinced that personhood comes with "the formation of the cerebral cortex" and argues that the fetus with anencephaly should be given the "human status" that is usually allowed fetuses.^^ O'Donnell, noting the Catholic practice of baptising the anencephalic infant, agrees that

^13 Bole, 126-127.

^14 O'Rourke, 55; Cataldo, 3.

^15 Craig, 45.

^16 NCCB, 267.

^17 Daniel, 68-69.
one should err on the side of personhood."

Regarding the anencephalic fetus as human or as a person does not mean that moralists will automatically oppose termination of pregnancy. The anomaly may prove to be too much of an impairment. Both Walsh and McQueen, and O'Rourke and deBlois regard the fetus with anencephaly as a person and believe that it must be "treated" as such. However, their underlying contention is that the severity of the anomaly makes termination of the pregnancy permissible. The deficiencies may be factored into the benefit/burden ratio when applying the principle of double effect (as in O'Rourke and deBlois) or determining proportionality (as in Walsh and McQueen). Again, the task at hand is not to examine the argumentation but the authors' perceptions of the fetus with anencephaly.

While anencephaly may not rob the fetus of personhood or human status, its effects are nevertheless severe and devastating. Drane characterises the fetus with anencephaly as "a fatally flawed genetic development." Daniel, who has an otherwise sympathetic view of the fetus,

148 O'Donnell, 38.

149 Walsh and McQueen, 359; O'Rourke and deBlois, 48, 51, 52.

150 Drane, 110.
describes the delivery of an anencephalic infant as a "monstrous, unviable birth."\textsuperscript{151} For O'Rourke, the fetus is "severely impaired."\textsuperscript{152}

Some of the authors take this last point further, contending that the impairment is so severe as to leave the fetus -- despite its acknowledged personhood -- without the ability to live a human life. Walsh and McQueen, for instance, believe that the fetus is capable only of "purely physical life," and has no consciousness and thus no potential for self-transcendence.\textsuperscript{153} O'Rourke and deBlois describe "a seriously impaired human being, deprived of any potential to think, love, and relate to other human beings because of its anomaly," a human being who will never "develop the capacity to perform human acts."\textsuperscript{154} Walsh and McQueen argue that, as a person, the fetus is of worth equal to that of its mother, but its life, which "cannot achieve the purposes of human life even minimally," is of a lesser value than its mother's.\textsuperscript{155} In a similar vein, O'Rourke and

\begin{itemize}
\item \textsuperscript{151} Daniel, 69.
\item \textsuperscript{152} O'Rourke, 55.
\item \textsuperscript{153} Walsh and McQueen, 359, 367.
\item \textsuperscript{154} O'Rourke and deBlois, 48, 50.
\item \textsuperscript{155} Walsh and McQueen, 366-367.
\end{itemize}
deBlois argue that the death of an anencephalic fetus is not as serious as the death of a fetus not so afflicted: 156

Drane, who accepts the "humanness" of the afflicted fetus, 157 contends that, without the capacity for consciousness, the fetus has "no capacity for human life in the sense of a personal history from which an individual existence derives meaning." 158 Further, without cerebral hemispheres, the fetus does not have the ability or the potential to reflect on its experience or to attach meaning to stimulus. It cannot, in Drane's opinion, be harmed or benefited. To prolong or terminate its life is of no consequence to this fetus. 159 While O'Donnell agrees that there is no need to preserve the fetus' life in utero, he argues that the fetus with anencephaly is not entirely beyond benefit and burden. It is a candidate for baptism, which may be its only "achievable good." 160

As well as affecting its neurological development, anencephaly leaves the fetus with a very short lifespan.

156 O'Rourke and deBlois, 50.
157 Drane, 112.
158 Ibid., 110.
159 Ibid.
160 O'Donnell, 39.
Craig describes the anencephalic infant as "in effect born dying.'" Drane refers to "a dying life, not a potential person developing toward independence." Walsh and McQueen characterise the fetus as "inevitably dying."

With the exception of Bole, the authors regard the anencephalic fetus as a human being, if not actually a person, and insist that it be treated as a person. The anomaly, however, has a wide range of meanings. For some, like Cataldo and O'Rourke, the defects, although serious, make no material difference to the treatment of this fetus. For others, like Walsh and McQueen, anencephaly means that, while this fetus is of equal value to any other person, its life is not and so pregnancy may be terminated for serious maternal considerations. O'Rourke and deBlois also believe that the death of the anencephalic fetus is not as serious as the death of an unafflicted fetus because it will never achieve independent life. For Daniel and Drane, anencephaly means that the fetus is dying and need not be the recipient of life-prolonging measures, including continuation of pregnancy. As Drane notes, "anencephaly is a physical

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161 Craig, 47.
162 Drane, 111.
163 Walsh and McQueen, 359.
condition which makes a moral difference." 

Meanings Attached to Pregnancy

Various adjectives have been used to describe the pregnancy complicated by anencephaly. Although O'Donnell insists that the anencephalic fetus be carried to viability, he nevertheless calls the pregnancy "doomed." Drane is just as stark in his description, writing that "an anencephalic pregnancy can be understood and experienced as an extended funeral." It is a "fatally flawed and futile process." 

"Futile" suggests that there is a particular purpose to pregnancy, a goal which cannot be achieved when the fetus is anencephalic. "When a diagnosis of anencephaly is made," write O'Rourke and deBlois, "the pregnancy in a very real sense is complete." In their view, gestation is meant to allow the fetus "time to develop the organs and faculties necessary for human function." Daniel notes that the insistence on continuing pregnancy at least until viability

164 Drane, 117.

165 O'Donnell, 37.

166 Drane, 109.

167 O'Rourke and deBlois, 52.

168 Ibid., 48.
is so that the fetus will have developed sufficiently to live outside of the womb." Drane concurs: "The structure and purpose of pregnancy is to bring an emerging human person to viability and independent existence." And O'Rourke and deBlois explain the insistence on continuing pregnancy "at least until the time of viability," as depending on a similar supposition:

the infant needs time to develop its human capacity in the womb, especially the physiological capacities that will serve as the substratum for future social and creative (cognitive-affective) functions."

When this goal cannot be met because the fetus is anencephalic, the pregnancy is often deemed to be futile -- which in turn implies that it need not be continued.

"Futility" is a term often used to indicate that a particular medical treatment need no longer be provided. The term's use by authors arguing for the permissibility of termination of pregnancy is not coincidental; for many of them, the pregnant woman is regarded as either being or containing a life support system. Craig, for instance, characterizes the womb as the fetus' "primary life-support

\[169\] Daniel, 69.

\[170\] Drane, 109.

\[171\] O'Rourke and deBlois, 49.
system," while Daniel refers to "the life support system of the placenta and umbilicus." Drane writes that "Because the anencephalic fetus can be regarded as irreversibly dying, maternal life supports may be discontinued."

Walsh and McQueen also view the womb as life-sustaining; however, rather than liken it to an artificial system, they describe the uterus as the fetus' "natural means of life support," indeed its "only life support." Their contention is that "intrauterine maternal sustenance is as necessary to the fetus' survival as air, food, and fluids are for life outside the womb." While they use this distinction between "natural" and "artificial" means of life support to argue that early induction of labour is a grave action even in the case of the fetus with anencephaly, they nevertheless make the analogy between pregnancy and a life support system of some kind.

Authors arguing against termination of pregnancy

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172 Craig, 45.
173 Daniel, 69.
174 Drane, 111.
175 Walsh and McQueen, 359, 361.
176 Ibid., 361.
177 Ibid.
also use the analogy of life support, but do not characterise it as futile. For O'Rourke, the fact of anencephaly in no way diminishes the integrity of the pregnancy. The womb is working as it ought; the anomaly belongs to the fetus.\(^{178}\) Cataldo believes that, while this pregnancy may not yield a viable baby, the life that it supports is nevertheless valuable.\(^{179}\) By implication, the in-utero life of the fetus is valuable. Diamond believes that the pregnancy is worthwhile because it supplies the necessities of life to the fetus; ending the pregnancy shortens fetal life.\(^{180}\)

Not all authors share Diamond's concern with preserving the anencephalic fetus' existence in utero, believing that such existence has little worth. Daniel "cannot see that any extra twenty or so weeks of intrauterine existence has any value for the anencephalus."\(^{181}\) O'Rourke and deBlois agree that the continuation of the pregnancy "will not benefit the

\(^{178}\) O'Rourke, 58.

\(^{179}\) Cataldo, 3.

\(^{180}\) Diamond, 21.

\(^{181}\) Daniel, 72.
anencephalic infant."^{82}

O'Donnell seems not to assign particular value to life in the womb for this fetus; more important is that the baby be baptized.^{83} Walsh and McQueen recognize that early induction prior to viability normally "causes the fetus to lose a period of earthly existence, i.e., the time between induced delivery and delivery at full term," and suggest that, for the fetus with anencephaly, early induction of labour results in "the fetus' earlier death."^{84} Although the procedure ought to be considered direct killing they believe that, in the case of the fetus with anencephaly, it is justifiable: "Purely physical life is not of value to the anencephalic fetus since it cannot achieve the purposes of human life even minimally."^{85}

Interestingly, Diamond notes that continuation of the pregnancy may be beneficial to the pregnant woman and her partner, exposing them to more support and facilitating the grieving process.^{86} Otherwise the authors view pregnancy

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182 O'Rourke and deBlois, 49.
183 O'Donnell, 39.
184 Walsh and McQueen, 360.
185 Ibid., 367.
186 Diamond, 19-20, 22.
as a process meant to benefit the fetus. For some, like O'Rourke and deBlois, and Drane, pregnancy is meant to allow the fetus to develop sufficiently so that it can live outside the womb. For others, like Cataldo, the pregnancy has worth because it is sustaining a valuable life. Pregnancy, then, is viewed as having a particular purpose and is evaluated in light of its success or failure to achieve that purpose. The pregnant woman and the fetus are regarded as two very separate individuals, their physical connection being their only point of intersection.

The Fetus with Anencephaly in Secular Health Care: The Dilemma

Moral theologians may debate the permissibility of ending a pregnancy before viability; from an obstetrical point of view, termination after viability can be equally problematic. Canada is currently without an abortion law; however, in the United States, Roe v. Wade made a distinction between a previable and viable fetus. The 1973 decision gave women the almost unrestricted right to have an abortion in the first trimester, because the procedure was seen to be safer than childbirth and because the fetus was not viable. The interests of the fetus were recognized as beginning with viability; the abortion of a viable fetus
could be undertaken only to safeguard a woman's health or life."

According to the ruling, then, elective abortions were allowed during the first trimester and therapeutic abortions at any time during the pregnancy. Unclear was whether selective abortions, usually done in the second or third trimester, were permitted. It is a question not unique to North America. Amendments to Britain's abortion law led to a number of letters in Lancet seeking and offering interpretation of the law as it might apply to selective termination of pregnancy after the twenty-fourth week of gestation."

In the clinical setting, late termination of pregnancy for genetic reasons is more than a legal question. For practitioners now able to offer therapeutic interventions to the fetus in utero, there is the question of the obligations they have to the viable fetus."

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188 See the letters appearing under the heading "Ethics and the Termination of Pregnancy" in Lancet 342 (1993): 499; 929-930.

words, there comes a point when obstetricians feel that they have not one patient, but two, and obligations to both of them. It is within this context that arguments are put forward permitting late termination of pregnancy for the fetus with anencephaly.

Position: That This Pregnancy May Be Terminated After Viability

Frank A. Chervenak, Margaret A. Farley, LeRoy Walters, John C. Hobbins, and Maurice J. Mahoney

In the seminal article by Frank A. Chervenak, Margaret A. Farley, LeRoy Walters, John C. Hobbins, and Maurice J. Mahoney (Chervenak et al.), "When Is Termination of Pregnancy During the Third Trimester Morally Justifiable?" the group of physicians and ethicists addresses the problem posed by the fetus whose anomalies are not detected until late in pregnancy. They note that, while selective termination of pregnancy is a procedure practised in the first two trimesters, there may be a reluctance to perform it "after 24 weeks of gestation, when the

probability of extrauterine survival increases . . . "\(^{191}\) They review the implications of *Roe v. Wade* and argue that, in very restricted cases, selective abortion in the third trimester ought to be permitted. Their position is that late termination of pregnancy be allowed, under very restricted circumstances, that is, when the anomaly renders the fetus incapable of "postnatal survival for more than a few weeks," or leaves the fetus with "total or virtual absence of cognitive function," and when the condition can with accuracy be detected prenatally.\(^{192}\)

The authors believe that anencephaly is the sole condition which meets these criteria.\(^{193}\) They describe a sample of twenty-eight cases in which fetuses were discovered to be anencephalic. Eighteen of them were detected before the twenty-fourth week of pregnancy and aborted; the remaining ten, which are the focus of the study, were detected later than twenty-four weeks. (In three cases, the diagnosis was made between thirty-three and thirty-six weeks.) They, too, were aborted although "there was no maternal complication necessitating delivery" thereby

\(^{191}\) Ibid., 501.

\(^{192}\) Ibid.

\(^{193}\) Ibid.
making them third-trimester selective abortions. In nine of the cases, early induction of labour was performed; the remaining case was delivered by caesarian section because of an earlier complication. Eight infants were stillborn; the remaining two died very shortly after birth.

The procedure was quite straightforward: the diagnosis of anencephaly was correct in these ten cases and the babies were delivered without incident to the mothers. However, for the authors there remained a dilemma:

The basic purpose of obstetrical care is to serve the best interests of both the pregnant woman and the fetus . . . [which] are usually served by active support of both lives.

Given this understanding of the goal of medical care, the authors wonder whether it is permissible to undertake an action that will end in the death of the fetus while benefiting the mother.

They contend that when the fetus has been reliably diagnosed as having severely compromised neurological function or very limited lifespan, then the woman carrying such a fetus may benefit from termination of pregnancy. The procedure would alleviate the emotional distress and, by shortening the pregnancy, allow her and her partner to

194 Ibid.
195 Ibid.
embark on another pregnancy sooner."^196

There remains the question of the practitioner's obligations to the third-trimester fetus, which would include, at the very least, not harming the fetus and possibly even acting to benefit it."^197 The authors consider fetuses for whom the concepts of "harm" and "benefit" may have no meaning, fetuses such as those afflicted with anencephaly. In these cases, they argue, "perinatal death does not constitute a harm nor does the prenatal termination of the fetus' life through induced abortion constitute an injury."^198

Chervenak et al., appeal to the principles of beneficence and nonmaleficence when working through the dilemma posed by the fetus diagnosed with anencephaly late in pregnancy."^199 It is not sufficient to establish the benefits of termination to the pregnant woman. Legally and

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196 Ibid.
197 Ibid., 502.
198 Ibid.
199 According to the principle of nonmaleficence, the agent acts to avoid causing harm to others; according to the principle of beneficence, the agent acts to enhance the well-being of others. For a fuller treatment of the principles, see Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, 3d ed. (New York: Oxford University Press, 1989), 120-255.
ethically a third-trimester fetus can be seen as having some claims as well, and the authors believe that, at the very least, practitioners ought not to harm the fetus. However, because of the severe neurological deficits, the fetus with anencephaly can be neither harmed nor benefited by the actions of the practitioners. Termination of pregnancy for such a fetus, even in the third trimester, is permissible.

Fritz K. Beller

In his work, "Interruption of Pregnancy After the 24th Week of Gestation," Fritz K. Beller, a physician, discusses the time limit placed on abortions performed for fetal indications (22 weeks in the Federal Republic of Germany, at the time of his article). It is a limit based on fetal viability, a term with which Beller takes issue, finding it very inexact and tied to "the availability of medical technology, especially premature intensive care units." Believing that less elusive criteria are needed, Beller draws attention to two significant events in early human life: implantation, which occurs approximately twelve

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201 Ibid., 257.
days after fertilization, and the closure of the neural tube, which happens by day thirty-five. For Beller, the closure of the neural tube is especially important; it is possible that this event renders the fetus capable of experiencing pain.

Beller makes the analogy between an anencephalic fetus and a child who, suffering severe brain damage, has been placed on life support. However, unlike the child, the anencephalic has never had functioning cerebral hemispheres. In light of this, Beller argues "that the anencephalic fetus has never lived and therefore is not 'killed' by termination of pregnancy." He believes that he differs from Chervenak et al. in assigning little value to the fact that anencephaly is a fatal condition and instead focuses on the fetus' neurological anomaly, which is severe enough to allow it to be classified as "brain dead." It is this, ultimately, which justifies termination of pregnancy.

Beller proceeds to discuss late termination of pregnancy in general. He wonders, for instance, whether amniocentesis, which requires several weeks before results

202 Ibid., 257-258.
203 Ibid., 258.
204 Ibid.
are available, should be offered after the twenty-first week of pregnancy if abortion is allowed only during the first two trimesters. As well, he notes that infants may be born alive following late termination of pregnancy and suggests that early induction of labour may have to include feticide. This is not problematic for Beller, who holds that "from a moral point of view there is no difference between destroying the fetus indirectly by inducing labor or killing it directly." Regarding the fetus with anencephaly, Beller writes, "an anencephalus is for various reasons dead and can therefore be terminated any time."

Frank Chervenak and Laurence B. McCullough

Frank Chervenak, a physician, returns to the issue in "An Ethically Justified, Clinically Comprehensive Management Strategy for Third-Trimester Pregnancies Complicated by Fetal Anomalies", written with Laurence B. McCullough, a health care ethicist. The authors provide a

205 Beller estimates that patients are required to wait for up to four weeks for results. See Ibid., 259.
206 Ibid.
207 Ibid.
systematic approach to "managing" pregnancies in the final trimester when a fetal anomaly has been discovered. The course followed will depend on the severity of the defect: the fetus may be treated aggressively (that is, measures will be undertaken to preserve fetal life) or nonaggressively (that is, no interventions will be initiated). There may be cases warranting termination of pregnancy, an option which the authors feel may need some justification given the obligations that practitioners may have to fetuses in the third trimester.\footnote{209} \footnote{210}

Building on the criteria set out in Chervenak et al., Chervenak and McCullough argue that where fetuses are afflicted with anencephaly or triploidy,\footnote{211} pregnancies may be terminated because the conditions leave the fetuses with severe neurological impairment and almost imminent death. As well, both conditions can be reliably diagnosed.\footnote{211} Clinically oriented, they judge the morality of the

\footnote{209}Ibid., 311.

\footnote{210}In triploidy the fetus has an extra set of chromosomes, sixty-nine instead of the forty-six normally found in humans. It is a lethal condition usually leading to a miscarriage or stillbirth. Liveborn babies afflicted with triploidy die shortly after birth. See James Wynbrandt and Mark D. Ludman, The Encyclopedia of Genetic Disorders and Birth Defects (New York: Facts on File, 1991), 300.

\footnote{211}Chervenak and McCullough, 313.
procedure by seeing whether it is consistent with the goals of medicine, one of which is "to avoid unnecessary mortality for patients," in this case, a third-trimester fetus.\textsuperscript{212} Because anencephaly and triploidy are fatal conditions, ending the pregnancy "does not introduce death as a new outcome to pregnancy; death is already a certainty in the prognosis."\textsuperscript{213} Should the fetus survive birth, the severity of the neurological defect renders the fetus incapable of deriving benefit from any life-prolonging measures. Practitioners, then, do not fail the anencephalic fetus when they terminate the pregnancy:

> Preventing a future that holds no benefit for a patient does not harm the patient. Thus, beneficence-based obligations to a fetus with a lethal anomaly are not violated by termination of the pregnancy.\textsuperscript{214}

Chervenak and McCullough rely on the principles of beneficence and nonmaleficence in determining their obligations to the fetus with anencephaly. They believe that because the condition means that birth will almost immediately be followed by death, and what little life there is will be spent in a state of severe neurological

\textsuperscript{212} Ibid., 314.

\textsuperscript{213} Ibid.

\textsuperscript{214} Ibid.
impairment, late termination of pregnancy is permissible.

Fritz K. Beller and Julia Reeve

In their 1989 article on organ transplantation and the use of fetuses with anencephaly as donors, physicians Fritz K. Beller and Julia Reeve address the issue of late termination of pregnancy. Their thesis is that the concept of brain death is neither helpful nor relevant with respect to fetuses afflicted with anencephaly. They instead propose the adoption of a definition of "brain life." Because anencephalic fetuses would be unable to meet the criteria for brain life, termination of an anencephalic pregnancy would be permitted in the third trimester.

From their examination of fetal development, Beller and Reeve conclude that brain life commences "with the fusion of the neural tube" which occurs sometime between the thirtieth and thirty-fifth day after conception. Prior to this, "the fetus may be considered brain-absent and to have only a biological (vegetative) life." In anencephaly, the neural tube never closes; because of this, "the anencephalic can never exceed a state of vegetative human life and cannot


216 Ibid., 13.
progress into personal human life." In the opinion of Beller and Reeve, the distinctive feature of anencephaly is not the imminent death of the fetus or infant, but the neurological damage that prevents this fetus from ever having had "brain life." They believe that early induction of labour is permissible for the fetus with anencephaly at any time during the pregnancy:

The fetus can die either during a routine (premature) delivery or, if alive, when neglected with regard to resuscitation. In this way the newborn is allowed to die a natural death without forcing the mother to extend her pregnancy.217

Carson Strong

Ethicist Carson Strong makes his contribution to the discussion in his article, "An Ethical Framework for Managing Fetal Anomalies in the Third Trimester."218 Like Chervenak and McCullough, he confronts the last trimester of pregnancy from a clinical perspective. Strong is concerned to balance legal considerations, which may restrict the practice of third-trimester abortions, and aggressive obstetrical and perinatal therapies, which may benefit both

217 Ibid., 14.

218 Ibid., 17-18.

fetus and mother. He believes it is important to determine the "moral status of [the] third-trimester fetus," and suggests that physicians look to the principles of beneficence, respect for patient autonomy, and "avoiding killing."

In his brief recapitulation of the facts of anencephaly, Carson draws attention to the fetus being "irreversibly unconscious," a characteristic with moral consequences. Without the capacity for consciousness, the fetus with anencephaly "cannot be said to have interests. Therefore, it lacks the capacity to be harmed or benefited in any way by our actions." The interests of the mother -- the harms and benefits she experiences -- are decisive. Strong believes that the options available to her ought to include abortion, a choice which would not violate the physician's duty to the fetus:

The ethical justification of abortion is based on the fact that the fetus is doomed to a short nonsentient existence; therefore, a prompt death associated with abortion would not deprive it of any benefit. Moreover, because of the absence of awareness, abortion could not cause pain or

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220 Ibid., 792.
221 Ibid., 794-795.
222 Ibid., 796.
suffering to the fetus."\textsuperscript{223}

It seems clear to Strong that termination of pregnancy in this case would not violate the principle of beneficence.

He next grapples with the prohibition against killing. He believes that, because of the fetus' acute neurological impairment affecting both its consciousness and lifespan and its "potential for personhood in the strict sense," abortion should be permitted:

This does not imply that abortion should be taken lightly in such cases, but it provides moral grounds for believing that the principle of avoiding killing has diminished the force in such circumstances.\textsuperscript{224}

Finally he discusses the issue of viability, a legally ambiguous term. In his opinion, beyond indicating length of gestation or fetal size, "viability involves the capacity for sustained extrauterine survival beyond a brief period."\textsuperscript{225} In this light, it is possible to regard the fetus with anencephaly as "not viable", in which case laws prohibiting abortions based on fetal viability would not apply.

\textsuperscript{223} Ibid., 796-797.

\textsuperscript{224} Ibid., 797.

\textsuperscript{225} Ibid.
Analysis of the Positions

Meanings Attached to the Fetus with Anencephaly

Working within the framework of secular health care, the authors just examined do not invoke the principle of double effect, but turn instead to such *prima facie* principles as beneficence and nonmaleficence, and to an understanding of the goals of health care, in order to work through the dilemma posed by the detection of an anencephalic fetus in the third trimester of pregnancy. The arguments provide challenging material for analysis; this section of the thesis will, however, restrict its examination to the authors' understanding of the fetus with anencephaly and the meaning of pregnancy.

The arguments permitting termination of pregnancy in the third trimester are predicated not on the assumption that fetuses, generally, are not persons or potential persons, but on the claim that the condition of anencephaly negates the fetus' personhood, or is so severe in its consequences as to make termination justifiable. Thus Chervenak *et. al.* insist on reliability in diagnosis:

Obviously a third-trimester fetus mistakenly thought to fulfill the conditions outlined above [that is, have no capacity for cognitional development or face almost immediate death after birth] could be gravely harmed through termination
of pregnancy."226

Strong, and Beller and Reeve deny the personhood and potential personhood of the anencephalic fetus. Strong believes that the anomaly means that this fetus is without the "potential for personhood in the strict sense."227 For Beller and Reeve, the fetus with anencephaly never achieves "personal human life," which, in their view, involves both the ability to process sensation and the capacity or at least the potential for cognitive awareness.228 Because its neural tube has failed to close, the fetus is capable of physical existence only, leading them to conclude that "in a philosophical sense the anencephalic is not a person, not an end in itself, but only a means."229

Chervenak et. al. neither affirm nor deny the personhood of the fetus with anencephaly, but find the effects of the anomaly to be so extensive as to justify a third-trimester abortion. Because of its severe neurological impairment and almost imminent death, the fetus can be neither harmed by termination of pregnancy nor

226 Chervenak and others, 502.
227 Strong, 797.
228 Beller and Reeve, 14, 16.
229 Ibid., 16.
benefited by efforts to prolong its life. Chervenak and McCullough continue this line of reasoning, claiming that "Preventing a future that holds no benefit for a patient does not harm the patient." Life itself is not seen to be of benefit to the fetus with anencephaly and taking away that life is not seen to be harmful to it.

Strong also believes that because the anencephalic is "irreversibly unconscious" it can experience neither harm nor benefit: "because of the absence of awareness, abortion could cause neither pain or suffering to the fetus." Beller and Reeve agree that anencephaly leaves the fetus without the ability to feel pain. The brain-stem function which supports the fetus has "nothing to do with sentience or cognitive function." The authors contend that, in this sense, "the anencephalic has never lived and so, in conclusion, can never die."

Beller puts forward a similar view, characterizing the fetus with anencephaly as "brain dead." He believes

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230 Chervenak and others, 502.
231 Chervenak and McCullough, 314.
232 Strong, 796-7.
233 Beller and Reeve, 16.
234 Ibid.
that, because it has never had a functioning cerebral cortex, "the anencephalic fetus has never lived and therefore is not 'killed' by termination of pregnancy."\textsuperscript{235}

Neither Chervenak \textit{et. al.} nor Chervenak and McCullough hold such an extreme position. The fetus is not dead but lives on the brink of death. The anomaly is "lethal," so that "termination of pregnancy does not therefore introduce death as a new outcome to the pregnancy."\textsuperscript{236} Strong also makes reference to the limited life span of the anencephalic fetus; he views abortion as a way of providing "a prompt death."\textsuperscript{237}

For these authors, then, anencephaly robs the fetus of interests. Strong, Chervenak \textit{et. al.}, and Chervenak and McCullough perceive the anomaly as being so severe as to render harm and benefit meaningless for this fetus. Beller, and Beller and Reeve adopt a more extreme position. Not only does anencephaly deprive this fetus of personal status, it makes "brain life" impossible. As Beller writes, the fetus who is anencephalic "is for various reasons dead and can

\textsuperscript{235} Beller, 258.

\textsuperscript{236} Chervenak and McCullough, 314.

\textsuperscript{237} Strong, 796.
therefore be terminated at any time."\textsuperscript{235}

Meanings Attached to Pregnancy

For the most part, the authors examined in this section spend little time contemplating pregnancy itself. Chervenak et. al. describe the pregnancy where the woman is carrying an anencephalic fetus as "seriously abnormal", pointing out that termination of the pregnancy will permit the couple to embark on "a subsequent pregnancy earlier than if the seriously abnormal pregnancy were allowed to continue to term."\textsuperscript{236}

Beller makes the analogy between a pregnant woman and mechanical life support:

\begin{quote}
In anencephalic fetuses, the vital functions are maintained by supply of oxygen and nutrients through the umbilical cord. This corresponds to the intravenous feeding and the artificial respiration of a brain-damaged child.\textsuperscript{237}
\end{quote}

Beller and Reeve also use this analogy, which makes it possible to describe termination of pregnancy as the withdrawal of fetal life support.\textsuperscript{241}

Chervenak and McCullough portray the pregnant woman

\begin{flushright}
\textsuperscript{235} Beller, 259.
\textsuperscript{236} Chervenak and others, 501.
\textsuperscript{237} Beller, 258.
\textsuperscript{241} Beller and Reeve, 14.
\end{flushright}
not as a machine but as an individual, separate from the fetus, who, like the practitioner, may have duties and obligations to the fetus.\textsuperscript{242} Chervenak \textit{et. al.} also separate the pregnant woman from the fetus, depicting her as one of two parties with "interests" in the pregnancy. Because of the severity of anencephaly, the interests of the pregnant woman ought, the authors believe, to prevail even in the third trimester, and the obstetrician is to be in the service of those interests.\textsuperscript{245} Beller notes the tendency to regard the pregnant woman and fetus as two separate parties, each with its own interests, which may, he feels, leave the clinician with "competing loyalties."\textsuperscript{244}

There is no suggestion that the \textit{in-utero} life of the fetus with anencephaly is of any value to this fetus. Indeed, given the severity of the anomaly, Chervenak and McCullough doubt the value of \textit{ex-utero} life to the fetus.\textsuperscript{32} Chervenak \textit{et. al.} concur, noting that whether the fetus' life is prolonged or terminated makes no difference to the

\begin{thebibliography}
\bibitem{242} Chervenak and McCullough, 314.
\bibitem{243} Chervenak \textit{et. al.}, 501-2.
\bibitem{244} Beller, 259.
\bibitem{245} Chervenak and McCullough, 314.
\end{thebibliography}
fetus itself. 246 And Strong writes that "a prompt death associated with abortion would not deprive it [the fetus] of any benefit." 247 No value whatsoever is assigned to this fetus' in-utero existence.

Summary: Meanings Attached to the Anencephalic Fetus and to Pregnancy

Despite their different positions, the authors considering the dilemma posed by the fetus with anencephaly in both Catholic and secular health care share assumptions about the meaning of the anencephalic fetus and pregnancy. These assumptions are worth examining.

Whether the authors believe that the anencephalic fetus should be treated as a person or is an entity without interests, they seem to be in agreement that anencephaly deprives the fetus of meaningful existence. This perception can stem from the belief that the anencephalic is a biological or vegetative life form only, unable to achieve personhood -- a position held by Bole, Beller and Reeve, and Beller. Those who do not hold such an extreme view of the anencephalic's moral status -- Walsh and McQueen, for instance -- nevertheless believe that termination is

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246 Chervenak and others, 502.

247 Strong, 796.
justified because the anencephalic's life is of less value than its mother's or of an unaffected fetus, or -- as Chervanak et. al. argue -- because its condition renders it incapable of being harmed or benefitted.

Even those who insist that the pregnancy be continued because the anencephalic fetus is a valuable life, do not necessarily attribute meaningful existence to it. Its value is a consequence of an unequivocal humanity achieved by virtue of its genetic composition or its parentage (see Cataldo, for example). There is no sense that the fetus afflicted with anencephaly is itself anything more than the passive entity described by those who would allow termination of the pregnancy. Those urging its continuation simply assign value to the life.

The authors are similarly in agreement in viewing pregnancy as a means to an end. For Diamond and O'Rourke, pregnancy is meant to sustain fetal life; for Drane and Daniel, it allows a beginning life to develop sufficiently to live outside of the womb. Pregnancy is judged according to how successfully the end is achieved. When the womb is compared to a life-support system, its efficacy is evaluated according to how well it serves the occupant. This in turn involves a judgement about the fetus: whether it is a worthwhile life, a dying life, or a life for whom the
provision of life's necessities is no longer beneficial.

Pregnancy, then, is a process, a matter of utility. The woman and fetus, meanwhile, are treated as separate individuals, having interests that may conflict. Their lives intersect only physically. If the woman is suffering emotional trauma, it is a problem that belongs to her alone, just as anencephaly is a solely fetal pathology.

It is true that anencephaly has severe consequences for fetal life, that it is physically egregious, neurologically debilitating, and terminal. It is also true that in pregnancy a woman supplies the nourishment and environment on which a fetus depends for life. However, if new light is to be cast on the dilemma posed by the fetus with anencephaly, it is necessary to ask whether this is the only way to understand the anencephalic fetus and pregnancy. Can the anencephalic fetus be understood as other than completely incapable of meaningful life? Is pregnancy more than the physical coexistence of two separate lives?

Arriving at an alternative understanding of the fetus with anencephaly and of pregnancy is the task of chapter four. However, this new understanding depends on a particular theological viewpoint. Establishing that viewpoint is the task of chapter three.
CHAPTER THREE
AGAPE

Introduction

Chapter three will consider Christian agape as an overarching moral point of view from which to reconsider the dilemma posed by the fetus with anencephaly. It will begin by showing that, for the most part, arguments in the previous chapter were grounded in principles and duties. Noting that principles exist within the context of a larger moral worldview, often left unexpressed, this chapter will suggest that, just as it is important to construct new understandings of the fetus with anencephaly and the meaning of pregnancy, so it is essential to articulate a specific moral point of view. In this thesis, the moral point of view will be one informed by Christian agape or love.

An examination of Edmund D. Pellegrino's article, "Agape and Ethics: Some Reflections on Medical Morals from a Catholic Christian Perspective," will show that the application of Christian agape to issues in health care ethics is not without precedent. Agape exists as a
philosophical concept. However, given the theological context of the thesis, the chapter will be confined to a discussion of the Christian understanding of agape. It will note the place that agape has in Christian moral life and the debate about the term's meaning and application.

Following the work of Anders Nygren and Barbara Hilkert Andolsen, the chapter will propose categories to be used as a rough shorthand for identifying the two understandings of agape. After describing and critiquing them, the chapter will consider how these models could be applied to the dilemma posed by the fetus with anencephaly. It will conclude by proposing an understanding of Christian agape to be adopted as the thesis' overarching moral framework.

The Need for an Overarching Moral Viewpoint

The arguments put forward in the preceding chapter, whether allowing or prohibiting termination of the pregnancy in which the fetus was discovered to be anencephalic, are based for the most part on rules, duties and principles. In determining what duties are owed to the pregnant woman and third-trimester fetus, authors working in a secular setting appeal to the principles of beneficence and nonmaleficence. They argue that the pregnant woman would benefit from the termination of the pregnancy while the fetus would not be
harmed by the procedure. Authors writing within a Catholic context also appeal to these principles. Drane, for instance, argues that, without consciousness, the anencephalic fetus does not experience harm or benefit and will gain nothing from the prolongation of the pregnancy. Diamond, on the other hand, does not restrict "harm" to physical pain. He understands early delivery to be harmful insofar as it erodes further the value assigned to the anencephalic newborn and other infants with defects who already hold a very precarious place in the human community. Cataldo understands the pregnancy as having benefit because it sustains a valuable life.

Generally speaking, however, authors examining the dilemma as it exists within Catholic health care turn to the principle of double effect in order to determine whether early induction of labour would constitute a direct attack on innocent human life. Here the authors come to different

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1Chervenak and others, 501-502; Chervenak and McCullough, 313-314; Strong: 796-797; Beller: 258.


3Diamond, 22.

4Cataldo, 3.
conclusions. Drane contends that, because the death of the fetus is not the aim of the procedure and is not directly caused by the procedure (it is the pathology that kills the fetus), early induction of labour is permissible. Responding to Drane, Bole contends that if the fetus with anencephaly is considered to have the same moral status as a fetus without the condition, there would not be proportion between the benefit to the pregnant woman and the harm caused to the anencephalic fetus. Termination is allowable if the fetus is understood to be neither a person nor a potential person. Arguing against early induction of labour, Diamond and Cataldo contend that the woman's well-being, while perhaps the direct consequence of the action, follows from the death of the fetus and is not permissible. Walsh and McQueen, and O'Rourke and deBlois also appeal to

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"This would have come as no surprise to Joseph T. Mangan, who wrote that the principle of double effect "is a subtle principle, and for this reason it is liable to misuse on the part of the untrained mind. Even moralists need to proceed cautiously in its practical application. Frequently, in making applications to identical cases, moralists arrive at opposite conclusions" (Joseph T. Mangan, "An Historical Analysis of the Principle of Double Effect," Theological Studies 10 [1949]), 41.

Drane, 113, 114.

Bole, 122, 125, 126.

Diamond, 21; Cataldo, 3-4.
the principle of double effect, with the former authors placing a great deal of weight on proportionality and the latter emphasising the intention behind the act undertaken.  

It is important to note that underlying the arguments and the authors' use of the principle of double effect is the prohibition against killing innocent human life directly. Like the secular writers turning to the prima facie duties of beneficence and nonmaleficence, these writers are also guided by duties and principles.

As guides to action, principles require interpretation. There are questions of what constitutes harm and benefit, of what qualifies as innocent human life, of what it means to attack that life directly. Where principles come into conflict, there may be questions of priority. Debates about how principles are to be interpreted and applied may seem almost to overshadow the dilemma itself.

As well, principles exist within the context of a moral viewpoint or stance. They derive their meaning from the moral worldview in which they operate and serve a particular notion of the good. One can ask, for instance, why beneficence and nonmaleficence are important. Are they obligations one person normally owes another? Do they serve

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9Walsh and McQueen, 365-366; O'Rourke and deBlois, 49-51.
a particular vision of the goals and meaning of health care? Are they simply component parts of current methodology in health care ethics?

Similar questions can be asked about the principle prohibiting direct attacks on innocent human life. Does it express what Christians are called to be, respecting and protecting in an unconditional way God's gift of innocent human life? Is it a prohibition that contributes to the identity of community by establishing the parameters of its moral stance? Is it a free-standing prohibition that demands conformity if one is to practise in a Catholic health care setting?

Just as this thesis will construct an understanding of the meaning of the fetus with anencephaly and of pregnancy, so it will articulate a moral framework or stance that is informed by Christian agape. It is a fitting moral point of view insofar as it is explicitly theological and its application to issues in health care ethics is not

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10 The concept of agapeistic love is not exclusively Christian but can be found in other religious traditions as well. See the articles on "Love" in Mircea Eliade, ed., The Encyclopedia of Religion (New York: Macmillan Publishing Company, 1987). Agape is also a philosophical term. Jules Toner provides a survey of its use in his The Experience of Love (Washington: Corpus Books, 1968), 17-58. Acknowledging the many contexts in which agape is found, this thesis will nevertheless limit itself to a Christian understanding of the term.
without precedent.

Edmund D. Pellegrino and Agape in Health Care Ethics

In his 1989 article, "Agape and Ethics: Some Reflections on Medical Morals from a Catholic Christian Perspective," Edumund D. Pellegrino makes the case for viewing medical ethics from an agapeistic point of view. He believes that a perspective is needed which speaks to the "internal morality" of medicine, and feels that a Christian view which seeks out and acknowledges the intrinsic good of medicine and insists on the dignity of all persons might serve this endeavor well. Grounding this perspective are the Gospels, which, Pellegrino contends, do not so much convey rules as proclaim a way of life to be lived. At the heart of this life is Christian love, or agape. Without providing an explicit definition of agape, Pellegrino nevertheless points to the transcendent aspects of an ethic guided by it. Within this moral worldview, the


Ibid., 278.
ultimate end of human existence -- that is, union with the
Creator -- is operative in all moral decisions and actions.
To act morally in light of agape is to progress in one's
journey towards God. Furthermore, it is through the action
of charity that one can discern right decisions and actions
which advance this journey.\textsuperscript{13} Pellegrino believes that
Christian agape could provide a framework from which to view
the way of life professed in medicine and to find
resolutions in medical-ethical dilemmas.\textsuperscript{14}

Contending that a charity-based ethic and a rules-
based ethic are not mutually exclusive, Pellegrino
demonstrates how an agapeistic perspective could lend depth
to \textit{prima facie} duties of beneficence, justice and respect
for patient autonomy.\textsuperscript{15} He notes that beneficence, for
example, can range from meeting the minimal needs of a
patient's well-being to undertaking heroic sacrifice on
behalf of the patient. He contends that in an agapeistic
ethic, physicians place the good of patients above their
own, thereby engaging in service to persons in need. The
practice of medicine becomes:

\textsuperscript{13}Ibid., 287.
\textsuperscript{14}Ibid., 286-288.
\textsuperscript{15}Ibid., 289-294.
a means of service to others, a mission and apostolate, a virtual ministry to those who have a special claim on the whole Christian community -- the sick, disabled, poor, or retarded . . . .

A principle such as beneficence is at once probed for its deepest meanings and obligations in the light of agape and thus becomes an aid in living and working according to Christian love.

Pellegrino believes that agape has an invaluable contribution to make to medical ethics, the practice of medicine and the moral formation of physicians. He writes that by living one's life and one's profession according to the Gospel, "charity becomes an interior principle, as it were, that encompasses the philosophically derivable internal morality of medicine and, without abrogating it, transmutes healing into an act of grace."

There are bound to be weaknesses and gaps in a very brief article that seeks to provide a framework for viewing all of medical ethics. Pellegrino is vague about what constitutes a "Catholic 'perspective' on morals" and the interior morality of medicine beyond serving the good of the

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16 Ibid., 290.
17 Ibid., 297.
18 Ibid., 277.
More problematic is his failure to provide a comprehensive definition of agape. As this chapter will show, the meaning of Christian agape is far from self-evident.

Despite these shortcomings, Pellegrino's aim is laudable. He is attempting to find and articulate an overarching moral viewpoint from which to understand the meaning of health care and one's role in it, and within which to work through particular dilemmas. Within this perspective, actions are to be evaluated in light of what persons are called to be and to become. This applies to one's professional life as well as to one's private life:

for the Christian the practice of medicine is transformed from a profession to a vocation, a means of gaining one's own salvation, assisting in the salvation of others, and witnessing the truth of the Gospel teaching in one's own life. 

By adopting a Christian response, Pellegrino acknowledges that humankind's transcendent end is to be united to the Creator:

Clearly in an agapeistic ethic, the motivation for being moral is explicitly different from what it is in a naturalistic ethic. The Christian knows that doing the right and the good is a means of

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19 Ibid., 279.
20 Ibid., 290.
growing closer to God, the Creator and Redeemer.21

An ethic based on agape is concerned not only with what people do but with who they are. It is concerned with action and character, with the totality of the moral person and the moral life.

Agape and Christian Moral Life

The Command To Love

There is no doubt that love or agape occupies an important place in Christian morality. When in Luke's Gospel the lawyer asks Jesus what he must do to have eternal life, Jesus replies by asking him what is written in the law. The lawyer responds that it says to "'love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbour as yourself.'" Jesus confirms his answer: "'You have answered right; do this and you will live.'"22 To love God with one's whole being and also to love one's neighbour as one's self will bring one to eternal life, the goal of the human journey.23

21 Ibid., 287.

22 Lk. 10:25-28; see also Mk. 12:29-31 and Mt. 22:36-40. The Revised Standard Version is used throughout this thesis.

23 Consonant with Christian tradition, a neighbour is every human being created in the image and likeness of God. This is the sense presumed in this thesis.
The Distinctiveness of Christian Agape

The term used to describe this love is agape. As a noun, it means "love, generosity, kindly concern, devotedness." In ancient Greek, it was distinguished from eros, "a passion, an ecstasy, a madness." Although Christians may claim the command to love in this way as their own, in fact it is very much a part of the Jewish tradition. Deut. 6:5 declares, "and you shall love the LORD your God with all your heart, and with all your soul, and with all your might," while Lev. 19:18 reads: "You shall not take vengeance or bear any grudge against the sons of your own people, but you shall love your neighbour as yourself."

Authors differ upon what basis Christians can claim that Jesus' teaching is original and not simply a reiteration of Hebrew tradition. John Burnaby, for instance, does not think that the distinctive feature of Christian agape is self-love. In his view, to love another as oneself, "simply describes a love as intense and compulsive as that of Jonathan who loved David 'as his own soul' (1Sam. 20:17)

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-- so that the fortunes of the beloved are as important to
the lover as his own."\textsuperscript{16} Burnaby sees the distinctiveness of
the commandment lying in its application as taught by Jesus:
that God loves all of us unconditionally, that God forgives
those who have repented, that God seeks to save us, and that
we are to love in a similar fashion.\textsuperscript{17} J. F. Sollier, on the
other hand, finds the uniqueness of Jesus' teaching in the
connection of love of neighbour and love of God. In linking
the two commandments, Jesus elevates love of neighbour,
giving it "the same value as the love of God."\textsuperscript{18} In loving
our neighbour this way, "we rise above the consideration of
mere natural solidarity and fellow-feeling to the higher
view of our common Divine adoption and heavenly heritage
... ."\textsuperscript{19} The connection elevates humankind itself.

Still other authors point to Jesus' insistence on
complete inclusivity as the distinguishing feature of his
commandment to love. The parable of the Good Samaritan (Lk.
10:29-37) demonstrates the unconditional nature of our

\textsuperscript{16} Ibid.

\textsuperscript{17} Ibid., 355.

\textsuperscript{18} J. F. Sollier, "Love," in \textit{The Catholic Encyclopedia},
ed. Charles G. Herbermann, Edward A. Pace, Condé B. Palen,
Thomas J. Shahan, and John J. Wynne, vol. 9 (New York: The

\textsuperscript{19} Ibid.
obligation to neighbour. As well, Jesus explicitly states
that we are to love not only our friends but our enemies as
well (Mt. 5:44-45; Lk. 6:27-28, 35). This is to extend love
beyond the confines of a particular community and beyond the
limit suggested by Lev. 19:18.30

To take a stand on the particular feature or
features which make Jesus' command unique is more suited to
a thesis whose sole task would be to analyse Christian
agape, a task which is beyond the scope of this thesis. It
is sufficient to note that these aspects -- humankind is
called to love as God loves; love of neighbour and love of
God are intimately connected; neighbour is a term meant to
be totally inclusive -- are all scripturally grounded, and
describe important features of Jesus' teaching. It may be
that the uniqueness of Christian agape is not to be found in
the words of Jesus but in the Person of Jesus, in the event
of the Incarnation. As social ethicist Enda McDonagh puts
it, "The depth and range of divine love for humanity and of
human response to God and neighbour is manifest in Jesus
where the Word, the narrative of God's love takes flesh."31:

30 See J. Bruce Long, "Love," in The Encyclopedia of

31 Enda McDonagh, "Love," in The New Dictionary of
Theology, ed. Joseph A. Kornonchak, Mary Collins, Dermot A.
The God who is love is born into the world as a human person. In Jesus, humankind sees what it is called to: complete union with God, which means not only loving as Christ commands but becoming one who loves as Christ does.

Living the Ideal of Christian Agape

Facing every Christian is the task of discerning how to put this love into action in this world. The writers of the epistles of the New Testament reflect on this challenge. Theirs is a community united by its love for Jesus (Eph. 6:24; 2Cor. 5:14), a community called to love God (Rom. 8:28) and neighbour (Rom. 13:8). It is a love that is to be expressed in action. Christians are called to be hospitable, to visit those in prison, to put their gifts in the service of others (Heb. 13:2-3; 1Pet. 4:8,10). Furthermore, this is a love that is meant to be inclusive, to be extended even to one's enemies (Rom. 12:19-21). These external actions lead to interior changes. Paul recognizes that in fulfilling the command to love, the Christian lives in a special relationship with God and is "known by him [God]" (1Cor. 8:3). John writes that "if we love one another, God abides in us and his love is perfected in us" (1John 4:12). In loving, the Christian is joined to God who is love (1John

Lane (Collegeville, Minn.: The Liturgical Press, 1990), 604.
Love is thus an action and a state of being. Love is God, who is activity and being simultaneously. Jesus serves as the model of this love for the Christian community (Eph. 5:1-2). John explicitly links love of neighbour to love of God, writing that one cannot love God fully without loving one's neighbour (1John 4:20). Further, it is through loving one another that we come to love God (1John 4:7).

Several epistles allude to the primacy of love. The command to love is the summary of the laws which have come before it (Gal. 5:14; Rom. 13:8-10) and it "covers a multitude of sins" (1Pet. 4:8). Love gives life to other virtues:

Put on then, as God's chosen ones, holy and beloved, compassion, kindness, lowliness, meekness, and patience, forbearing one another and, if one has a complaint against another, forgiving each other; as the Lord has forgiven you, so you must also forgive. And above all these things, put on love, which binds everything together in perfect harmony (Col. 3:12-14).

After his lyrical tribute to love, Paul concludes, "so faith, hope, love abide, these three; but the greatest of these is love" (1Cor. 13:13).

Later writers continued to reflect on the meaning of Christian love. While it is beyond the scope of this thesis to provide a detailed examination of this reflection, it is important to note that Augustine and Aquinas placed
Christian love within a moral system that was essentially eudaemonic. In such a system, happiness is the proper end of human actions.

For Augustine and Aquinas, human happiness is to be found in union with God. Christian love, for Augustine, is the ardent longing, the restless heart that rests only in God. The human person longs for "a loving union with and possession of God." While Aquinas indentified charity as "the mother and the root of all the virtues, inasmuch as it is the form of them all," the moral life is nevertheless directed to human happiness in the Beatific Vision. Luther objected to this eudaemonism. Even if the object of desire was nothing less than God, one's motive for doing good was based on satisfying one's own desire for happiness. He urged a return to a Scriptural understanding of Christian love: entirely selfless and completely obedient to God and to

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12 Ibid., 605; Burnaby, 355; Jean Nicolas Grou, Morality Extracted from the Confessions of St. Augustine, with an Introduction by Roger Hudleston (London: Burns, Oates and Washbourne, Ltd., 1934), 1.


God's command.  

It was this distinction between a love that is motivated by selfish desire and that which sought to be selflessly obedient to God's will that became the basis of Anders Nygren's work, *Agape and Eros*, generally acknowledged to be the foundation of modern discussions of Christian love.

**Anders Nygren and "Agape and Eros"**

Nygren's understanding of agape, expressed in his work, *Agape and Eros*, finds its foundations in the Synoptic gospels and Pauline epistles. It is a love that is selfless and directed completely to the one who is loved. It is to sacrifice oneself for the sake of the other. It is the love with which God loves humankind, the love that draws humankind to God. It is given without regard to the merits or character of the object of love. It is without motivation and is freely and unconditionally given. It is a theocentric love in which God calls humankind into

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37 Ibid., 210.
fellowship with God and through agape makes the fellowship possible.  

Nygren's contention is that the Christian understanding of agape has been contaminated by eros, an essentially egocentric love. This has led to a serious misunderstanding of how Christian love operates and what it requires of Christians, a misunderstanding that continues to this day.

Following the platonic understanding of the term, Nygren acknowledges that eros is much more than lusting after sensual pleasures. It can have a "heavenly" aspect, being directed towards Beauty and Goodness. Christianity, influenced by neoplatonism, adapted this tendency to refer to humankind's essential desire for God, and the means to make it possible to satisfy this desire. It is a love that recognizes worth in the object of desire and responds to that worth by loving it; but for Nygren it is at heart a selfish love, directed to satisfying its own desire by possessing the beloved object.

With eros, the love of God is based on the value or worth that one sees in or assigns to God. In achieving

38 Ibid., 206.
39 Ibid., 51, 175.
fellowship with God, the movement is initiated from below: humankind, recognizing the goodness of God, tries to make its way towards God:

Eros and Agape are the characteristic expressions of two different attitudes to life, two fundamentally opposed types of religion and ethics. They represent two streams that run through the whole history of religion, alternately clashing against one another and mingling with one another. They stand for what may be described as the egocentric and theocentric attitude in religion.

Two Streams of Christian Love

Other writers recognize this two-tiered understanding of Christian love. Vincent MacNamara, for instance, distinguishes between "bestowal-love" and "appraisal love": The former follows Nygren's understanding of agape insofar as it is a love given unconditionally, flowing without regard for the qualities or characteristics of the beloved individual. It is "spontaneous and unmotivated: it must be pure agent-commitment . . . ." The latter exists with the knowledge (perhaps an act of faith in itself) that the beloved is

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40 Ibid., 205.

41 Vincent MacNamara, Faith and Ethics: Recent Roman Catholicism (Dublin: Gill and MacMillan, 1985), 151-152.

42 Ibid., 151.
worth being loved, and that this worth comes from God: "what claims our regard is not simply our neighbour but God in our neighbour and our neighbour in God." Enda McDonagh makes a similar distinction, characterizing the two understandings of love as either "creative (value-bestowing)" or "responsive (value-recognizing)" -- categories set out by Nygren. Like MacNamara's analysis, this schema juxtaposes the love which is bestowed without consideration given to the object's merit, and the love which is given "based on the recognition of the good or value of the person or object loved and desired." Both MacNamara and McDonagh focus on the perceived value of the beloved as the distinguishing feature of these two understandings of Christian love. However, there are other points of contrast. There are questions concerning the agent. Does agape allow the agent to enjoy satisfaction in loving? Are humans capable of loving in a way that is agapeistic? Is self-love a part of agape? What is the place

\[43\] Ibid., 152.
\[44\] McDonagh, 605.
\[46\] McDonagh, 605.
of sacrifice in agape? How are so-called "special relations" to be treated? Childress puts it this way:

> It is generally agreed that agape requires seeking the neighbor's (even the enemy neighbor's) welfare, but there are sharp disagreements about whether agape excludes self-love, mandates self-sacrifice, or pursues mutuality.

While he makes the case that agape has a contribution to make to health care ethics, Pellegrino fails to provide a definitive description of the term's meaning. McDonagh and MacNamara skim the surface of two different streams when they use categories of bestowal-love and appraisal-love, creative and responsive love. Clearly there is a need for another kind of analysis, a richer categorization, to accommodate the many points of diversity in the understandings of Christian love.

**Barbara Hilkert Andolsen and Agape**

In her 1981 article, "Agape and Feminist Ethics," Barbara Hilkert Andolsen distinguishes between love modelled on the Cross and the love modelled on the Trinity. She contends that an ideal of love that emphasises other-

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centredness to the exclusion of any regard for self and which elevates self-sacrifice, especially in the private sphere, is detrimental to women generally. This is because women's socialization urges them to be other-centred at the expense of their own identities and interests. The purpose of her article is to show that an ideal of love which allows self-regard and emphasises reciprocity and communion is an authentically Christian love and one which Christian feminists would do well to adopt.

Of interest to this thesis is Andolsen's division of agape into love characterized by selflessness and sacrifice, which is disinterested, indiscriminant and unmerited; and love that emphasises mutuality, connection and a balance between regard for self and other. The former type, found in the writings of such theologians as Nygren, Reinhold Niebuhr and Gene Outka, is, according to her schema, modelled on the Cross. There Christ gave himself totally for the love of others. The latter type of agape, which is the subject of such theologians as Martin D'Arcy, is modelled on the love found in the Trinity, where each Person exists in eternal

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49 Ibid., 74-76.
50 Ibid., 69.
51 Ibid., 70-72.
giving and receiving of love.\textsuperscript{52}

In making these distinctions, Andolsen is following Nygren, who juxtaposes the complete selflessness of the agape of the Cross with the self-regard and perhaps acquisitiveness of agape modelled on the Trinity.\textsuperscript{53} While Nygren argues for the superiority of agape modelled on the Cross, Andolsen contends that the Trinity provides a better model for Christian agape.

There are dangers in adopting categories such as the Cross and Trinity to describe the two understandings of agape. One or both perceptions may verge on caricature, with broad strokes and generalities obscuring important nuances. While every attempt will be made to provide a sympathetic and detailed view of each position, it must be remembered that this thesis is not about agape itself. For the purposes of this thesis agape is a point of view, a construct which may be of use in reviewing, re-evaluating and perhaps shedding light on the dilemma posed by the fetus with anencephaly.

\textsuperscript{52} Ibid., 72-73.

\textsuperscript{53} Nygren, 739-740.
Agape Modelled on the Cross:

This section of the thesis draws primarily from the works of Anders Nygren, Paul Ramsey, Victor Furnish and Colin Grant. The examination is not meant to provide an overview of the authors' thought and development or to compare them with each other, but to highlight only those aspects of their work which are relevant to the study of agape modelled on the Cross.

Agape as God's Love

Agape is divine love: that is its essential quality. According to Grant, agape is "the overflowing of divine plenitude"; it is "God reaching out to humanity, providing the assurance and inspiration for any love that we might express." Nygren, although cautious about some aspects of the Johannine perception of agape, nevertheless cites the evangelist's declaration that God is love as an important

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55 Grant, 4.
development in the Christian understanding of agape. 56 This love cannot be separated from its religious or theological context, whether it is referring to God loving humankind or neighbours loving each other. Neighbour-love, then, necessarily includes a divine component. 57 Not only does this distinguish agape from other forms of love, such as benevolence or altruism, but it requires that love for neighbour be a "reflection" of divine love. 58 In order to understand how neighbours are to love each other it is necessary to examine how God loves humankind.

Nygren lays the groundwork, describing God's love as "spontaneous and unmotivated". 59 It is "uncalculating, unlimited, and unconditional." 60 God's love does not depend on any worth that we have; if it did, it would not be freely given and divine love itself would have limits. Instead, God loves us because of who God is, "because it is His nature to love." 61 Furthermore, God's love for us is not dependent

56 Nygren, 47.
57 Nygren, 95; Grant, 17-19; Kierkegaard, 48; Furnish, Love Commandment, 205-6.
58 Nygren, 95.
59 Ibid., 75-76.
60 Ibid., 91; italics in original.
61 Ibid., 74.
upon our returning God's love. As Ramsey puts it, God does not love us because there is something lacking in God that must be filled. God has no deficiency. Rather, agape is meant to be a "giving out of abundant self-possession and overflowing benefaction." It is almost as if God is a bottomless reservoir, and agape is a waterfall, spilling God's love down on humankind.

Because God is agape, both the love itself and the one who loves, there is some debate as to whether humankind is capable of returning this love. According to Nygren's reading of him, St. Paul denies that we have the ability to love in a manner consistent with agape:

In relation to God, man is never spontaneous; he is not an independent centre of activity. His giving of himself to God is never more than a response. At its best and highest, it is but a reflex of God's love, by which it is 'motivated.'

It is important to note that in this relationship God is the one who loves humankind, the one who initiates the relationship. We can but respond, returning God's agape, albeit in a modified form. This love is best understood as "belonging without reserve to God" or "absolute possession

62 Ramsey, Basic, 106; see also Nygren, 212.
63 Nygren, 125.
64 Ibid., 80, 213; Ramsey, Basic, 127, 130.
We receive God's love in gratitude and in that spirit give ourselves over totally to God: "Man loves God . . . because God's unmotivated love has overwhelmed him and taken control of him, so that he cannot do other than love God." In this way our love for God can be said to be unmotivated and spontaneous, at least "compared to ordinary human love."

Neighbour-Love

While we may in some sense be incapable of loving God with agape, according to Nygren we are nevertheless required to love our neighbour this way. In his view, we manage this by allowing the love with which God fills us to spill onto our neighbour: "The Christian has nothing of his own to give; the love which he shows his neighbour is the love which God has infused into him." The love that we extend to our neighbour is thus nothing less than God's love, which is really and truly agape. In effect, we become "'tubes,'" conduits of God's love.

65 Nygren, 94.
66 Ibid., 213-214.
67 Ibid., 94.
68 Ibid., 129.
69 Ibid., 216, 740.
For authors adopting a less extreme understanding of neighbour-love, we are capable of love consistent with agape insofar as we imitate the love which God extends to us, the love that is lived in Jesus Christ. Paul Ramsey sees in the Incarnation the model for how humankind is to love God: completely, perfectly, with a love that is humble and obedient, grateful and selfless.\textsuperscript{70} Furthermore, Jesus loves humankind not as a response to any particular characteristic but because Jesus' love is "obedient love".\textsuperscript{71}

Two implications are worth noting here. First, as an act of obedience to a commandment, this love is not affective but volitional: "Christian love depends on the direction of the will, the orientation of intention in an act, not on stirring emotion."\textsuperscript{72} It is a love that can be commanded, which means, secondly, that it is not the object of love that elicits love from us; something external to the relationship prompts that love.\textsuperscript{73}

Agape as Disinterested Love

According to this understanding, agape is not

\begin{itemize}
\item \textsuperscript{70} Ramsey, \textit{Basic}, 18-19, 129, 131.
\item \textsuperscript{71} Ibid., 42.
\item \textsuperscript{72} Ibid., 100.
\item \textsuperscript{73} Furnish, \textit{Love Commandment}, 201-202.
\end{itemize}
dependent upon its object. We are called to love our neighbour without thought to the neighbour's merit or possible response to our love. It is a "disinterested love"; which, in some sense, renders the object of the love irrelevant. In another sense, the disinterestedness is meant to ensure that agape is absolutely without selfish motivation, a point which requires some explanation.

Agape is divine love: it is the love with which God loves us, the love with which we are to love God and neighbour. God's love is entirely without motivation. There is no gain for God in loving us; we can do nothing to earn God's love or increase it. Agape thus understood is in no way acquisitive nor is it based on desire. There is a complete absence of self-interest, even benevolent or, to use Ramsey's word, "enlightened" self interest. We are commanded to regard our neighbour -- all our neighbours -- in this way, to love them purely for their own sakes.

Love of enemy serves as a litmus test for this

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74 Ramsey, Basic, 95-99.
75 Furnish, Love Commandment, 209.
76 Ramsey, Basic, 105-106.
77 Ibid., 102.
78 Ibid., 76; see also Kierkegaard, 41, 46; and Furnish, Love Commandment, 209.
understanding of agape:

When Christian love is directed to enemies, it shows itself to be real Agape, spontaneous and creative. It creates fellowship even where fellowship seemed to be impossible.\(^7\)

For Ramsey, "if love persists notwithstanding hostility, then it is in truth disinterested."\(^8\) And New Testament scholar Victor Furnish notes that no special case has to be made for loving one's enemy: "Love of neighbor and love of enemy are not two different kinds of love but one and the same."\(^9\):

The Demands of Neighbour-Love

What does neighbour-love require? First, it is love that must be directed to the neighbour. Nygren takes issue with those who would denigrate neighbour-love by collapsing it into love of God. Agape has God's love at the centre. In neighbour-love it is the neighbour who is to be loved "in his concrete situation and his concrete condition, not some imagined ideal of my neighbour and not 'God in my neighbour.'"\(^{10}\)

\(^7\) Nygren, 102.

\(^8\) Ramsey, *Basic*, 99.


\(^{10}\) Nygren, 98; see also Ramsey, *Basic*, 95.
Ramsey specifies that neighbour-love means more than an attitude of good will or positive intention but concretely, specifically meeting the neighbour's needs.\textsuperscript{83} Furnish echoes this sentiment: "It is the more immediately 'practical' point that the 'neighbor' is the next person encountered, and that obedience in love means serving him."\textsuperscript{84} Agape is meant to be lived, expressed through action. The needs of our neighbours -- whatever those needs may be -- direct our actions.\textsuperscript{85} We may even be required to sacrifice ourselves for our neighbour's sake. Nygren, relying on St. Paul, describes agape as "a love which gives itself away, that sacrifices itself even to the uttermost."\textsuperscript{86}

Agape and Self-Love

The Cross provides a dramatic picture of the sacrificial nature of agape. Jesus, in loving obedience, agrees to suffer and die for the redemption of humankind. He turns away from his own interests and places himself entirely in the service of others. He gives up his own life

\textsuperscript{83} Ibid.

\textsuperscript{84} Furnish, \textit{Love Commandment}, 202.

\textsuperscript{85} Furnish, "Love of Neighbour," 332.

\textsuperscript{86} Nygren, 118.
for humankind, embodying what Kierkegaard calls the "self-denying" nature of agape.\(^{37}\) In this view, agape is utterly other-centred; it is love directed to God and to neighbour. There is no self-love in agape:

> It is self-love that alienates man from God, preventing him from sincerely giving himself up to God, and it is self-love that shuts up a man's heart against his neighbour.\(^{37}\)

In his reading of Jesus' command to love, Nygren acknowledges the existence of only two commandments: to love God and to love neighbour. He maintains that the inclination to love ourselves is to be overcome by loving our neighbour with what otherwise would be self-love.\(^{38}\)

Ramsey, too, believes that Christ did not command self-love: "No more disastrous mistake can be made than to admit self-love onto the ground floor of Christian ethics as a basic part of Christian obligation . . . ."\(^{39}\) The love which God commands is "self-effacing," which is not, Ramsey insists, to counsel self-annihilation; rather, he urges a "simple willingness to be oneself before God, [a] self-acceptance which, stripped of self-love, can still love the

\(^{37}\) Kierkegaard, 43.

\(^{38}\) Nygren, 217.

\(^{39}\) Ibid., 91, 95, 101.

\(^{90}\) Ramsey, Basic, 101.
neighbor for the sake of nothing else." Only in this stance of self-acceptance are we free to direct our love to others completely.

Agape and Fellowship

The fruit of neighbour-love is fellowship with God and neighbour. It is a fellowship that is extended not merely to the righteous, as in Hebrew tradition, but to sinners. Furnish sees the building of community as a central outcome of agape, but it is not a community founded on merit or even reciprocity. Instead, it is a building of the Kingdom, a community which "is the creation of God's reconciling love and at the same time is summoned to be the instrument of such love." Fellowship is created with our neighbour even when the love is not returned. As Furnish observes, "the formation of deeds of love is at the same time a formation of a community of love." While these "deeds of love" might find their impetus in God's command to

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91 Ibid., 101, 104.
92 See also Furnish, Love Commandment, 207; Furnish, "Love of Neighbor," 332.
93 Nygren, 68.
94 Furnish, Love Commandment, 211.
95 Ibid., 210.
love, agape is more than obedience. Agape requires loving one's neighbour, really and truly loving the neighbour, and being changed by that love. The relationship, formed independent of response or merit, contributes to the building of fellowship between God and humankind.

Critique of Agape Modelled on the Cross

Certainly there is criticism levelled at this model of agape. Andolsen states that "feminists are critical of the emphasis on sacrifice as the quintessence of agape and of the denigration of self-love." While this sense of agape may serve as a corrective to people plagued by pride and undue concern with self, Andolsen believes that these sins are unfairly attributed to women, who have been socialized to be other-centred at the expense of their own self-development. Agape modelled on the Cross serves as a way of reinforcing oppression by insisting that women continue to sacrifice their own interests, and by condemning any form of self-love.

In their replies to Colin Grant's article on agape, both Gene Outka and Edward Vacek find Nygren's treatment of

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96 Ibid., 208.
97 Andolsen, 69.
self-love problematic. As Outka puts it, "for him
[Nygren], neighbor-love completely dispossesses and
annihilates self-love . . . ." Vacek notes that, in
Nygren's view, even God is not allowed self-love. According
to Nygren's understanding, our love for God does not come of
our own choosing, nor do we love our neighbour; "rather,
God's love flows through us who serve as empty tubes."

In late twentieth-century North America, where autonomy
and initiative are cherished, it is not surprising that
Nygren's perception of agape, with its emphasis on human
passivity, finds little support. Nevertheless it would be
wrong to dismiss this model out of hand.

First, it is important to remember that agape
modelled on the Cross is not confined to the work of Nygren.
Ramsey and Furnish, allowing self-acceptance while
condemning self-love, also operate within this framework.
Radical other-centredness may jar modern sensibilities, but
it does eliminate one set of competing claims, which would

98 Gene Outka, "Theocentric Agape and the Self: An
Asymmetrical Affirmation in Response to Colin Grant's
Edward Vacek, "Love, Christian and Diverse: A Response

99 Outka, 36.

100 Vacek, 29-30.
pit the self against the other. Furthermore, the neighbour is not an object or abstract ideal, but the next person we meet. By insisting that we attend to this neighbour now, agape modelled on the Cross avoids the moral paralysis that can result from confronting the enormity of need in the world. In a world wounded by sin there is great need for a love that does not expect gratitude (the recipient's own woundedness may make this impossible). There is a need for a love which is not dependent upon merit (the neediest may be the most apparently heinous or loathesome). There is a need for a love which is utterly unconditional and, to use Nygren's word, "spontaneous."

There remains the troubling issue of how this model treats the self, and love of oneself. By prohibiting self-love, those who subscribe to agape modelled on the Cross hope to eliminate a self-centredness that would interfere with loving God and neighbour. Nygren takes this further, insisting that we engage in hubris if we think ourselves capable of agape. In this he sees the chasm that separates humanity from God; he sees it and does not turn away from it or minimalize it in any way. He fully acknowledges that it is an abyss that can only be bridged by God. Lest this seem too harsh a reality, Nygren reminds us that in Jesus' death on the Cross, God did indeed provide that bridge. For
Nygren, the wonderful mystery is not that we can make our way to God but that God has made a way to us.

Nygren, however, does not adequately address what it means to have been made in God's image and likeness. While there can be no comparison between the infinite wonder that is God and the finite creaturely existence that is humankind, there are links, threads across the chasm. As creatures we must necessarily be related to the one who created us. More than that, human beings have the distinction of somehow having been made in God's image and likeness. Sin may have tarnished the likeness and made us blind to it, but it has not done away with it altogether. The image of a tube does not do justice to humanity or to God. Is this what God wants to redeem?

Ramsey and Furnish allow that humankind may cultivate self-acceptance and thus have a real "self" to put in the service of God and neighbour; but there can be no self-love. They are quite right to be wary of anything that might be an obstacle to loving God and neighbour. However, agape has at its heart the love that God has for humankind. God really and truly loves us. Neighbours are called really and truly to love one another. We are proper objects of love.
Agape Modelled on the Cross and the Dilemma
Posed by the Fetus with Anencephaly

Application

Can agape modelled on the Cross be used to inform an argument supporting the continuation of an anencephalic pregnancy? With sacrifice, obedience and duty as watchwords, it seems possible to make the case against termination of the pregnancy.

In agape modelled on the Cross, love is very much an act of will, a response to a command of God. It is not elicited by the attractiveness or worth of the beloved; indeed, it seems to have little to do with the object of one's love. We love out of duty and gratitude to God who graciously loves us. We extend this love to others.

Agape modelled on the Cross is a self-emptying love. It is a sacrificial love that does not suggest ways of circumventing the suffering that may be required in loving one's neighbour. It is an obedient love. The Incarnation is the model of an otherwise incomprehensible love. While Jesus may not have looked forward to the events of his passion and death, he nevertheless gave himself over to the will of the one who sent him. This obedience to the Father's will is an expression of the love which Jesus has for the Father and for humankind.
This love is also other-centred. The needs of the self are utterly subservient to the needs of other. The love is always directed outward to others with no thought to reciprocity or response. In this, it is a love that insists on action, on assisting not only through good will but attending to the other materially and concretely.

Agape modelled on the Cross could provide an argument supporting the continuation of the anencephalic pregnancy. In caring for the doomed fetus, the parents love without hope of response. This fetus will not become an infant with the potential to return its parents' love. It is questionable whether the fetus or infant even experiences the love which the parents might have for it. To love this fetus or baby is very much like taking a leap into the unknown. It means being prepared to be satisfied to love without requital. In this sense it is very much a selfless love, a love without ego. Within this framework it is possible to love without complaint, perhaps even joyfully and gratefully, letting the love which is God spill into love for this extremely vulnerable and perhaps unconscious neighbour because God commands it.

This model of agape holds up love of enemy as the paradigm of what love requires; love for the fetus with anencephaly could also be paradigmatic. In agape for one's
enemy, love is bestowed without any regard for merit on the part of the beloved and without hope of response. It is love extended in the face of hostility. In agape for the fetus with anencephaly, love is not based on merit, requires much sacrifice and appears to be entirely unilateral. It is love extended in the face of silence.

Agape modelled on the Cross attends to the needs of others, insisting not simply on good intentions but action. The case could be made that, for the fetus with anencephaly, continuing the pregnancy means continuing to provide the environment and sustenance which prolong the fetus' life. This entails sacrifice on the part of the pregnant woman and those involved in her care. It means continuing the pregnancy when the outcome is surely doomed and the sacrifice itself will elicit no response from the intended recipient of the loving act. Regarding the motivation for agreeing to this thankless task, agape modelled on the Cross could justify it as an instance of extending selflessly to

\[\text{101 The fetus is not capable of accepting the Cross in the sense that the pregnant woman can. Because of the fetus' severe anomaly, it will never have the means to make such choices. Whether this sacrifice should be extended to the woman forgoing a therapeutic abortion and risking her own life rather than harm the fetus is a point worth further study. However, this thesis is limited to the question of selective termination of pregnancy and cannot pursue the issue of therapeutic abortion in light of agape modelled on the Cross.}\]
another the love with which God loves. God loves us not for any particular quality that we possess. God loves us whether we respond to that love or remain oblivious to it. God loves because that is who God is.

The Clinical Setting

To return to the task of this thesis, a sound argument in favour of continuing this pregnancy is one that will have support not only theologically but in the clinical setting as well. As as laudable as the arguments informed by agape modelled on the Cross are, they may be less than compelling in the examining room. Much of health care practice is currently driven by the principle of respect for patient autonomy, which is very much in keeping with the late twentieth-century drive for self-determination generally.102 In this climate of thought, concepts such as being other-centred to the exclusion of self or being grateful to serve as a tube conveying God's love without thought to the object of that love may seem very alien indeed. An attempt to convince practitioners of the merits of continuing an anencephalic pregnancy based on a framework informed by agape modelled on the Cross would probably be met with wonder. This deontological system would likely find

little sympathy in an outcome-driven moral milieu.

This is not to say that the deontological model has no contribution to make to the discussion. It can be helpful to have the concept of self-sacrifice treated with respect rather than derision and to value the notion of doing one's duty. This may be especially true in hard cases where there will be no happy endings or comfortable principles to fall back on. Conception, birth, and death often serve as reminders that humanity is not the measure of all things and that there is a transcendent aspect to human existence. Agape modelled on the Cross accommodates those events, affirming us as creatures who ought to be awestruck in the presence of the Creator. There is a place even in the clinic for a framework which allows and helps one to make sense of the mystery of human life.

Theologically, there is something admirable about the framework’s uncompromising insistence that we are called to meet the needs of the neighbour in a concrete way. Confidence that action is possible is based on the belief that God’s love animates us and guides us directly in the task, empowering us, enabling us to meet any of our neighbours’ needs. For the person of faith, it may be this belief that ultimately sees the woman and her partner through the challenge posed by the fetus with anencephaly.
Agape Modelled on the Trinity

As a contrast to agape modelled on the Cross, a love meant to be other-centred and disinterested, Andolsen offers the paradigm of agape modelled on the Trinity. This section of the thesis will draw on Post, Guroian, Gilleman and Plé.13 The aim of this examination is not to provide an exhaustive account of the authors' work but to expand the somewhat cursory description provided by Andolsen. The first point to consider is the significance of the Trinity as a model of love.

Love and the Trinity

In this context, the Trinity refers to the Christian belief that there is one God who exists as three Persons:

The Trinity is the term employed to signify the central doctrine of the Christian religion -- the

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truth that in the unity of the Godhead there are Three Persons, the Father, the Son and the Holy Spirit, these Three Persons being truly distinct one from another.\textsuperscript{124}

This mystery has several implications. The Christian God is a community of three distinct Persons who exist in one God. The three Persons who make up the Godhead exist in an unending circle of agape, loving and being loved. We are called to this love, and our communion with God\textsuperscript{125} is achieved by loving God, loving our neighbour, and by loving ourselves. Each point requires some explanation.

Agape and the Love of God

Commenting on 1 John 4:8 and 16, Walter Kasper writes:

this revelational event [that God is love] consists precisely in making known the eternal communion of love, life and reciprocal glorification between Father, Son and Spirit, in order that through this revelation the disciples and, with their help, mankind may be drawn into the same communion of love and life.\textsuperscript{126}

The love that is God is self-sufficient and in need of


\textsuperscript{105} Plé, 73.

nothing, eternally giving and receiving love within the fellowship that is the Trinity. Human persons, on the other hand, are mortal and incomplete, needing one another and God for completion. "The human person is possible only in the plural; it can exist only in reciprocal acknowledgement, and finds its fulfillment only in the communion of love." We are called to partake in the divine fellowship, drawn to the God who loves us into existence, invited to receive God's love and to return it, imitating the model of perfect love -- the Trinity itself.

If we are called to this communion, there must be the possibility not only of being able to receive God's love but to return it as well. Given the effects of original sin and our own limitations, we are in need of assistance in this. Plé contends that it is through God's love for us, through the Holy Spirit, that we are able to love "God himself and for himself." Not only does agape make it possible for us to love God, "it divinizes us by making us share the very life of God." God's love, the love which enables us to love God, is therefore a transforming love.

107 Ibid., 308.
108 Ibid., 306.
109 Plé, 70.
Far from insisting on self-abnegation or self-annihilation, agape modelled on the Trinity values the self at the very least as a necessary element in the relationship of love. This is the case in the Trinity, which is a dynamic fellowship, an intimate community of three distinct Persons. Paradoxically, as Gilleman points out, our fulfillment as individuals is dependent upon living in such a state of communion. When we respond to God's loving invitation, when we love God, we find our real fulfillment: "to give or refer ourselves to our Creator is to live consciously and deliberately the act of receiving ourselves from His hands." Plé concurs, contending that as we love God we discover ourselves, "[our] freedom, . . . [our] independence, . . . [our] personality."

The love that God expresses in the Trinity, the love that God has for us and the albeit imperfect love we return, is characterized by mutuality. It is a love that seeks communion and personal transformation without loss of individuality or personhood. Ultimately agape seeks union

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110 Gilleman, 150.
111 Ibid., 149; see also Post, "Purpose," 189.
112 Plé, 69.
113 Gilleman, 149.
between humankind and God. This has several implications for love of neighbour.

**Neighbour-Love**

First, love between neighbours is meant to be a mutual love. Arguing against a selfless, disinterested love, Post declares that "mutual love or reciprocity is the only appropriate fundamental norm for human interrelations and for the divine-human encounter as well."\(^{114}\) It should be noted that mutuality means that the love seeks, rather than depends upon, a response; after all, God loves us whether or not we return that love.

What is the impetus behind neighbour-love? According to Plé, our longing to love God leads us to love of neighbour. This is not to make neighbour-love a mere by-product of love of God. Rather:

> charity makes me really love the person of my neighbour; more than do forms of human love, charity penetrates to the hidden depths of that person. In loving him [the neighbour] 'for God', I love what is most personal in him -- his fundamental relation to God; in him I share the motivation to love and blessedness that God extends to him when he calls him by his name.\(^{115}\)

Because love of God informs neighbour-love, the

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\(^{114}\) Post, "Suffering," 52.

\(^{115}\) Plé, 73.
neighbour is loved for the neighbour's own sake as well as for the neighbour's own good. In Plé's view, we are all called to be in communion with God. By loving and being loved, we come closer to realizing that end:

the more I love God in my brother, the more I love him [the neighbour] 'within', in his longing for blessedness which in the last resort rules his whole life and urges him on to become himself in his most personal aspect.\(^\text{116}\)

Gilleman echoes these sentiments. He contends that we by our very nature are called to love others and that we have "an active inclination to associate with other human loves, which all ascend unanimously toward God, as so many voices in one harmonious choir."\(^\text{117}\)

Two points are worth noting here. First, because it is centred on the good of communion with God and with each other, agape modelled on the Trinity does not emphasise meeting the material well-being of neighbours. Gilleman puts it this way: "in love we are less interested in bringing to the other a good to be possessed than in wishing that he be in a relation of communion with us and with God."\(^\text{118}\) This understanding of agape does not ignore concrete assistance

\(^{116}\) Ibid.

\(^{117}\) Gilleman, 133.

\(^{118}\) Ibid., 151.
altogether but, in Post's view, seeks to redress an imbalance. Neighbour-love has been directed to meeting the material needs of others while bringing the neighbour to God has been downplayed -- to the detriment of the neighbour. Post contends that people would not be truly happy, even were their material needs met, unless they were in fellowship with God. It is this communion that is the source of true happiness. Whether the fetus who is anencephalic can partake in this communion will be explored in chapter four.

The second point to be noted is the interrelatedness of loves in this model of agape. With the Trinity as its paradigm, agape implies a "triad" of love: When one engages in neighbour-love, one also engages in love of God and love of self. Neighbour-love is meant to bring the neighbour to God and to authenticity. But it also brings the one who loves closer to God and to authenticity.

Agape and Self-Love

In agape characterized by mutuality, there is self-gain even in love directed towards the good of neighbour.

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119 Post, "Purpose," 192.
120 Post, "Communion," 17.
121 Plé, 69.
Because we are called to love and to be in communion, we achieve some measure of self-fulfillment in loving others:

each one who loves enters into an 'ecstatic' relationship with others and fulfils himself: thus the other is his good and his end. This relationship to another 'completes' and 'perfects' him.\(^{122}\)

Along with God and neighbour, the self is one of the three "terms" in agape.\(^{123}\) Agape modelled on the Trinity includes love of self, though Gilleman notes that our love, quite unlike God's, is imperfect and that we may initially be drawn to love for selfish reasons. Though our love for others may be motivated by thoughts of our own gain, Gilleman believes that:

there is nothing wrong in this, for sincere love sees in this enrichment a first communication of God or of the beloved, a prelude to communion. Love even finds in it a way of unifying its natural dispersion and of thus becoming able to contribute to this communion a sufficiently concentrated and rich ego. But love becomes egoistic when it ceases to see this enrichment as a phase of communion and refers it to the ego as an absolute.\(^{124}\)

Self-interest may be the impetus behind seeking out others, but, Gilleman believes, the end result may still be consistent with the principles of agape:

\(^{122}\) Ibid., 68-69.

\(^{123}\) Post, "Communion," 17.

\(^{124}\) Gilleman, 141.
If it is true that we must struggle against the egoism of uncontrolled self-love, and that only by going forth from self toward others and toward God are we liberated from this egoism, then we must admit that love for others is the most practical form of love for ourselves. ¹²⁵

Like neighbour-love, love of self cannot be divorced from the other two terms in agape. As paradoxical as it may seem, self-love is not restricted to love of self:

To love ourselves as humble participations of God is to love God more than ourselves. And in loving ourselves as bound to others by a necessary relation, we implicitly allow them to participate in the love which we have for ourselves. ¹²⁶

God is at the very centre of our existence and, in this view, our love is necessarily love of God even as we love ourselves. Furthermore, we are individuals who exist in community. Just as we direct our love to our neighbours, so our neighbours direct their love to us. Their love joins with ours as we love ourselves; ultimately this union of love is love of the God who created and sustains us. The result of agape, whether it be directed toward self or others, is a communion in which there is intimate unity of distinct persons. This is the goal of agape modelled on the Trinity.

¹²⁵ Ibid., 148.
¹²⁶ Ibid., 147.
Trinitarian Agape and the Cross

For agape modelled on the Trinity, the event of the Cross is important but not the central reality of Christian love. Post contends that the Cross was only one event in Jesus' earthly existence; to have a balanced view of what agape requires, it is necessary to examine Jesus' entire life. Post believes that Jesus' suffering and death were not willed by Jesus or the Father, but occurred en passant, as a necessary precondition for the conversion of sinners. Ultimately, for Post, "the cross symbolizes the violation of love more than it does love itself."\textsuperscript{127}

Guroian sees the Person of Christ as epitomizing what humankind is called to, that is, complete union with God:

In Jesus Christ, God and humanity are reconciled, not by some substitutionary formula or the measure of infinite satisfaction in the mind of God or the human being, but by the metanoia of the creature - a total conversion or turning toward God.\textsuperscript{128}

According to this view, agape involves being oriented toward other, but it is given sum and substance by mutuality and communion, not self-sacrifice:

The work of Incarnate love is not ended on the Cross. It is finished only when all who are of

\textsuperscript{127} Post "Suffering," 61; see also 59, 62.

\textsuperscript{128} Guroian, 34-35.
good will toward God and humankind are gathered together in the resurrected life. Its work is completed only when the sin which has brought mortality and desolateness to life is defeated and replaced by everlasting life and the unity of fellowship in Jesus Christ.\textsuperscript{129}

For Gilleman, the Cross is the ultimate example of what agape requires, but agape does not end with the Cross:

Jesus Christ crucified is the most perfect translation in human terms of a love-natured God. Humanly speaking, He could not do more, even though His thirst for giving Himself was far from being quenched. No finite manifestation can exhaust infinite love.\textsuperscript{129}

\textbf{Critique of Agape Modelled on the Trinity}

Several features distinguish this understanding of love from agape modelled on the Cross. Firstly, its mutuality means that it is not content to flow one way. It longs for a response. It is closer to the type of love that lies within the experience of most individuals. To be loved is to call forth a response; to love is to hope for reciprocity.

Post allows that there may be instances of desirable unilateral love, but, because people are essentially communal in nature, we seek communion with others.\textsuperscript{130} This

\textsuperscript{129} Ibid., 37.

\textsuperscript{130} Gilleman, xxvi.

\textsuperscript{131} Post, "Communion," 29.
does not mean that a response from the beloved will necessarily be forthcoming. Like proponents of agape modelled on the Cross, those who propose a Trinitarian model of agape believe that love cannot be coerced and that the response must be freely given. It is possible for agape to be unrequited, for the beloved to turn away from the lover, whether the lover be a neighbour or God. Nevertheless, within this Trinitarian model, love is offered with the hope of forming communion with the beloved. This love is "interested." Ramsey allows that reciprocity is an acceptable but altogether unintended byproduct of agape, but Post disagrees:

In the absence of requital the possible joy of love is displaced by suffering, and the reinforcement of beneficent action that issues from the circle of mutuality is displaced by stagnation.  

According to the Trinitarian model, the self is ever open to the benefits of a love returned.

Secondly, the Trinitarian model has an elevated understanding of the human person, whether as lover or beloved. We are not empty tubes waiting to be filled with the love of God. Rather, God loves us and invites us to

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132 Ramsey, Basic, 116.

133 Post, "Communion," 17.
communion. With God's grace we are able to respond to this invitation, to say yes and to reciprocate God's love.

Thirdly, this model of love does not simply allow self-love but insists on it. Trinitarian agape takes very literally the command that we are to love others as we love ourselves. The implication here is that, whether by virtue of God's love or of having been created in God's image, we are worthy objects of love -- even of our own love. Like all forms of agape, self-love is to be theocentric, a way of moving towards communion with God. However, self-love is treated as a necessary component of agape, commanded by Jesus. It must be noted, however, that this view of persons as espoused in Trinitarian agape is tempered by the insistence that any human dignity or capability has its source in God.

Finally, the Trinitarian model of agape differs from agape modelled on the Cross in the way it approaches the question: to what extent are we regarded and loved for our own sake? The Cross model attempts to confront the utter sinfulness and powerlessness of persons, and show that we are loved even in this abject state. This is God's completely gracious act. We in turn are commanded to love the neighbour as neighbour, shrinking from no one and attending to whatever needs there may be. This daunting task
is made possible precisely because of God's love that works through us.

There is a tendency in agape modelled on the Trinity to downplay the material needs of persons in favour of their spiritual needs. This preference arises out of a concern for the neighbour's real well-being, which will be achieved only when the neighbour stands in communion with God and humankind. It is the neighbour who is loved, but love of neighbour cannot be divorced from love of God. Proponents of Trinitarian agape would not view this theocentric vision of love and humankind as in any way undermining the dignity or worth of persons. Neighbours are loved for their own sake; they exist in relationship with God who forms them in God's likeness.

Agape Modelled on the Trinity and the Dilemma Posed by the Fetus with Anencephaly

Application

According to the Trinitarian model of agape, God lives in an eternal giving and receiving of love, actively inviting humankind to partake in this communion. In neighbour-love we recognize the divine in the neighbour and we are allowed to recognize it in ourselves. However, we also recognize that we and our neighbour are sinful and imperfect. As creatures our need is to be united to our
Creator and, in loving our neighbour, we hope to help the neighbour journey towards God as this neighbour-love helps us on our own journey.

In the case of the fetus with anencephaly, the Trinitarian model of agape could urge parents and practitioners to recognize the "divine" in a possibly grotesque and vulnerable neighbour. The model could urge them to look beyond the physical deformities of the fetus to see a fellow creature who is also made in God's image and likeness and whose purpose is to be united in love with the Creator and with humankind. This line of reasoning may appear more consistent with agape modelled on the Cross, according to which the fetus is recognized as a neighbour with needs that must be addressed out of duty. To apply Trinitarian agape to the case, several points must be addressed.

First, Trinitarian agape is a love that longs for a response from the beloved so that communion may be achieved. Love need not be returned, of course, but the model is built around mutuality. Can a being whose consciousness is in doubt be a partner in love? In the case of the fetus with anencephaly, whose sentience is questionable, how can communion be achieved?

Second, Trinitarian agape allows the possibility of
self-fulfillment not as a goal in itself but as a result of loving God and neighbour. Again and again, the adjective used to describe the anencephalic pregnancy is "futile." What meaning, if any, can the woman and those who support her find in continuing this pregnancy? How can it lead to any type of self-fulfillment beyond the knowledge that one has done one's duty?

Third, love of self is one of the terms of Trinitarian agape, even in neighbour-love. In light of this, one must necessarily ask whether continuing the pregnancy where the outcome is so clearly doomed can be seen as anything other than a self-sacrificial act on the part of the pregnant woman.

Finally, the fetus itself must be considered. To be a neighbour, it must in some sense be a "self" with interests. Is this the case? Can the anencephalic fetus benefit in any way from the continuation of the pregnancy? The point is worth examining as a way of determining whether agape extended to the fetus will be an instance of unilateral love, or whether it signals the tentative beginnings of communion.

This section raises more questions than it answers. It is included in order to show that, if the pregnancy is to continue as an act of agape in the Trinitarian sense, there
must be the possibility of communion, of reciprocity, and of bringing the various neighbours involved to God. Chapter four will address these points.

The Clinical Setting

While agape modelled on the Cross may provide a straightforward argument supporting continuation of the pregnancy, it is not easily transferred to the clinical setting. The framework's treatment of the self gives little credence to currently important clinical considerations such as the principle of respect for patient autonomy and beneficence.

A more promising match might occur when current health care ethics is paired with agape modelled on the Trinity. Within this theological framework, the self is allowed to have interests, making Trinitarian agape more compatible with the principle of respect for patient autonomy. This love is not egotistical, however, and for those who wonder if patient autonomy ought to have limits, Trinitarian agape may be a welcome corrective, emphasising the communal nature of persons and connection to a transcendent reality.

Trinitarian agape appears to have a more moderate approach to sacrifice than does agape modelled on the Cross.
Sacrifice is neither automatic nor inevitable, nor is it the distinguishing feature of Trinitarian agape, which seeks to form connection and communion between the beloved and the one who loves, drawing all closer to God and one another.

In this respect, agape might have a contribution to make to bioethics generally. Already health care ethics has moved from paternalism, which left decision-making in the hands of experts, to respect for patient autonomy, which insists that patients be active participants in decisions about their own care. Trinitarian agape offers a model of interdependence which may more accurately reflect the human condition and what it requires.

Because it allows for self-regard, agape modelled on the Trinity can accommodate the notion of beneficence; it values actions that contribute to the well-being of persons. Indeed, in its ideal form Trinitarian agape can itself be regarded as beneficent. Both the one who is loved and the one who loves gain in the relationship. Both find satisfaction in agape. Whether this is possible when the beloved is an anencephalic fetus remains to be seen, but beneficence stands as another possible point of intersection between agape modelled on the Trinity and current health care ethics.

Can Trinitarian agape be applied in the clinical
setting? The theological framework emphasises spiritual health over material health, contending that genuine well-being can be achieved only insofar as we live in conscious communion with God. Thus, neighbour-love may be understood to require that neighbours be brought to God before meeting their material needs. It can hardly be expected that such a theocentric attitude would find much sympathy in a secular milieu. The pursuit of transcendent well-being may be less than compelling in the clinical setting which is oriented to finding practical solutions to immediate problems.

**Conclusion: A Working Model of Agape**

In proposing agape as a framework within which to work through the dilemma posed by the fetus with anencephaly, this thesis hopes to work with a point of view that is at once transcendent and concrete; that is, one which can accommodate the challenging and ultimately mysterious components of human life that are conception, suffering and death, and still have application in the clinical setting when the pregnant woman, her partner and the health care team discover that the fetus which she is carrying is anencephalic. Because of the balancing of considerations required for this framework are based on the foregoing examination of Christian love, this thesis will
adopt a slightly modified version of agape modelled on the Trinity to inform the argument supporting continuation of the anencephalic pregnancy.

As in both types of agape, it is a love that is theocentric, finding its centre in God who is the source of love and who commands us to love. It is a love that must be extended to everyone without hesitation. Unlike agape modelled on the Cross, it comprises three terms: love of God, love of neighbour, and love of self. Its aim is communion. Ultimately the three terms are interconnected as humankind seeks reunion with God and each other. While it is not dependent upon reciprocity, it is a love which seeks response. It is a love which seeks to transform both the beloved and the lover without reducing one to the other. Its model is the Blessed Trinity, in which three Persons exist in perfect communion, united in love yet separate as Persons, engaged in a constant giving and receiving of love.

While it acknowledges the complete transcendence of God, it nevertheless recognizes the connection that exists between Creator and creature. Created out of love, we are made in God's image and likeness. Ultimately our end is to be united to our Creator. We are tainted by sin. Nevertheless God graciously loves us; by God's grace we respond in love, turning our hearts towards God and
neighbour. By this same grace we may love ourselves, ever aware of the divine component of this love, cherishing ourselves without taking any credit for our worth. This self-love, like neighbour-love, is a response of gratitude and wonder at God's love.

As interconnected as the three terms of agape are, there is a need to protect the integrity of the persons loved. In this respect, agape modelled on the Cross may be helpful, insisting that in neighbour-love it is the neighbour who is loved. Agape is not to be collapsed into love of God when the neighbour proves difficult to love. Further, this love is to be expressed in action, concretely meeting the needs of the neighbour as they are presented. This emphasis on attending to material as well as spiritual needs of the neighbour is an important component of agape modelled on the Cross and not incompatible with Trinitarian agape. We have, after all, the model of Jesus, who healed the sick, fed the hungry and provided wine for a wedding feast.

If this synthesised vision of agape has theological soundness, there nevertheless remains the issue of application to the dilemma posed by the fetus with anencephaly. As discussed earlier, there are several unanswered questions, two of which are pivotal. The first is
whether, in this tragic situation, communion is even remotely possible. Can the fetus, so physically compromised, be a real partner? What satisfaction, if any, can the pregnant woman find in this relationship?

The second question is whether (and, if so, how) continuing the anencephalic pregnancy can be viewed as an act of agape. Is there any point in continuing a pregnancy whose outcome is so clearly doomed? Because Trinitarian agape presupposes interconnection, the question must be posed in light of the fetus, the pregnant woman (and her partner) and the larger community.

Answering these questions will be the task of chapter four.
CHAPTER FOUR

TOWARDS AN UNDERSTANDING OF PREGNANCY IN WHICH THE FETUS IS DISCOVERED TO BE ANENCEPHALIC

Introduction

Thus far this thesis has outlined the dilemma posed by the fetus with anencephaly, examined arguments both in favour of and opposed to termination of the pregnancy, and offered an understanding of agape to be used as a theological viewpoint for reviewing the dilemma. This chapter will undertake the task of putting forward the argument that continuing the pregnancy in which the fetus is discovered to be anencephalic may be seen as an act of agape according to the Trinitarian model.

The previous chapter identified two particular challenges in the application of this understanding of agape to the anencephalic pregnancy. First, there is a need to find meaning in this pregnancy which is so often described as futile in order to determine whether its continuation can serve the fetus and the pregnant woman. There is also the question of whether a love that seeks communion is possible
when the fetus is anencephalic. Chapter four will attempt to answer these questions.

It will begin by exploring the meanings attached to pregnancy. The chapter will show that the authors examined in chapter two tended to view pregnancy as a means to an end. Drawing on the work of researchers in the area of prenatal attachment, this chapter will show that pregnancy is an active life state for the pregnant woman.

This chapter will explore the phenomenon of prenatal attachment, examining factors which influence it and observing that prospective fathers as well as expectant mothers experience attachment to the fetus. Noting that postnatal attachment appears to be a separate process, the chapter will come to an understanding of pregnancy in light of prenatal attachment.

Chapter four will then utilize the work of researchers in fetal psychology to show that pregnancy is also a dynamic state of life for the fetus. Using the fetus' development of auditory capacity as an example, the chapter will show how the constant exchange between the fetus and uterine environment makes pregnancy an active time for the fetus and lays the foundations for behaviours and capacities in postnatal life. Thus the chapter will offer an understanding of pregnancy, viewing it not as a means to an
end but as having value in itself as a life state for both the fetus and the pregnant woman.

Next, the chapter will consider whether the pregnancy can have value when the fetus is anencephalic. This section of the chapter will begin with an examination of the behaviours and capabilities of the infant who is anencephalic. Using the work of D. Alan Shewmon to offer an explanation for the observations of researchers, the chapter will suggest that the apparent similarities in behaviour between anencephalic and non-anencephalic neonates may be explained by brain-stem function and the possibility of neuroplasticity. Extrapolating from this understanding of the anencephalic infant and accepting the earlier hypothesis that infant capabilities have their origins in the prenatal period, the suggestion will be made that the fetus with anencephaly may have a richer prenatal experience than previously imagined. By exploring the theory that anencephaly is a degenerative condition the chapter will show that there may even have been a time when the afflicted fetus was almost "normal." However, anencephaly is a fatal condition and death is a part of this young life. The argument will be made that pregnancy can be understood as a valuable life state for the fetus with anencephaly.

The chapter will conclude by showing how continuing
the pregnancy in this case could be regarded as a loving act consistent with the Trinitarian model of agape.

Towards an Understanding of Pregnancy

Meanings Attached to Pregnancy

According to the American Medical Association's Encyclopedia of Medicine, pregnancy is "the period from conception until birth." Dorland's Illustrated Medical Dictionary defines it as "the condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon."

While it may be simple enough to describe the biological or physiological facts of pregnancy, there nevertheless remains the more complex problem of coming to an understanding of the meanings we attach to pregnancy. On one level, pregnancy may be viewed as a process necessary to bring another human life into the world. The changes that occur in a woman's body are meant to sustain this life and, when the time comes, usher it into the world. This purely biological understanding which treats pregnancy as a means to an end can have the effect of similarly reducing the


pregnant woman. Simone de Beauvoir provides a graphic
description of this reduction:

Ensnared by nature, the pregnant woman is plant
and animal, a stock-pile of colloids, an
incubator, an egg; she scares children proud of
their young, straight bodies and makes young
people titter contemptuously because she is a
human being, a conscious and free individual, who
has become life's passive instrument.3

Shulamith Firestone is more succinct: "pregnancy is the
temporary deformation of the body of the individual for the
sake of the species."

According to this view, the woman herself becomes an
object, surrendered completely to the fetus that exists
within her. This can have the result of placing the fetus
and woman in an adversarial position. Furthermore, it is a
perception not always consonant with women's experience of
pregnancy, especially of a hoped-for pregnancy. As nursing
researcher Patricia A. King writes:

In my experience, a woman who wants to have a
child sees herself involved in a relationship with
the fetus -- a relationship that is not
adversarial or antagonistic. The fetus is both a
part of a woman's body and a separate, distinct
entity that may suffer injury not suffered by the
woman. A woman's experience of pregnancy is thus

3Simone de Beauvoir, The Second Sex, translated and
edited by H.M. Parshley (New York: Alfred A. Knopf, 1968),
494.

4Shulamith Firestone, The Dialectic of Sex. The Case
complex, informed with multiple meanings, not fully captured by the language that emphasises separateness and rights.  

Sheila Kitzinger, a childbirth educator, places pregnancy within a social framework:

Birth is a keypoint in the social system. When a baby is expected the pregnant woman is one of the major protagonists in a process of social integration which unites previously disparate elements and reinforces weak links in the chain of interaction. The bringing of a child to life is not just a personal, private act but one which actively promotes social cohesion.  

On a more intimate level, she observes the power that pregnancy has to establish a connection between women, especially intergenerationally:

Pregnancy links the generations as the expectant mother starts to relive through her body an experience which is universal and shared by most women, and the older woman lives through the recollected emotions of childbearing.

On a more existential level, Vangie Bergum suggests that it is possible to think of pregnancy "as the unique, the original, the profoundly significant experience for gaining

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\footnote{Sheila Kitzinger, \textit{Women as Mothers} (New York: Vintage Books, 1978), 81.}

\footnote{Ibid., 80.}
understanding of our human origins."³

Pregnancy as a Means to an End

In chapter two of this thesis, authors making the case both for and against termination of the anencephalic pregnancy shared a particular understanding of the "period from conception to birth." A brief review is in order.

Their view is that pregnancy has a purpose, that is, to result in the birth of a viable infant.⁹ In that respect, pregnancy is a time of fetal physiological development with the womb providing the environment and nourishment necessary for that development. Indeed, it is common for authors on both sides of the debate to liken the pregnant woman to a life-support system with her body at the service of the developing entity, supplying the fetus with the material necessities of life.¹⁰ Little is said about what the pregnancy might mean to the woman: the changes in her body and to her identity brought about by the pregnancy. For all of the authors, pregnancy is very much fetus-centred.

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⁹See, for instance, O'Rourke and deBlois, 48, 49; Daniel, 69; Drane, 109.

¹⁰Drane, 111; Daniel, 69; Walsh and McQueen, 359; Beller, 258.
Furthermore, it is a state that has no intrinsic worth: it is a means to an end. Authors arguing for termination of the pregnancy believe that the chance of the end being jeopardized -- that is, the chance of a less-than-perfect baby being born -- calls the value of the pregnancy itself into question.

Authors arguing against termination are loathe to call the pregnancy futile because they believe that the life it sustains is valuable.\(^1\) It does not matter whether the fetus will survive until birth; what is important is that the fetus is alive now and deserves to have its life maintained. For these authors, too, pregnancy has no intrinsic worth. It is valuable insofar as it serves fetal life. The pregnant woman is a life-support system, valued as the supplier of life's necessities to the fetus.\(^2\) Once again, the value of the fetus will determine the value of the pregnancy.

Is this the only way to view pregnancy? Turning to the works of Reva Rubin, Mecca S. Craney, Ramona T. Mercer, M. Colleen Stainton\(^3\) and other researchers in the area of

\(^{1}\)Cataldo, 3; O'Rourke, 57.

\(^{2}\)Cataldo, 3.

prenatal attachment, this thesis will argue that pregnancy itself has value. It is during pregnancy that the relationship develops between the woman and the fetus and, through the mediation of the woman, between the fetus and the larger world.

Reva Rubin and the Tasks of Pregnancy

In 1975 Reva Rubin published "Maternal Tasks in Pregnancy," which would become a seminal work for those trying to understand the developmental work of pregnancy and prenatal attachment in particular. In response to those who see pregnancy solely as a physiological phenomenon, Rubin writes:

Pregnancy is more than a period of gestation, growth, and development of the fetus. Pregnancy involves more than anatomical growth, development, and displacement and the physiological adaptations for accommodation and nurturance of the growing fetus. Pregnancy is also a period of identity reformulation, a period of reordering interpersonal relationships and interpersonal space, a period of personality maturation.\textsuperscript{14}

Among the changes that occur in the pregnant woman is a heightened "sensory perceptivity, particularly in the tactile and kinesthetic modalities." The woman becomes aware of the changes in her body and of the fetus within her, which leads to what Rubin calls a "'turning inwards,'" which has ramifications.\textsuperscript{15} The pregnant woman now engages in the work of becoming a mother. This involves the practical work of preparing for and providing for the baby, but it also includes attending to the relationships that must be built or altered and the identities to be worked out. Rubin identifies four major tasks of the prenatal period for the woman:

1. seeking safe passage for herself and her child through pregnancy, labor, and delivery;
2. ensuring the acceptance of the child she bears by significant persons in her family;
3. binding-in to her unknown child; and
4. learning to give of herself.\textsuperscript{16}

\textsuperscript{14} Rubin, "Tasks," 143.
\textsuperscript{15} Ibid.
\textsuperscript{16} Ibid., 145.
Elaborating on these tasks, Rubin notes that in the first trimester, the woman may concentrate on her own safety, making sure that she is pregnant rather than suffering from illness. By the second trimester, her pregnancy may be obvious to others; she, however, is now concerned with the fetus and will undertake behaviours meant to protect and sustain it. Prenatal care, for instance, is directed towards the fetus' welfare. In the third trimester, the woman is concerned with both fetal and maternal well-being, which now seem to be intertwined.  

The second task, having her child accepted by those close to her, will be important to the course of the pregnancy. As Rubin puts it: "security in acceptance is a condition necessary to produce and sustain the energy for all other tasks." The pregnant woman involves herself in finding a physical and psycho-social place for her child. There is risk involved here. By the third trimester, this woman who has invested so much in this baby may herself feel vulnerable to rejection if this baby is not accepted. Much of this vulnerability stems from the emotional ties the woman has to the fetus. Rubin identifies pregnancy as a time  

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17 Ibid., 145-146.

18 Ibid., 147.
when the woman binds-in to the fetus. She rejects the notion that attachment between mother and child begins with birth:

The bond between a mother and her child that is so apparent immediately after the birth of her child is developed and structured during pregnancy. At birth there is already a sense of knowing the child, within the limitations of not having had perceptions through the usual sensory modalities. At birth there is already a sense of shared experiences, shared history, and shared time on an intimate and exclusive plane. There is a sense of 'We-ness,' a sense of 'I-and-you.'

Rubin sees little evidence of the binding-in process in the first trimester when attention is focussed on the pregnancy (rather than the fetus) and incorporating its reality. With the second trimester and quickening the process of binding-in accelerates. While the fetus may be hidden from the rest of the world, "kinesthetically and tactiley, the pregnant woman is very much aware of the real presence and activity of the living being within her." The second trimester is often viewed as a marvellous stage of pregnancy and Rubin observes that as the woman becomes more content with herself during pregnancy, she becomes more content with the fetus. "The child's value and worth becomes [sic] increasingly meaningful, and a possessive love

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19 Ibid., 149.

20 Ibid., 150. This article was written in 1975, before ultrasound became a common feature of prenatal care.
generates." In the third trimester there is more ambiguity. While the woman may love the child, she no longer wants to be pregnant. Because the end of pregnancy means enduring labour and delivery, it can be a time of some anxiety.  

According to Rubin, the pregnant woman must also come to terms with the task of giving of herself. In the first trimester, much time is spent trying to understand what the pregnancy and child will mean to her, and to anticipate what they will need from her. By the third trimester, it becomes apparent that the woman must herself be a recipient of care and support if she is going to be able to give. It is at this time that support from those close to her is so important.

In conclusion, Rubin contends that these four tasks, all integral parts of pregnancy, continue to require attention after birth as the mother concerns herself with the safety and acceptance of her child, developing a relationship with that child, and continuing to give of herself.

Clearly there are shortcomings in Rubin's work.

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21 Ibid.

22 Ibid., 152.
Written in 1975, it does not address the impact that prenatal diagnostic techniques have had on pregnancy. Her observations may not reflect the attitudes or tasks a woman undertakes in an unwanted pregnancy. However, because this thesis is concerned with selective abortion rather than elective termination of pregnancy, there is the assumption that the pregnancy is "wanted" and so her remarks may have some relevance.

Rubin's piece has been very influential, spawning an interest not only in pregnancy as a time of dynamic processes rather than passive waiting, but particularly in the development of prenatal attachment.

Maternal Prenatal Attachment

In the early 1970's, researchers Marshall Klaus and John Kennell concluded that the period immediately following birth was a crucial time for mother-child bonding. Their observations influenced post-natal care. However, other researchers were finding that "women described interaction and communication with their unborn children. They ascribed individual characteristics to them and reported feelings of

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Women (and their partners) talked to their unborn babies, stroked them and had special names for them. They formed an affective attachment to their babies before birth.

In her 1981 article exploring this phenomenon, Mecca S. Cranley defines prenatal attachment as "the extent to which women engage in behaviors that represent an affiliation and interaction with their unborn child." Similarly, Ramona T. Mercer states that maternal attachment is "a developmental process beginning during pregnancy and continuing over the months following the birth in which the mother forms an enduring affection for and commitment to the child." According to Virginia Kemp and Cecilia Page, "Developmental theorists agree that attachment to the fetus during pregnancy is one of the critical developmental tasks for the pregnant woman." In other words, researchers found that the pregnant woman not only prepares for the baby who will be born but also becomes attached to the fetus she carries.

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24 Cranley, "Origins," 41.
26 Mercer, Becoming, 130.
Hoping to understand what factors might influence prenatal bonding, Carolyn W. Lerum and Geri LoBiondo-Wood note that "not all women develop positive feelings about the fetus or come to terms with pregnancy and mothering demands, and the result is said to be poor maternal role attainment. . . ." The authors do not mean to cast doubt upon the existence of the phenomenon, but merely to observe that not everyone manages to engage in a relationship with the fetus, or the infant for that matter:

it is important to note that a body of data gathered on pregnant women strongly suggests that attachment begins before birth. This attachment can be documented early in pregnancy and continues throughout pregnancy, and it changes significantly after quickening.38

Lerum and LoBiondo-Wood feel that it is important to learn more about this phenomenon in order to understand what women might be experiencing when they lose a baby or miscarry.

In her 1990 study of parental perceptions of the fetus, M. Colleen Stainton discovered that parents had a great deal to say about the unborn baby. She observes that expectant parents often talked to the fetus (and rarely


39 Ibid, 16.
referred to it as a fetus) and devised an image or idea of the fetus' personality based on its activity. Parents had a sense of the fetus as an entity in itself, particularly after quickening, and some of the parents thought of the fetus as an active participant in the parental-fetal relationship. Stainton observes that "complex interactive and sensory data about unborn infants are acquired by expectant parents, as revealed in these descriptions during the third trimester of pregnancy."37 She concludes that:

parents' development of sensitivity to the infant begins prenatally, is a part of the parent-to-infant attachment, and that a range of parental responses falls within the boundaries of healthy prenatal attachment.38

Her concern is that the parents' own experience of the fetus is overlooked in prenatal care and replaced by more "objective" data gathered through medical or technological intervention.

This experience of getting to know the fetus is very much a part of pregnancy, according to Margarete Sandelowski and Beth Perry Black.39 It is a challenging task. While

30 Stainton, "Parents'," 95.

31 Ibid., 96.

there is evidence of its existence, the fetus is not visible except through technological intervention. As well, just as the fetus undergoes tremendous changes as it grows and develops in the womb, so the parents' perceptions of it are constantly changing. The authors find that the prospective parents often oscillated between imagining the baby they were going to have, the baby actually in the womb and the baby they would give birth to. Interestingly, many couples found that the child they had come to know in the womb was very different from their newborn baby.33

For Mercer, parents' interest in knowing the fetus is evidence of attachment.34 Stainton, too, sees acquaintance as intimately linked to attachment:

it is precisely getting to know the infant as a separate person during pregancy that engages parents into an involved, committed, concerned relationship loaded with emotion. . . . This interaction from which knowledge emerges generates delight, anxiety, fear, carefulness, watchfulness, stress, and, under some conditions, loss, bereavement, and depression.35

33 Ibid., 604-605.
34 Mercer, "Commentary," 617.
35 Stainton, "Commentary," 618.
Factors Influencing Prenatal Attachment

What factors influence the attachment process? In testing her Maternal-Fetal Attachment Scale, Cranley found that attachment was not linked to demographic factors such as maternal age, education or economic status. This finding is also supported by Jeanne T. Grace, and others. The authors conclude that prenatal attachment is very much a part of the pregnancy itself, a developmental task quite independent of these factors. It is a phenomenon that appears to increase in intensity as the pregnancy goes on. Quickening -- actually feeling the fetus' movements -- is a significant event in the process.

Whether quickening facilitates attachment or attachment hastens quickening is a moot point. In their 1989 study, Heidrich and Cranley suggest that women already experiencing feelings of attachment may be particularly

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36 Cranley, "Development," 284.


sensitive to fetal movement; indeed, they may be looking for it. Women not committed to the pregnancy or the fetus may feel movement later in the pregnancy." Heidrich and Cranely found that women planning to have amniocentesis felt fetal movement later in the pregnancy than did their counterparts not planning to have the test. Once the test results were known (there were no "abnormal" results for this particular group) the attachment levels were similar to those of women who had not undergone the test. The authors conclude that "women may withhold investment in the pregnancy and the child until a good result is known." Barbara Katz Rothman calls this phenomenon the "tentative pregnancy." Ultrasound was not found to aid maternal-fetal attachment. Although Lerum and LoBiondo-Wood discovered that ultrasonographic images have a positive effect on attachment in their own study, they note that other studies do not support their findings. Their opinion is that, depending on the stage of gestation, very different images will be on the

40 Heidrich and Cranley, 83-84.
41 Ibid.; see also Cranley, "Origins," 44.
screen and may elicit very different responses. Heidrich and Cranley did not find ultrasonography to be a significant factor for maternal-fetal attachment.

The risk status of the pregnancy seems not to be a factor in the process of attachment. In an attempt to discover more about prenatal attachment, Mercer et. al. included a high-risk group of pregnant women in their 1988 study. They found that parents (both partners) in the low-risk group had very usual concerns about the birth process and speculated about what the baby would be like. However, "as expected, more parents in the high-risk groups expressed concern and anxiety about the coming infant." The authors find this attitude quite reasonable under the circumstances and indicative of attachment, concluding that the risk status of the pregnancy does not interfere with the process of attachment for either parent.

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43 Lerum and LoBiondo-Wood, 16.

44 Heidrich and Cranley, 83.

45 According to Kemp and Page, "High-risk is a label applied to a pregnancy in which a significant possibility of fetal demise, fetal anomaly, life-threatening illness to the newborn, or serious health risks for the expectant mother exist" (Kemp and Page, 180).

46 Mercer and others, "Further," 88.

47 This finding is also supported by Kemp and Page in their 1987 study. See Kemp and Page, 182.
There may, in fact, be instances when a high-risk pregnancy appears to lead to greater attachment. Mercer et al. found that in low-risk groups the existence of young siblings may interfere with or delay attachment, but this was not the case in high-risk pregnancies. The authors speculate on the reasons for the difference:

Perhaps when there is a real threat to the life of the coming infant, and the family is giving of themselves to the highest extent, feelings about the vulnerable infant are unaffected by the presence of other children."

In the high-risk pregnancy, fetal welfare may overshadow factors that might otherwise diminish attachment.

The research of Stainton, McNeil and Harvey supports Rubin's understanding of pregnancy as a time of achieving particular tasks, even in high-risk pregnancies. Through a series of interviews, they found that while every pregnancy means preparing for the unknown, "uncertainty" is the predominant trait of the high-risk pregnancy and it affects the tasks undertaken. The authors note that women who have lost babies in previous pregnancies may attempt to stave off binding-in as a way of protecting themselves, but this becomes more difficult to do as the pregnancy progresses.

After quickening, "The now viable infant draws the reluctant

"Mercer and others, "Further," 92."
mother into a relationship." While it is beyond the scope of this thesis to evaluate the studies cited or to comment on the factors that may influence prenatal attachment, it is important to note that underlying these studies is the understanding that the phenomenon of prenatal attachment exists.

Prenatal Paternal Attachment

Attachment is not merely a maternal task of pregnancy; studies show that prospective fathers also form a relationship with the fetus during pregnancy. In this the man is very much dependent upon the woman to provide access to the fetus. She does this by allowing him to feel the fetus' movement, describing sensations, involving him in prenatal care and so on. The woman acts as the mediator in the relationship between the father and unborn baby.

The father's awareness of the fetus will necessarily be different from the woman's actual experience.

49 Stainton, McNeil, and Harvey, 120.


51 Stainton, "Parents'," 94.
As Sandelowski and Black put it: "his knowledge of the fetus is disembodied and, therefore, more disconnected and abstracted that hers." Although ultrasonography provides a measure of hard evidence, for most fathers the baby will be truly real when he has first-hand, unmediated knowledge at birth. Until then, "father's sensory access to the unborn infant is limited due to obvious physiologic reasons, and is often dependent on maternal permission."

Despite these difficulties, pregnancy can be an important time for men:

A man's experience of pregnancy is not triggered by hormonal or bodily changes, but his personal and social transformation may be as great as his partner's. To become a father for the first, second, or fifth time requires a total reorientation of the meaning of his life. Men need the nine months of gestation to help forge their new identity.

Part of coming to terms with the reality of fatherhood is coming to terms with the reality of the child, a task that begins prenatally. According to Jordan, it means understanding the pregnancy for what it is (the pregnant woman is not ill or simply putting on weight), and then

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52 Sandelowski and Black, 607.
53 Jordan, 13.
54 Stainton, "Parents'," 94.
55 Colman and Colman, 134.
coming to a knowledge and acceptance of the existence of the fetus. For this latter task, feeling the fetus move and seeing its image on the ultrasound screen can be extremely helpful. Jordan notes that prospective fathers participate in attachment behaviour, giving the fetus a pet name and talking to it. Men also undertake "nesting tasks," preparing the baby's room and putting the crib together.\textsuperscript{55} The pregnant partner is instrumental in helping the expectant father to form a relationship with the fetus. Working to ensure acceptance of the fetus by significant others is one of the developmental tasks identified by Rubin.

Prenatal and Postnatal Attachment

Interestingly, there seems to be little connection between prenatal and postnatal attachment. In testing her Maternal-Fetal Attachment Scale, Cranley found that it was not at all clear that a woman's attachment to her fetus is an indication of her subsequent attachment to her infant.\textsuperscript{56} Rejecting the idea that there might be discontinuity between the woman's antenatal and postnatal attachment to her infant, Cranley attempts to explain the discrepancy by

\textsuperscript{55} Jordan, 13-14.

\textsuperscript{56} Cranley, "Development," 283. See also Cranley, "Roots," 68.
citing the differences in the scales used to measure the two
types of attachment. However, later studies could find
little continuity between pre- and postnatal attachment
either. In her longitudinal study, Grace found that prenatal
attachment does not predict or develop into postnatal
attachment. Researching the parental task of getting to
know the fetus, Sandelowski and Black found that many of the
study couples discovered:

either prospectively (as they moved through
pregnancy) or retrospectively (after the birth of
their babies) that the evolving being with whom
they were acquainted in pregnancy was not the same
being they were getting to know after birth.

In her 1991 review of prenatal attachment, Cranley also
concluded that, while people might like to think of
postnatal attachment as flowing unobstructed from prenatal
attachment, studies have failed to show continuity between
them.

Prenatal Attachment and the
Meaning of Pregnancy

For the woman, pregnancy -- especially a wanted

\[58\] Cranley, "Development," 284.

\[59\] Grace, 231.

\[60\] Sandelowski and Black, 605.

\[61\] Cranley, "Origins," 44.
pregnancy -- is not simply a time of physical change. It can be a time of re-ordering identities, hers and perhaps her partner's, a time to prepare for the birth, and a time to get to know and become attached to the fetus who is growing and developing within her body. The fetus itself -- and not simply the baby who will be born -- can have significance in its own right. Very often parents bestow on it a name that will be discarded at birth, and treat it as having a particular personality or temperament conveyed by its movements. This perception may not last beyond the birth of the baby. It is specific to the fetus. Birth may mean coming to know the entity in its new life state as the attachment process continues.

For the woman and her partner, pregnancy can be a time of expectation and anticipation, a time of planning and dreaming about the baby who is coming, and about the changes that will occur to their identities and to their lives. But it is also a state that is lived in the present. Pregnancy is not a time of suspension, of holding one's breath until "real" life begins again; it possesses an identity of its own and experiences unique to it. It exists within fairly strict temporal limits but it is no more time "away" from reality than the undergraduate years at university (another time of expectation and forward planning). Wearing maternity
clothes, engaging in prenatal care and behaviours aimed at the well-being of herself and her unborn baby, a pregnant woman is recognized as living in a particular state of life. When a miscarriage occurs, it signals the end not only to a dream of parenthood, but also to this particular pregnancy, which itself is cause for grieving.\textsuperscript{62} To see pregnancy merely as a means to an end is to overlook the richness and meaning of the state itself.

The Fetus and Pregnancy

Researchers in fetal psychology view pregnancy as a very active time for the fetus, a point of view which may contradict conventional wisdom. As William P. Smotherman and Scott R. Robinson note, there is a pervasive view which:

\begin{quote}
    depicts the fetus as a passive agent that grows in an unchanging world buffered from environmental stimuli . . . . Only at the time of birth is the fetus transformed into an active and interactive organism.\textsuperscript{63}
\end{quote}

That the fetus would be an active agent developing and


responding to stimuli says a great deal not only about the fetus but about the uterine environment.

Peter G. Hepper contends that the womb is not a sensory deprivation tank:

Research in recent years has clearly indicated that the fetus does not live in a featureless, stimulus-free, unchanging environment, but is exposed to a diverse and changing array of stimuli, which will stimulate most, if not all, of the fetal sensory modalities from early in pregnancy.  

The fetus does not spend pregnancy in suspended animation, waiting for birth, but lives actively in the mother's womb, the environment precisely suited to its development. As Hofer puts it: "the intrauterine environment not only provides protection and constant supportive conditions, but also contributes specific regulators of the fetus' vital functions." The mother provides within her body a place and the stimuli which allow the fetus to develop.

The importance of stimuli to fetal development must not be underestimated. While it may seem only logical that a


system of nerves and muscles should precede behaviour, in fact, in the case of the fetus, activity leads to both neurological and muscular development:

The developmental processes that are responsible for the creation of the neuromuscular system do not first build the structure and later set it in motion shortly before birth. Rather, the neural elements start to function very early and that activity plays numerous critical roles in determining the specific nature of the structures that subsequently develop, even in organs outside the nervous system itself. 66

The interaction between the pregnant woman and fetus is vital to this development.

Researchers have long recognized the physiological exchanges that occur between the fetus and pregnant woman. The woman has a great deal of influence over the physiological development of the fetus. If this were her only role and were the fetus a stable and unchanging entity, then the view that compares the pregnant woman to a life-support system might be adequate. However, there is more to the maternal-fetal exchange than physiology. The fetus' auditory capacity and the stimuli provided by the mother is a case in point.

It has long been known that the fetus responds to sound by the second trimester and possibly even in the first

66 Hofer, 9; see also Hepper, 145.
months of life. The fetus can "hear." Fifer and Moon point out in their study of the auditory capability of the fetus that the fetus lives in an environment filled with sound. There are the noises of the mother's body as well as external sounds. Most prominent is the sound of the mother's voice, which is different in pitch and rhythm from other voices, and involves the movement of the diaphragm. The maternal voice is not merely heard, it is experienced; and the fetus carries that experience into the postnatal period. This has broad implications for an understanding of both prenatal and postnatal life.

Researchers have observed the infant's preference for its mother's voice. William P. Fifer and Christine Moon cite studies which indicate that newborns prefer female voices over silence and the voice of the mother over other female voices. The newborns' ultimate preference is for the sound of the mother's voice muffled, as it would have been experienced in utero. These findings suggest that the recognition of and preference for the maternal voice begin prenatally. While this may be evidence of the fetus'

67 Hepper, 137.

ability to learn, this exchange between fetus and mother makes other development possible.

Annette Karmiloff-Smith notes that the basis for learning language begins in the prenatal period. Not only is the fetus able to make the distinction "between music, language and other sounds . . . ." it is exposed to the rhythms and sounds of vocal communication. This exposure to the cadences of speech will aid the infant in its own language development.

Rhythms and sounds of speech also convey information about the speaker. By attending to these aspects of speech, the listener learns something about how the speaker may be feeling, which raises the possibility of making emotional connections with the speaker. This may happen prenatally:

A fetal disposition to attend to the prosodic elements of speech could also serve the function of providing the newborn with the basis for acquisition of information about caretaker emotional state. Pitch, stress, rhythm and intonation are carriers of cues to emotional state. Empathy, an integral component of emotion,

69 Ibid., 182; see also Hepper, 140-143

70 Stainton "Commentary," 619; Hepper, 144.


72 Hepper, 146; Karmiloff-Smith, 1295.
may be present at birth, and attention to prosody may be an important cue for infants in the earliest stages of emotional development..." 

The auditory stimuli provided prenatally by the mother's voice lays the foundations for learning language and making emotional connections. These connections may in turn be important aids in the attachment that occurs between the newborn baby and its mother, an attachment necessary for the infant's survival and later development of social relationships."

Researchers are finding that the neonate is far from a helpless and passive being but is indeed capable. This discovery emerged as research stopped measuring the infant against standards of behaviour set by children or adults and instead began to appreciate the infant's own capabilities:

We now know that human babies are sentient beings who are aware of their surroundings, can learn within hours of birth, and are responsive to their environment at sensory, behavioral, and psychological levels."

71 Fifer and Moon, 179.

74 Hepper, 147.


76 Krasnegor and Lecanuet, 3.
Within their own limits, neonates are active participants in the parent-child relationship. According to Krasnegor and Lecanuet, "research has convincingly documented that newborn human babies are capable of adaptation, of identifying caregivers, and of eliciting behavior from them." Within their own limits neonates actively engage in attachment.

Clearly the complex abilities of the newborn do not emerge spontaneously with the birth of the baby. Researchers believe that they have their origins in the prenatal period. This may be true of emotions as well as of physical capabilities:

emotional experiences are likely to begin prior to birth. The early preference for the sound of the mother's voice may be evidence for this. Further support of the notion lies in the observation that emotional responses originate in phylogenetically and ontogenetically older parts of the brain ... structures which are relatively more developed in the third trimester fetus than sites for cognitive processing."

Stainton agrees that the fetus "is an integral part of the prebirth experience of relating.":

While not going as far as to state that the fetus engages in attachment, Hepper believes that it may be the

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Ibid., 3-4.

Fifer and Moon, 182.

Stainton, "Commentary," 619.
case that the infant's attachment is "primed before birth." He concludes in this way:

Much work is still to be done, but there can be no doubt that the neonate arrives in the world with a behavioural repertoire that is structured, shaped, and refined by its experiences of the preceding nine months, which forms the foundation for the development of the individual's future abilities.

Conclusion: Towards an Understanding of Pregnancy

There is a tendency to treat pregnancy as lacking meaning in itself, as waiting for real life to begin (in the case of the fetus) or to resume (in the case of the pregnant woman). In fact pregnancy can be understood as a dynamic life stage for both the pregnant woman and the fetus. It is a time of tremendous physiological and emotional change and development for both parties. As a life stage, it can be seen to have worth in itself as it prepares the groundwork for future life stages. This latter point does not reduce pregnancy to a means to an end. Every moment of every day is both preparation for future moments and an end in itself.

Every stage of life is both preparation for future stages and an end in itself. Pregnancy, the experience of a

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80 Hepper, 147.
81 Ibid., 149.
woman and an unseen entity, is no different. It is true that it is a time during which the woman and fetus prepare for a very different life after birth; however, pregnancy itself is a time of intimate human relationship, perhaps the most intimate of human relationships. Rothman describes it this way:

"[Pregnancy] is an experience of attachment and separation, both more total than is possible in any other relationship. It is an attachment so complete that it can only be torn apart in blood and pain."

Pregnancy can be understood to be a community of two separate lives, intimately connected, experiencing continuous physiological exchange, coming to know each other and knitting together an emotional attachment one to the other. In pregnancy, there is no time when these two beings are not together. In one sense, they are a world unto themselves, experiencing a relationship that others can know only vicariously. On the other hand, the community which they are is part of a larger social network of family and friends, colleagues and employers, health care professionals and neighbours. Through the mediation of the woman, the fetus becomes a part of this community, as an expected child or grandchild, a neighbour-to-be, a new patient, an additional dependent. As the woman carries the fetus, she

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82 Rothman, *Tentative*, 111.
reveals the pregnancy, allows people to comment on it, seeks their acceptance of her in her pregnant state and permits those close to her to feel the baby and get to know it. She allows others to care for her and the fetus and involves them in making preparations for the child to be born.

Before birth, while the fetus is part of this intimate community of two, it becomes part of the larger world. It learns something of the world around it, hearing sounds and sensing light through the abdominal wall, learning the rhythms of the day through the woman's wake-sleep cycle, and being exposed to the affective side of life through the biochemical responses elicited by the woman's emotional changes. All the while, the fetus remains physically contained within and attached to the woman who nourishes it and cares for it. Pregnancy may be portrayed as "the quintessential female experience." It would also be accurate to describe it as one of the most universal human experiences: all human beings have been fetuses: All human beings have belonged to this most intimate community before their entry into the larger community.

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83 Ibid.
Rothman notes the difficulty in describing the relationship adequately:

In the experience of pregnancy two beings both are, and are not, one. That is an obvious reality, but it is one we continuously deny as first we speak of them as a unit, and then speak of them as separate. The uniqueness of the pregnancy relation eludes our ability to define. We have to learn to see, to express, attachment and separation at once."

To be one and not one, to be attached and separate simultaneously, may seem incomprehensible in a binary world of either/or, and yet this relationship is familiar to Christians. It is the mystery that lies at the centre of the Christian understanding of the Trinitarian Godhead. In the Trinity, the unity is absolute, the community so complete that even as there are three Persons, there is one God. Within the community of Persons there is perfect unity of wills and an eternal exchange of love. The Christian mind marvels at this mystery and yet, in a very pale and imperfect form, it is lived every day in this world.

Made in God's image and likeness, human beings are individuals who live in community. In this fallen world, pregnancy is the prototype and first experience of this mystery. Here, two individuals exist in the most intimate physical relationship that is humanly possible. Here, the

\[85\] Rothman, *Tentative*, 112.
seeds of attachment take root as the woman comes to know her fetus as it is in the womb, unseen but experienced by her in a way that no one else can experience it. The fetus comes to experience this woman in a way that may be unknowable to the woman herself. Here, the community of two becomes a part of a larger community as a unit and as separate individuals.

The woman approaches her familiar community in an unfamiliar state. She is pregnant and seeks acceptance of herself in the pregnancy. It is not without risk that she shares her news with those close to her and then more publicly as she reveals her pregnant state. For its part, the community is changed by her pregnancy. A man becomes an expectant father, parents become expectant grandparents, health care professionals assume the care of a new patient, and so on. Even if the baby is not born, the woman and those close to her are changed by the pregnancy, by the existence of the fetus.

In a vicarious way, the fetus comes to know something of this community, hearing a medley of noises and voices, feeling the unseen hands of a practitioner palpating the uterus, moving towards a needle probing for amniotic fluid. But it is the immediate community that is most important to the fetus. It is its mother's voice that it will remember, its mother's odor that it will seek out, its
mother's heartbeat that will soothe it once the fetus leaves the womb and is born. Even if the baby is not born, it will have had this relationship; it will have been a part of this very intimate community.

Pregnancy, then, can be understood as a life stage lasting approximately nine months. It is both preparation for postnatal life (for both the woman and the fetus and the community of which they are a part) and a stage in itself. During those nine months, both the woman and the fetus grow and develop physically and emotionally. At its heart, however, pregnancy can be understood as a relationship -- primarily between the woman and fetus, and secondarily between the woman and fetus and the larger community. Birth leads to the further unfolding of a relationship that was begun months earlier.

Pregnancy and the Fetus with Anencephaly

While pregnancy is a necessary prerequisite for postnatal life, it need not depend on postnatal life for its own meaning and worth. As a relationship, it can be seen as paradigmatic of human existence where two separate entities live as a community. It may even be understood as the nearest possible human imitation of a Trinitarian existence where separate persons dwell in intimate unity within a
larger community. Pregnancy as a state in itself can be understood as having intrinsic worth. Can the same be said when the fetus is anencephalic?

As chapter two of this thesis has shown, many authors classify the anencephalic pregnancy as futile, not only because so many anencephalic fetuses die in utero or are stillborn, but because those who are born alive have a severe neurological anomaly and face imminent death. If, as these authors believe, pregnancy has worth solely as preparation for postnatal existence, then the pregnancy in which the fetus is anencephalic has very little value because postnatal existence is so short and so compromised. The pregnancy may be discontinued on these grounds.

This thesis has argued that there is another way to view pregnancy. Still, the question remains: if pregnancy is understood as a particular stage in the life of the woman and her fetus, comprising physical and emotional growth and development but best characterized as a relationship, can it be understood to be valuable in these respects when the fetus is anencephalic? To answer the question, this thesis will examine the capabilities of the anencephalic infant in order to come to an understanding of the anencephalic fetus.
The Anencephalic Infant

In 1949, J.M. Nielsen and R.P. Sedgwick published their observations of an anencephalic baby who was in their care for almost eighty days. Their summary is succinct: "Anencephalic monster. Slept, awakened, sucked, expressed hunger, fear and contentment. Grasp reflex well developed. Death due to frontal epidural abscess. Necropsy."*6

The authors' primary interest was to determine the source of emotions and instincts in humans. They had observed that even preterm infants exhibited instinctual and emotional responses, leading the authors to posit that such responses did not depend on the infant having a fully mature brain. With its neurological deficits and, in this particular case, apparently without thalami, the anencephalic infant allowed the authors to explore their theory further.

Ultimately the authors conclude that infantile instincts and emotions have their origin in the brain

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*6 J.M. Nielsen and R.P. Sedgwick, "Instincts and Emotions in an Anencephalic Monster," Journal of Nervous and Mental Disease 110 (1949): 387-394. Although fifty years old, this is a seminal study that continues to have relevance.

*7 Ibid., 387; italicised in original.
stem. Whether they are correct in their assumption is beyond the competence of this thesis. What is of concern is that, in their observations, the authors found the anencephalic subject to have affective reactions similar to those of an unafflicted newborn:

Most interesting to the writers was the presence of instincts and emotions. If we handled the patient roughly, he cried weakly but otherwise like any other infant, and when we coddled him he showed contentment and settled down in our arms. When a finger was placed into his mouth he sucked vigorously . . . . He would sleep after feeding and awaken when hungry, expressing his hunger by crying. This conclusion came as a surprise to the authors, who found the anencephalic infant to have exhibited "far more cerebral function than one would ordinarily consider possible from

88 Ibid., 394.
89 Ibid., 389.
90 Ibid., 394.
Struck by the infant's capabilities, the authors do little more than enumerate them. Nevertheless, for the purposes of this thesis, it is significant that the anencephalic infant "showed contentment and settled down in our arms" when the authors "coddled him." This ability to be comforted, to respond positively to behaviour meant to be comforting, means that the infant is an active participant in an affective exchange. The baby's expression of discomfort elicits a response in the caregiver to offer comfort. By "settling," the infant indicates acceptance of the caregiver's offer of comfort. An exchange occurs between caregiver and infant. Nielsen and Sedgwick show that an anencephalic infant may be a capable emotional partner."

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91 Ibid., 387.

Brain-Stem Function

How might this be possible, given the severe defects which characterize anencephaly? Shewmon, and Shewmon, Capron, Peacock and Shulman (Shewmon et. al.) contend that researchers must not underestimate the significance of brain-stem function.\textsuperscript{32} Shewmon et. al. note that anencephalic infants whose brain stems are largely functional are capable of recognizing their mothers, of being comforted, and of some learning. Indeed, they believe that the functional capability of a newborn anencephalic, whose brain stem is relatively undamaged, is very similar to that of a newborn infant who is not anencephalic, because the cerebral cortex even in a "normal" baby is relatively immature. Both newborns rely largely on brain-stem function during the first weeks of life.\textsuperscript{33}

Shewmon makes these observations:

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\textsuperscript{94}Shewmon and others, 1776; Shewmon, 13-14.
\end{quote}
Because the neural structures that mediate typical newborn behaviours are located mainly in the brainstem, those anencephalic infants with relatively intact brainstems exhibit many such behaviors, for example, purposeless back-and-forth movements of the extremities, sucking and swallowing, normal orofacial expressions to gustatory stimuli, crying, withdrawal from noxious stimuli, and wake/sleep cycles.\footnote{95}

The phenomenon of neuroplasticity may also account for similarities in functioning in both the anencephalic and non-anencephalic newborn. Given the deficiencies in the cerebral cortex at such an early stage, the brain stem may "assume somewhat more complex integrative activity than would ordinarily be the case, as has been suggested in some animal studies . . . ."\footnote{96} It is thus possible to account for the functional similarity in the anencephalic and non-anencephalic infant.

Given the complex operations of the brain stem in neonates, including those who are anencephalic, Shewmon, and Shewmon \textit{et. al.} are hesitant to deny altogether the possibility of consciousness in the anencephalic infant. While they admit that is is very unlikely that the infant "with complete craniorachischisis" has any awareness,\footnote{97} the

\footnote{95}{Shewmon, 13.}
\footnote{96}{Shewmon and others, 1776; see also Shewmon, 14.}
\footnote{97}{Shewmon points out that such infants are rarely born alive (Shewmon, 15).}
authors observe that the diagnosis of anencephaly covers a wide range of anomalies and that an anencephalic infant may have a relatively functional brain stem.25

In establishing the possibility of awareness in the anencephalic infant, two difficulties must be overcome. The first is the bias with which scientific authority has treated infants generally. Earlier in this chapter it was remarked that, until recently, infant capabilities went unrecognized because they were measured against adult standards. Shewmon observes that for some time researchers and health care professionals treated neonates, especially those born preterm, as having very little consciousness. This was particularly evident in their attitude towards newborns and pain. Researchers and health care professionals simply believed that young babies had no capacity to feel pain and so performed procedures on them (procedures which adults would find painful) without administering anesthetics or analgesics. Practices are changing as scientific authorities now allow that infants, even those born prematurely, are capable of experiencing pain.27

8 Shewmon and others, 1776.

Researchers and health care professionals are acknowledging the complex capacities in infantile behaviour.

The second difficulty is that the anencephalic infant may not be capable of providing cues recognizable to observers that suggest awareness. Shewmon et. al. note the difficulties in determining when brain function has ceased in the anencephalic. While it is clear in this infant that there is not higher brain activity, "there are more peripheral factors that can create a false impression of brain-stem nonfunction." 100 It is not uncommon for anencephalic infants to be blind or hearing-impaired. Nielsen and Sedgwick's subject was unable to perceive light and they were uncertain as to whether he had a sense of smell. Another research subject who lived five and one half months could not see but responded to auditory stimuli. 101 Under these circumstances, it may be easy to conclude that the anencephalic infant, so severely compromised, cannot have consciousness. Shewmon, and Shewmon et. al. caution against making this judgement too hastily.

The authors believe that the anencephalic infant's

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101 Nielsen and Sedgwick, 389; Brackbill, 196.
functional similarity to a nonafflicted neonate coupled with the possibility of the brain stem assuming a more complex functional role in the anencephalic infant "might possibly suffice to provide a decerebrate newborn with some primitive form of awareness." Ultimately the authors believe that there is very little functional difference between the anencephalic newborn whose brain stem is largely undamaged and a non-anencephalic newborn:

at the newborn stage, the essential difference between normal and decerebrate infants is in the area of potential for future development, with only subtle differences in actual, present functioning.

For Peter McCullagh, the question of consciousness in the anencephalic infant is very much a side-issue. In his opinion, the capabilities of the afflicted newborn should not be judged according to which part of the brain may or may not be functioning; rather, we should look to the behaviours displayed by the infant:

My impression is that the bulk of observers, medically trained or not, would judge a subject as a live human infant on its behaviour and not on the basis of what was currently believed as to the part of the brain mediating that behaviour. If an anencephalic infant manifests features which, when they occur in a normal infant, contribute substantially to the development of empathy with

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102 Shewmon, 14; see also Shewmon and others, 1776.

103 Ibid.
it on the part of others, then the precise neuro-anatomical location of those functions (or currently accepted understanding of this) would not appear to me to be of primary importance.

He points out that the behaviour of anencephalic infants, so similar to non-afflicted newborns, elicits a response from caregivers. This is reflected in the treatment the infant receives. Hospital protocols, for instance, do not advocate abandoning such babies but providing them with comfort care. Those being kept alive specifically as organ sources receive "medication to prevent distress, and ... consistent comfort care." It matters to the nurses that "the infants were receiving warm attentive loving care."

One hospital ethics committee, grappling with the question of how to care for an infant with anencephaly:

knew that without any higher brain structures,

104 McCullagh, Brain, 138.

105 Lois Van Cleve, "Nurses' Experience Caring for Anencephalic Infants Who are Potential Organ Donors," Journal of Pediatric Nursing 8 (1993): 80. McCullagh finds that the practice points to the flawed logic beneath some practitioners' attitudes towards anencephaly. He observes that, "if the infants were, as advertised, totally incapable of appreciating pain, administration of an analgesic was quite superfluous," and, "on the other hand, if analgesic use was indicated because there existed a reasonable possibility of retention of the capacity to feel pain, the foundations of the argument for the utilization of anencephalics as organ sources necessarily collapse" (McCullagh, Brain, 136).

106 Van Cleve, 82.
many of the attributes that are considered essential to humanhood (such as thought, ability to experience pain and happiness, ability to interact with others) could not exist in this infant.\footnote{107}

However, the case came before the ethics committee precisely because primary caregivers found themselves responding sympathetically to the infant and felt compelled to advocate on the baby's behalf. Although the committee never wavered from its intellectual position, it was nevertheless prompted to wonder: is it "possible that there are basic human needs that cannot be assessed scientifically, and that contradict what science tells us?"\footnote{108} The anencephalic infant raises such questions.

The Possible Capabilities of the Fetus With Anencephaly

As Shewmon, Shewmon \textit{et. al.}, and Nielsen and Sedgwick have shown, the anencephalic infant is capable of a wide range of basic behaviours such as swallowing, sucking, licking lips, reacting to unpleasant stimuli, moving limbs and head. These authors have also observed more sophisticated behaviours: expressing hunger and fright,


\footnote{108} Ibid.
recognizing the maternal presence, being comforted. In a normal infant, these last two capabilities would be indentified as an important component of attachment between mother and baby. It seems that the anencephalic baby may have similar behaviours, expressing needs and being soothed when those needs are met. The baby may also recognize and show a preference for the mother. With sympathetic caregivers during its short life, the anencephalic baby may experience and elicit attachment.

Such capabilities, whether in an unafflicted or anencephalic newborn, do not emerge spontaneously with birth but have their origins in prenatal life. The anencephalic fetus, severely compromised as it may be, may nevertheless be actively developing these capabilities during pregnancy. It is nourished and grows, is exposed to stimuli and reacts, comes to know as much as it able about its environment and the woman who carries it. Although without a cerebral cortex, the fetus may be processing stimuli in utero, coming to know the voice and heartbeat of the mother it will recognize after birth.

Of course there are many ways in which the fetus might not be normal. Its swallowing ability may be compromised, leading to an excess of amniotic fluid in
uterine. Its movements may be jerky and sporadic. Because of its lack of cerebral cortex, it may never habituate as a normal fetus or infant, treating all stimuli as if experiencing them for the first time. Certainly the anencephalic fetus' appearance is so different as to be detectable by ultrasound. Nevertheless, for all the devastating effects of the anomaly, it is possible that the lives of anencephalic and non-anencephalic fetuses have more in common than previously imagined. There is also the continuity that exists between the anencephalic fetus and the anencephalic infant to be considered. The presence of an anomaly which existed long before birth does not prevent caregivers from offering the infant with anencephaly the comfort and care that would be due to any other infant.

Anencephaly as a Degenerative and Fatal Condition

To be anencephalic means to be without a brain. Researchers know that the condition encompasses a wide range of anomalies, but it also appears to be degenerative. According to Shewmon et al., "the supratentorial brain tissue in preterm anencephalic fetuses, prior to involution

109 Visser and others, 177-178.

110 Brackbill, 199; although as Shewmon notes, this is not the case for all anencephalics (Shewmon, 13).
in utero, may surprisingly resemble cerebral hemispheres with a midline fissure present." This is consonant with Wilkins-Haug and Freedman, whose observations have led them to believe that anencephaly is often preceded by exencephaly, that is, by an absence of skull. In the early development of the fetus who will be anencephalic, there is often "cerebral tissue" present but, without a skull or scalp to protect it, the tissue degenerates. Given the lengthy period of gestation of the human fetus, the degeneration can be so extreme as to render the fetus anencephalic.

That anencephaly may occur as the result of a degenerative process means that the severity of the deformity may increase with fetal age, and that there may have been a time in the fetus' life when it was close to "normal." The failure of the neural tube to close and the

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1 Shewmon and others, 1777.


1 Wilkins-Haug and Freedman's exencephalic subject appeared to have "a well-circumscribed [sic] mass with sonographic penetration consistent with tissue" in the 16th and 18th week which had degenerated into "a thin layer of tissue above the frontal bone" by the 29th week (Ibid., 228-229).
subsequent destruction of neural tissue are events that change the life of this fetus.

While the case may be made that brain-stem function may allow the fetus and neonate who are anencephalic to have capabilities similar to nonafflicted fetuses and neonates, and that there may have been a time when they were physiologically similar, anencephaly nevertheless introduces a significant difference to their lives: imminent death. Many anencephalic fetuses will never be born. According to the Stumpf et al., "65% of fetuses with anencephaly die in utero." Of those fetuses who survive until term, "it is possible that three-fourths will be stillborn and most of the remaining quarter will die within twenty-four hours of birth." Many fetuses, without a skull to protect them or because of brain-stem damage, will not survive the demands of birth. Many survivors will die very shortly after birth because their brain stems, damaged in the process of birth or otherwise defective, are unable to sustain the respiratory function or blood pressure necessary for life outside the womb."

Deficiencies in the infant's endocrine system may

"Stumpf and others, 670.

"Shewmon and others, 1778."
lead to death for those who do not die immediately after birth. As Shewmon observes, such irregularities "could result in ultimately fatal electrolyte imbalances and inability to handle various physiologic stresses, eventually leading to hypoventilation or cardiac arrhythmia as the immediate cause of death." The few anencephalic infants who live for a month or more may succumb to aspiration or infection. While Shewmon et al. and Shewmon contend that medical intervention might be effective in prolonging the life of the anencephalic who has relatively normal brain stem function, death is nevertheless an inevitable part of the life of this fetus and infant.

Conclusion: Towards an Understanding of the Fetus With Anencephaly

How then might the anencephalic fetus be understood? First, it appears that there is a brief stage in development when the fetus who will be anencephalic is physiologically similar to the fetus who will develop normally. Until approximately the twenty-third day of gestation when the neural tube normally closes, they develop along similar pathways.

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16 Shewmon, 15.

17 Ibid.; Shewmon and others, 1779.
Second, while anencephaly means to be without a brain, it is possible that the fetus who becomes anencephalic has some cerebral cortex at some point in its development. This is especially likely if the theory of progression from exencephaly to anencephaly is correct, in which case the fetus may develop the beginnings of a higher brain only to have it disintegrate in utero because there is no scalp or skull to protect it. Even with disintegration, it is possible that the cerebral hemispheres may not be completely absent. According to researchers, "some, even most, anencephalics have rudimentary cerebral hemispheres." This is further evidence of the possibility of the progressive nature of the condition. There may be a time in the fetus' development when it is close to "normal."

Third, while the anencephalic fetus may be without a functioning higher brain, it may have a relatively functional brain stem which will serve it in utero and, for a brief period, outside of the womb. The brain stem allows for physical development: the anencephalic fetus grows and moves, digests nutrients and eliminates waste, circulates blood -- in short, has physical life and development in large part because of brain-stem capability. In this, the anencephalic fetus is very much like the nonanencephalic

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118 Ibid., 1777; see also McCullagh, 112.
fetus. Both rely on brain stem function to sustain them in utero and in the immediate postnatal period.

Fourth, the anencephalic infant can in some cases display a wide range of behaviours, including recognizing the mother and being comforted. In ordinary circumstances, such behaviours would be acknowledged as being an important part of postnatal attachment. This suggests that, as in the case of a non-anencephalic infant, pregnancy may be a very active time for the anencephalic fetus -- a time of coming to know and adapt to its interuterine environment, of becoming familiar with the woman who carries it, and, through her, with the world outside of the womb. This may even be the case for the fetus who does not survive birth, or the fetus who dies long before birth.

Fifth, death is an inevitable part of this young life. Those fetuses who survive to term will die shortly after birth. The anencephalic fetus is a dying life.

The Fetus with Anencephaly, Pregnancy and Agape

A victim of a condition whose cause is not yet known, which occurs early in its development and is likely to be progressive in nature, the anencephalic fetus nevertheless has brain-stem capacity which may afford it a richer experience of pregnancy than previously thought.
Whatever the fetus' actual capacities, it is a severely compromised individual, a deformed life in which it may be very difficult to recognize "neighbour." Yet continuation of the pregnancy may be very important to this fetus, and not merely because it will add days to the life in utero. Given that the fetus may never be "born," it is possible that this pregnancy will be the only relationship it will ever know. The uterus may be its only world and the woman who carries it the only person it will ever know intimately. Pregnancy, thus regarded, is far from futile.

It is a relationship of unequals. Any fetus is completely dependent on its uterine environment to nourish and sustain it. The fetus is dependent on the woman who carries it to provide the place that will stimulate personal development. Removed from this environment before viability, the fetus will die. In the case of the anencephalic fetus, death will come shortly after birth even when the pregnancy goes to term. For the anencephalic fetus, sustained life, if possible at all, is possible only in the womb.

If neighbour-love requires meeting the needs of the neighbour, it may seem reasonable for the pregnant woman and those who care for her to continue the pregnancy as long as possible for the sake of the fetus. But the model of agape adopted by this thesis does not insist on doing duty merely
for the sake of duty. How can continuing the pregnancy be seen to be an act of agape without falling back on duty? How can the pregnancy be anything other than tragic and burdensome for the pregnant woman and those who care for her and the fetus?

For the woman carrying this fetus, anencephaly means that she will likely not be bringing this baby home from the hospital. Grieving and loss will almost certainly be a part of this pregnancy. However, if she is able to see neighbour in the misshapen fetus and to view it not as a monster or a pathology, the pregnancy may be valuable to her. Those few months are the only time the fetus will live in an intimate human relationship, and they are the only sustained time the woman will have with this human life. By continuing the pregnancy, she and those supporting her care for this fragile life, this dying individual in the only life state it may ever know. In doing this, they not only serve the fetus but build and strengthen the community that is pregnancy.

In its most intimate sense, this community is the pregnant woman and the fetus. They exist as separate individuals who are intimately connected. While she may not experience the same degree of dependence as the fetus does, the pregnant woman is very much affected by the presence of
the life within her. The physical changes to her own body are evidence of the fetus even before that life makes itself felt. Psychologically she begins to prepare for the baby that will be born and experiences attachment to the fetus within her. She reaches out to those close to her to support her in this, and actively engages others in her care and the care of the fetus. This intimate community is thus part of a larger community comprising the woman's partner, family, friends, health care professionals, neighbours and colleagues.

When the fetus is discovered to be anencephalic, it may no longer be what she hoped to be carrying, but it is the fetus in her womb, growing and developing as best it can. The woman must confront her disappointment and sadness at the change in her expectations of pregnancy, but it may be possible for her to become attached to this fetus, stroking it and speaking to it, sharing its movements and moods with her partner, loving the fetus for who it is. She may realize that, while her tragedy began when the blood tests returned with abnormal results or the ultrasound screen showed a cranial deformity, for the fetus the tragedy occurred when the neural tube failed to close and its life was changed forever.

The woman's partner and those most closely involved
in the care of the pregnant woman and fetus must deal with their own shock, disappointment and sadness. They must face the questions of the meaning of suffering and death -- transcendent questions of human existence. It is a very human response to long for a way to make tragedy not have happened, but even termination of the pregnancy will not do this. Whether the pregnancy is carried to term or ended suddenly, the anencephalic fetus will always be a part of their lives, grieved for the baby it was not.

But the fetus is also grieved for itself, and the intensity of grief may be surprising.\textsuperscript{119} Health care professionals working in the areas of miscarriage and stillbirth recognize that the grieving process may be facilitated when the fetus is made as real as possible for the parents. Having the parents see the baby and hold it even if it is dead, having the parents name the baby and keep a picture of it, are becoming common practices after

fetal and infant death. To have this connection is very important. In her research, Lovell found that "acceptance [of the loss] was linked to the way that the baby's existence, though short, had been acknowledged and made tangible."\[120\]

For the most part, interventions to facilitate this connection happen after the fact, that is, after the baby has died. Continuing the pregnancy when the fetus is known to suffer from a fatal condition may strengthen bonds between the pregnant woman and fetus while the fetus is still alive. This in turn may ease the grieving she inevitably faces. Each day lived consciously sustaining this life and allowing the process of attachment to continue and deepen will make the fetus more real to her and her partner. They in turn can draw those around them into this ministry to the very fragile life that lies within her. Those who join them will have the opportunity to celebrate the tiny life for what it is and, when the end should come, they will have the satisfaction of knowing that they loved this neighbour as best they could. The parents will still grieve and need support but, as Mander points out, "grief is the

price which we must all pay for our experience of loving."

Health care staff will have their own feelings of helplessness and inadequacy in the face of the tragedy. They may have to confront their own humanity as they work through the meaning of their profession and realize that as much worth as there is in the miracles of medicine, there is also value in compassion, that is, suffering with those in pain and need. In other words, they may realize that their gift also lies in being members of the human community, struggling with others in solidarity as they wrestle with the larger questions of meaning, humbly before the God who gives them life. It is no shameful thing to be imperfect humans who depend on a loving God to sustain us and bring us to perfection.

This is the gift of the anencephalic fetus. In neighbour-love, according to the Trinitarian model, we mean to bring the neighbour to God. By loving the anencephalic fetus and sustaining its life for as long as they can, the pregnant woman, her partner and those who care for them have the opportunity to bring this life daily to the Creator. To do this, they must turn constantly to each other, relying on each other if not for answers then for the strength that comes from love and regard. Daily they must turn to God.

\[12\] Mander, 11.
And in this turning, they may find that the anencephalic fetus has brought them to God. In this way, the anencephalic fetus may be seen to bring a gift of its own to the community that loves and cares for it.
CHAPTER FIVE

AN EVALUATION OF THE RESPONSE
SUGGESTED BY AGAPE

Introduction

The previous chapter proposed alternative understandings of pregnancy and the fetus with anencephaly, and then applied these understandings and the model of Trinitarian agape to the dilemma posed by the anencephalic fetus. The goal of the chapter was to cast new light on the dilemma and construct an argument in favour of continuing the pregnancy. Chapter five will continue to examine this position by considering a case which details the experiences of one woman who received abnormal results from prenatal testing. Since the arguments put forward in chapter two are meant to be applied to such a case, chapter five will then use the viewpoint of agape, and review these earlier arguments in light of the thesis' understanding of the fetus with anencephaly and the meaning of pregnancy. The chapter will return to the case of the woman with abnormal test results, and suggest that the anguish at its heart may be caused by the realization that safety and acceptance do not
exist for her and her fetus; and that it is in this respect that Catholic health care may have a particular contribution to make. The chapter will review the spiritual foundations of Catholic health care and the beginnings of Canadian Catholic health care in the nineteenth century. The chapter will conclude that actively supporting the continuation of the pregnancy where the fetus is discovered to be anencephalic could be seen as being very much in keeping with this tradition.

The Need for an Alternative to Selective Termination of Pregnancy

In an article appearing in the Journal of the American Medical Association, a pediatrician using the pseudonym Judy Brown describes her own experience with prenatal diagnosis and selective termination of pregnancy. Through chorionic villus sampling, she learned that the fetus she carried had a chromosomal abnormality; the article details the anguish she felt as she terminated the pregnancy and the lack of support for women in her position.

She undertook the test without imagining that she would receive an abnormal result. As she writes: "How could this have happened? Nearly all the women I know had had the

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test; all had been reassured by good news." In writing this, Brown describes one of the paradoxes of prenatal diagnosis: most women see testing almost as a form of prenatal care, as part of what they undergo to ensure the health of their babies. They expect to receive "reassurance, rendering attitudes to termination for fetal abnormality of little consequence." They do not connect prenatal diagnosis and termination of pregnancy. With an abnormal result, however, this perception changes dramatically:

It was not that I had to have a perfect child. I knew full well there were no guarantees of that. Had any of my children been born with a defect or ever have a serious accident or illness, I would love that child no less. But this was different. We had been presented with a choice.

Certainly Brown was presented with the option to terminate the pregnancy, but was she presented with a choice? Mander notes that, when anomalies are detected, there can be "'enormous' pressures applied to mothers to go through with termination . . . ." Some practitioners insist that patients agree beforehand to abort if there are abnormal results as a condition of receiving prenatal

2 Ibid.
3 Mander, 45.
4 Brown, 2735.
5 Mander, 45.
testing. There are also subtler but no less compelling pressures:

by providing little -- and even less -- support to families and to people with disabilities, women are made to feel little choice but to abort fetuses that would become children and adults whom the state would treat so badly.

This was Brown's predicament. She did not know how she and her family would cope with the addition of a child with a handicap. There was no sense in her narrative that she could reach out to anyone beyond the family, no sense that there would be support for a decision to continue the pregnancy and bring such a child into the world.

As this thesis noted earlier, Rubin contends that one of the tasks of pregnancy is "seeking safe passage" for the baby. It is possible that, on a very basic level, when women find that safe passage is not possible -- that there is no support for bringing the child into the world and caring for it -- they feel that it would be better for the child not to be born. The distress this decision may cause to the pregnant woman should not be underestimated:

an earlier miscarriage paled in comparison with this. At least that was straightforward, and there was comfort in the fact that there was nothing I could have done to prevent it. This time, the

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6 Ibid., 44.

7 Rothman, "Commentary," 81.
semblance of control and the heart-wrenching options magnified the pain many times over. I had chosen my pain."

Review of the Arguments For and Against Selective Termination of Pregnancy in the Case of Anencephaly, in Light of Agape and Revised Understandings of Pregnancy and the Fetus with Anencephaly

The arguments put forward in chapter two were meant to address cases such as Brown's. Using various types of arguments -- appealing to the principles of beneficence or nonmaleficence, perhaps, or applying the principle of double effect -- the authors supported or made the case against selective termination of the pregnancy where the fetus is found to be anencephalic. Despite their different approaches and conclusions, the authors agreed for the most part in their perceptions of the anencephalic fetus and the meaning of pregnancy. While it is beyond the scope of this thesis to re-engage those arguments with the nuance and attention they deserve, it is important to show how the position taken by the thesis might answer some of the points raised -- bearing in mind at all times that there is room for further dialogue.

Drane, Daniel, and O'Rourke and de Blois all suggest that when a woman is carrying an anencephalic fetus, the

*Brown, 2735.
pregnancy is futile because it does not achieve its desired end. This thesis has argued differently. Perhaps the most forceful point raised by the findings in chapter four is that pregnancy can be understood to have value as a state in itself, as a community of individuals existing in relationship.

The anencephalic fetus, relying for the most part on brain-stem function, nevertheless develops in many ways like a normal fetus, responding to stimuli, coming to know its mother and the outside world, growing and developing. It may never have higher brain function and will not have prolonged life outside the womb but its life in utero is in many ways similar to the life of an unafflicted fetus. One important distinction is that, for the anencephalic fetus, life in utero may be its only existence. As the previous chapter argues, however, a life state is not simply preparation for future stages but has value in itself, just as the individual has value in that state.

Pregnancy is a life state for the woman as well. Often regarded as a period of transition, a necessary stage for becoming a mother, pregnancy can also be viewed as a state of being, a time during which the woman physically sustains a life within her and becomes attached to that life. Anencephaly may mean that the woman will grieve the
baby who was never born, but it can also make pregnancy a precious time, a time to be with this life within her and to care for it in its fragility. As such, it is a ministry of love that she undertakes with those around her, drawing them into a circle of love. Although there may be suffering and much to grieve, the pregnancy can thus be understood as far from futile.

This thesis has also argued that pregnancy ought not to be understood as a life-support system. Even those like Cataldo who argue against termination often fail to appreciate the intimate relationship of pregnancy. By using the analogy of life-support, they risk dehumanising and diminishing the woman, portraying her as nothing more than a necessary means of sustaining fetal life.

According to this thesis, the woman is more than a womb, and pregnancy is more than a physical state. It is a state of being where the lives of the woman and fetus intersect. This thesis has argued that, contrary to the contention of Daniel, Drane, Beller and Reeve, and Beller, terminating a pregnancy cannot be compared to forgoing treatment. When a pregnancy is terminated, a state of being comes to a close and must be grieved.

While some authors like Chervenak et. al. and Chervenak and McCullough may advocate terminating the
pregnancy so that the woman and her partner may achieve a successful pregnancy sooner and so get on with their lives, this thesis has pointed out that this may not always be in the woman's best interests. Selective termination of the pregnancy cannot erase the fact of the pregnancy or the fetal anomaly. Research also suggests that the grieving process is aided when the reality of a tragedy is confronted and accepted -- a very difficult undertaking, requiring a great deal of support. This thesis has argued that in the case of an anencephalic fetus, the process may be aided by continuing the pregnancy. These factors should be taken into account when constructing beneficence- and nonmaleficence-based arguments around selective termination of pregnancy and when considering the proportion of harm and benefit in applying the principle of double effect.

This thesis has also argued that selective termination of pregnancy is not an indifferent act from a fetal point of view. Acknowledging that the anencephalic fetus may be capable of meaningful fetal existence means that one must consider carefully before concluding that it is entirely without interests, as Chervenak et. al. and Chervenak and McCullough contend, or that existence in utero is of no benefit, as O'Donnell, O'Rourke and deBlois, and Strong suggest. This thesis contends that continuation may
benefit the anencephalic fetus by prolonging the only earthly life it will ever know.

To ascribe the possibility of meaningful fetal life to the anencephalic fetus is to contradict Beller, and Beller and Reeve, who believe that this fetus does not even have what they consider to be recognizable life. Their extreme position strips the fetus of any meaning or value except as a means to an end -- a source of organs, perhaps. In their view, the anencephalic fetus is never a subject but only an object. Given the data in the previous chapter, this is an incautious conclusion. So too is the position put forward by Drane, Walsh and McQueen, and O'Rourke and deBlois, who contend that the fetus is capable only of physical or biological or vegetative existence, making its life less valuable than other lives and its death less serious. While it is true that this fetus will not, or not for long, experience a life state beyond pregnancy, it is living in utero and may have capabilities and life which are worthwhile given its state of being.

To ascribe the possibility of meaningful life to the anencephalic fetus, as this thesis does, avoids a vitalist position as well. As an active agent engaged as far as it is able in its own being and development, the anencephalic fetus has value not in the abstract but as a concrete life.
Protection, if it is to be protected, should not be from a sense of duty alone, but because the fetus is a life worth celebrating, worth loving, and worth bringing to God.

Reviewing the dilemma in light of agape does not mean doing away with an ethic that appeals to duty and principle. It is still possible to invoke the principle of preserving life or the duty to act in a way that benefits others or at least does not harm them. However, principles and duties may acquire different interpretations in keeping with the context in which they operate, the overarching understanding of what moral agents are and are called to be. Such an understanding is not static but will necessarily be the subject of ongoing reflection.

According to the Trinitarian model adopted by this thesis, humankind comprises persons in community, each made by God in God's image and likeness, each called to live in communion with God. This is achieved by loving all that God is and all that is connected to God -- God, neighbour, and self. All life is God's creation, standing in relation to God as creature to Creator. All God's creatures have commonality insofar as all are connected one to another. Humankind has the distinction of being made in God's image and likeness and, as such, is a worthy object of love.

When informing a duty- or principle-based ethic,
this understanding of agape means that there will be equal emphasis on individual rights, community, connection, and commonality. In the dilemma posed by the fetus who is anencephalic, the woman and fetus need not be viewed as adversaries with conflicting interests but common creatures of God -- each called to fellowship with God and with fellow creatures and each existing imperfectly in an imperfect world, relying on God and God's grace to achieve this communion.

How this communion is to be achieved is known ultimately and completely only by God. This thesis has argued, however, that by understanding pregnancy as a community of individuals -- the woman, fetus, and those who care for them -- and by actively sustaining that community in love, it may be possible to find healing when the fetus is anencephalic.

The Case Reviewed in Light of Agape

The aim of this thesis, in speaking to the arguments, has not been to put closure on the issue but to move the dialogue forward by challenging presuppositions about the fetus with anencephaly and pregnancy, and urging further reflection on and articulation of the overarching moral points of view informing the arguments. How, then,
might the thesis engage the case described by Brown?

According to the modified version of the Trinitarian model adopted by the thesis, agape means not only bringing the neighbour to God but meeting the neighbour's needs in concrete ways. Clearly it would appear that counselling ought to be offered when women decide to terminate pregnancies because of fetal defects. Not only is the grief often unanticipated but the decision to terminate is usually taken very shortly after the diagnosis is made. In Brown's case, the abortion occurred one week after the test results were made known.

Haste can compound the confusion and distress. One group of researchers describes the dynamics of selective termination. The information that the fetus has an anomaly may be overwhelming. Parents who receive the news:

are usually in a state of shock and are confused, and although they make an informed decision to terminate, they are unable to retain all this new information. In the succeeding weeks and months they may become troubled by doubts and anxiety that it may have been the wrong decision. It may be necessary for counsellors to reiterate several times that the condition which affected their child really was a serious genetic abnormality, and that their decision to terminate was justified on these grounds.

However, it is possible that the heart of the

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"Mary Seller, Chris Barnes, Sarah Ross, Teresa Barby and Pauline Cowmeadow, "Grief and Mid-trimester Fetal Loss," Prenatal Diagnosis 13 (1993): 342."
dilemma and the source of anguish does not lie in the woman's doubts about her choice as much as in the gut-wrenching suspicion that there really was no choice. With medical science increasingly narrowing the category of acceptable pregnancies, many women may come to believe that it is unreasonable for them to continue the pregnancy when the fetus they have become attached to is discovered to be "defective." They may believe that there is no alternative but to abort.  

The need expressed in Brown's account may be the need for safe passage for her and her fetus. The need may be for caregivers who will accept the privilege of being part of the community that is this pregnancy; who will support and affirm her in her care of the fetus; who will themselves love her and this fragile life; who will, when the pregnancy should end, share her grief and join her in the celebration of a life lived. The need may be for a community to journey with her. There is no cure for anencephaly, but in the relationships that are built and in the love that is generated there can be healing. It may be here that Catholic health care could have a particular contribution to make in an exhortative way, opening possibilities for reflection.

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Agape and Catholic Health Care*

Catholic health care, like Christian denominational health care generally, seeks to imitate Christ's healing ministry. His was a radical ministry: out of great love and compassion, Jesus restored sight to the blind, enabled the lame to walk, and raised loved ones from the dead. His love was effective and unconditional. He healed on the Sabbath. He did not turn away from those who were unclean. It is this vision of lived neighbour-love that Catholic health care seeks to imitate.

By attending to the needs of the fetus with anencephaly, the pregnant woman and her partner, and the needs of those who care for them, those engaged in Catholic health care could be imitating this healing ministry of Christ. They could also be continuing the tradition begun in the last century when groups of women religious arrived in this country and undertook to care for the sick and dying.

In Toronto, the Sisters of St. Joseph came to care

*It should be noted that, while the impetus for this thesis arose out of the context of Catholic health care practice and is meant to have application there, the arguments put forward are not limited to this one Christian denomination. If agape modelled on the Trinity has appeal, it will speak to others who share the belief in the centrality of Christian neighbour-love and the Trinitarian Godhead who loves and is love. While the following sections address Catholic health care, they may have application to the rich tradition of Christian health care generally.
for the Irish immigrant population and found themselves nursing those taken ill in the scarlet fever and diphtheria epidemics. Their work did not go unnoticed: "So impressed was Dr. Allan [Toronto's chief medical officer] by the Sisters' kindness and devotion to the patients that he proposed that they open a general hospital in the city." St. Michael's Hospital opened with "26 beds, and assets totalling $1,054.55, most of which had come from begging."^12

The hospitals that the Sisters built are now a part of the landscape of Canadian health care. Their beginnings were very humble; they stand as testimony to the faith and the courage of the women who founded them. The Sisters underwent tremendous personal sacrifice to live out their imitation of Christ's healing ministry. In the early years in Toronto, the Sisters of St. Joseph:

in order to maintain themselves and those they served, made bags for local stores, did laundry, ironed and sewed for St. Michael's College. They also went about begging to provide themselves and those they served with the necessities of food, clothing, and money."^13

Their ministry was to care for the sick and the dying and to

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^13 Dwyer, 74.
attend to those who would otherwise not receive care. No one was to be turned away from their hospitals.

By their practices, the Sisters stood as witnesses to the importance of agape, of recognizing neighbour in the most marginalized and extending unconditional love to that neighbour. Their mission to provide health care to the poor became an identifying feature of Catholic health care. It was also seen eventually by the larger society to be desirable. In the late nineteenth century, universally accessible health care was a radical ideal; one hundred years later, it is a distinguishing characteristic of Canadian health care.

By their practices, the Sisters testified to the dignity and worth of all people and the importance of a community caring for one another. By their actions, they expressed their commitment to that ideal of the good. By their example, they challenged a larger society to reconsider its own more discriminating practices. In short, the Sisters displayed an ethic of exhortation.

Their actions were explicitly meant to imitate Christ's healing ministry. They invited others to embrace this vision of the good, but this conversion was not their primary concern. Their first aim was to love and care for their neighbours -- especially those most in need -- as
Jesus did, and to be living witnesses to that love.

**Conclusion: Catholic Health Care and the Fetus with Anencephaly**

Like the nineteenth-century practice of providing health care without discrimination, actively supporting the woman and her partner in the continuation of the pregnancy where the fetus is anencephalic is decidedly counter-cultural and, as this thesis has argued, much needed. It is possible that, at the end of the twentieth century, those engaged in Catholic health care could be called to imitate Christ's healing ministry by providing for those who are among the most marginalized of patients -- in this case, the pregnant woman and the anencephalic fetus she carries. She may feel that her attachment to the fetus is both irrational and meaningless. As for the fetus, in the minds of many practitioners, its anomaly makes the pregnancy futile. The anencephalic fetus and the woman who carries it need a support, a form of sanctuary. It may be that Catholic health care is called to show solidarity with the marginalized -- with the woman who appears unreasonable and the anencephalic fetus whose existence is considered valueless.

In a world that emphasises utility and assigns value accordingly, it may be that the woman needs to be with
people who will accept her and her fetus as they are. She may also need help in finding meaning in this apparent tragedy, of finding God in the midst of her desolation. There is room in Catholic health care to consider these questions, which are part of the human journey towards truth and wholeness.

Those engaged in Catholic health care may be called to build fellowship, to live this embodied version of the Trinity by helping to strengthen the community that is the pregnant woman and her fetus and which is extended to include her partner and the larger community of family members and caregivers. To imitate its perfect and mysterious model, the earthly fellowship must be founded on a love that sustains life and heals not only the pregnant woman and her vulnerable fetus but those who love and care for them.

Finally, those engaged in Catholic health care may be called to share their insights and knowledge with the larger community. They must subject their practices to critical review, and engage in research to show that there is an empirically grounded alternative to selective termination of pregnancy when the fetus is anencephalic.

Just as the Trinitarian model of agape challenges Christians to consider the importance of supporting and
joining the intimate relationship that is the pregnant woman and her fetus, of seeing neighbour in them both and being neighbour to them, so the empirical nature of the arguments put forward challenges persons of good will to reconsider their understandings of the fetus with anencephaly and the meaning of pregnancy. The conviction that actively supporting the woman in the continuation of the pregnancy in which the fetus is anencephalic need not be dependent on the conversion of the larger health care community, however. In an exhortative ethic based on agape, it is sufficient to bear witness to a positive alternative to selective termination of pregnancy when the fetus is anencephalic.
CONCLUSION

This thesis has set out to argue that continuing the pregnancy where the fetus is discovered to be anencephalic is a theologically sound and empirically grounded alternative to the current practice of terminating such pregnancies on fetal indications. It has done so by adopting an ethical point of view informed by agape modelled on the Trinity. Trinitarian agape is a model of Christian love that understands humankind as comprising individuals who live in community and who are called to communion with God and neighbour. It urges Christians to imitate the eternal giving and receiving of love that exists at the heart of the Trinity. It emphasises the fact that all persons are made in the image and likeness of the God who loves them into existence, a fact which is not diminished by human sinfulness.

The thesis also reviewed the meanings attached to the fetus who is anencephalic and to pregnancy. Finding that authors arguing both in favour of and against termination of pregnancy shared common assumptions in this respect, the
thesis sought to discover whether pregnancy could be seen as other than a means to an end, and the fetus with anencephaly as other than incapable of meaningful existence. Drawing on research in prenatal attachment and fetal psychology, the thesis made the case, first, that pregnancy could be understood as a state in itself, a state of being with its own identity and tasks. Pregnancy is a relationship, primarily between the woman and her fetus and, secondarily, between them and the larger social network of which they are a part. Second, the thesis argued that the fetus could be understood not as passive entity, but one actively engaged in its own development, and that anencephaly did not make meaningful fetal life impossible.

These data, viewed in the light of agape, formed the basis for the argument supporting the continuation of the pregnancy in which the fetus is discovered to be anencephalic. Far from being a futile process, this pregnancy could possess added poignancy as the only relationship this fetus may ever experience, and as the only time the woman may have with this fragile life. The larger community of family, friends and health care providers could thus be called to support the woman and her partner in this ministry to the dying individual who is the fetus and to find meaning in the apparent tragedy. Ironically, the woman
and her partner and those who support them may find that as they mean to bring the fetus to God, by their caring and struggling and loving, they themselves are brought to God. In this way they become part of the eternal giving and receiving of love that is Trinitarian agape.

The thesis has taken care to provide theological and empirical grounding for its position, but the application of an exercise in Christian ethics in a non-Christian world is no easy task. This thesis argued that adopting a policy of actively supporting the continuation of the pregnancy where the fetus is anencephalic would be in keeping with the Roman Catholic health care tradition. Further, the argumentation at work in this thesis -- the appeal to Trinitarian agape on the one hand, and the reliance on research in the life sciences on the other hand -- means that its conclusions have application beyond the Catholic health care setting. It is possible for Christians of other denominations and non-Christians to find merit in the stance of this thesis.

This combination of deductive and inductive reasoning is not without tension. Trinitarian agape calls one to an ideal of human existence modelled on the divine Godhead who exists in a community of love. The empirical data generated by research in the life sciences reminds one of the reality and value of concrete experience.
That this tension is not wholly resolved is in keeping with the tenor of this thesis. Rather than outlining morally obligatory rules for action, this thesis is an invitation to reflect on shared values and consider how they might shape moral action. Rather than providing definitive answers, the thesis is content to act as a catalyst for further dialogue and discernment by inviting the reader to consider an ethic informed by agape. In short, this is an exhortative approach to the problem.

Clearly there is room for further study. An issue at the heart of an ethic of agape is who moral agents are and what they are called to be. This will necessarily be the subject of ongoing reflection. A closer examination of the relationship between an ethic informed by agape and one which relies on rules and principles is also in order, as is a critical examination of the principle of double effect and proportionate reason as devices for working through the dilemma posed by the fetus with anencephaly. More research is also needed on the phenomenon of pregnancy and the fetal life state -- both their physiological aspects and their existence as social constructions. And, because this thesis has expressly limited itself to the question of selective termination of pregnancy, it has not addressed cases where a woman carrying an anencephalic fetus may also be contending
with risks to her life or health.

Even with these unanswered questions, the position of the thesis is clear: that, all things being equal, continuing the pregnancy where the fetus is found to be anencephalic is a theologically and empirically sound alternative to selective termination of the pregnancy. It is hoped that Christians, and all persons of good will who treat anencephaly as an exception to rules governing termination of pregnancy, will evaluate each case in light of this position. This position is founded on the beliefs that pregnancy is valuable in itself, that the anencephalic fetus may be capable of meaningful fetal existence, and that an ethic informed by Trinitarian agape calls us to join the eternal giving and receiving of love that is the Godhead. The thesis is an exhortation to be open to the personal and societal transformation which this love makes possible.
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