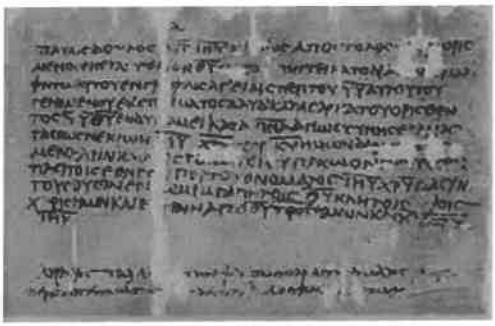
WHERE ANGELS FEAR TO TREAD

Week Five:

How to think well... About abortion



They marry, as do all [others]; they beget children; but they do not destroy their offspring. They have a common table, but not a common bed. . . .To sum up all in one word--what the soul is in the body, that are Christians in the world.
"Mathetes" (disciple),
Letter to Diognetus (c. 2nd cent)

GRACE
MILLS RIVER

Northern Ireland abortion law changes: What do they mean?

By Marie-Louise Connolly BBC News NI Health Correspondent

Chinnapong

No criminal charges will be brought against healthcare workers who provide a termination or assist in one

Abortion in Northern Ireland has been decriminalised, after the laws changed at midnight.

That means women and girls can terminate a pregnancy without fear of being prosecuted.

The possibility of prosecution is also lifted from healthcare workers.

In this interim period from now until March, those affected will continue to travel to England for medical terminations.

- Clock is ticking for NI abortion law

- NI abortion law found to breach human rights
- How many abortions are carried out in the UK?

However, information can be shared and medical assistance provided for any women who have taken medication.

The Department of Health, alongside a consultation, will be working with front line medical staff who deliver information and medical services to identify agreed policies and guidelines, which will bring services into line with the rest of the UK by 1 April 2020.

While some are hailing this as a momentous change for women's human and reproductive rights, others are describing it as a "sad day" for Northern Ireland.

The law change comes after MPs at Westminster voted for a law change in July, on the basis that a Northern Ireland Executive did not return by Monday 21 October.

There was a brief sitting of the Northern Ireland Assembly in a last-ditch attempt to stop the changes but it ended in failure.

Before now, abortion was only allowed if a woman's life was at risk or there was a danger of permanent and serious damage to her physical or mental health.

What does it mean for the law?

Guidance issued by the Northern Ireland Office (NIO) outlines that no criminal charges can be brought against those who have an abortion or against healthcare professionals who provide a termination or assist in one.

Women and girls who require a medical abortion will continue to be financially supported to avail of services in England.

The law in Northern Ireland has changed after MPs voted through new Northern Ireland legislation in July

A carer's expenses will also be covered.

In the interim period, abortions in cases of "fatal or serious fetal anomaly" can be carried out in Northern Ireland up to 28 weeks.

Each will treated on a case-by-case basis, with a consultant taking into consideration the mental and physical needs of the patient.

Abortion in Northern Ireland - how it will work

- The government states that there are no plans for additional services to be routinely available in Northern Ireland before 31 March 2020.
- From April 2020, medical abortions will be provided on two hospital sites in NI
- Doctors who have qualified in the past eight years or so will require training in this specialist area
- It is understood buffer zones will be put in place around the hospital sites, meaning anyone protesting in these areas or causing obstruction

could be prosecuted - NI will be among the first jurisdictions to introduce such a move
- The Department of Health will fund this additional service, despite its current financial pressure - this including units where medical abortions will be performed and staff training to ensure all safety and quality standards are met
- It's thought about 1,060 terminations will take place each year in Northern Ireland when the new arrangements come into place

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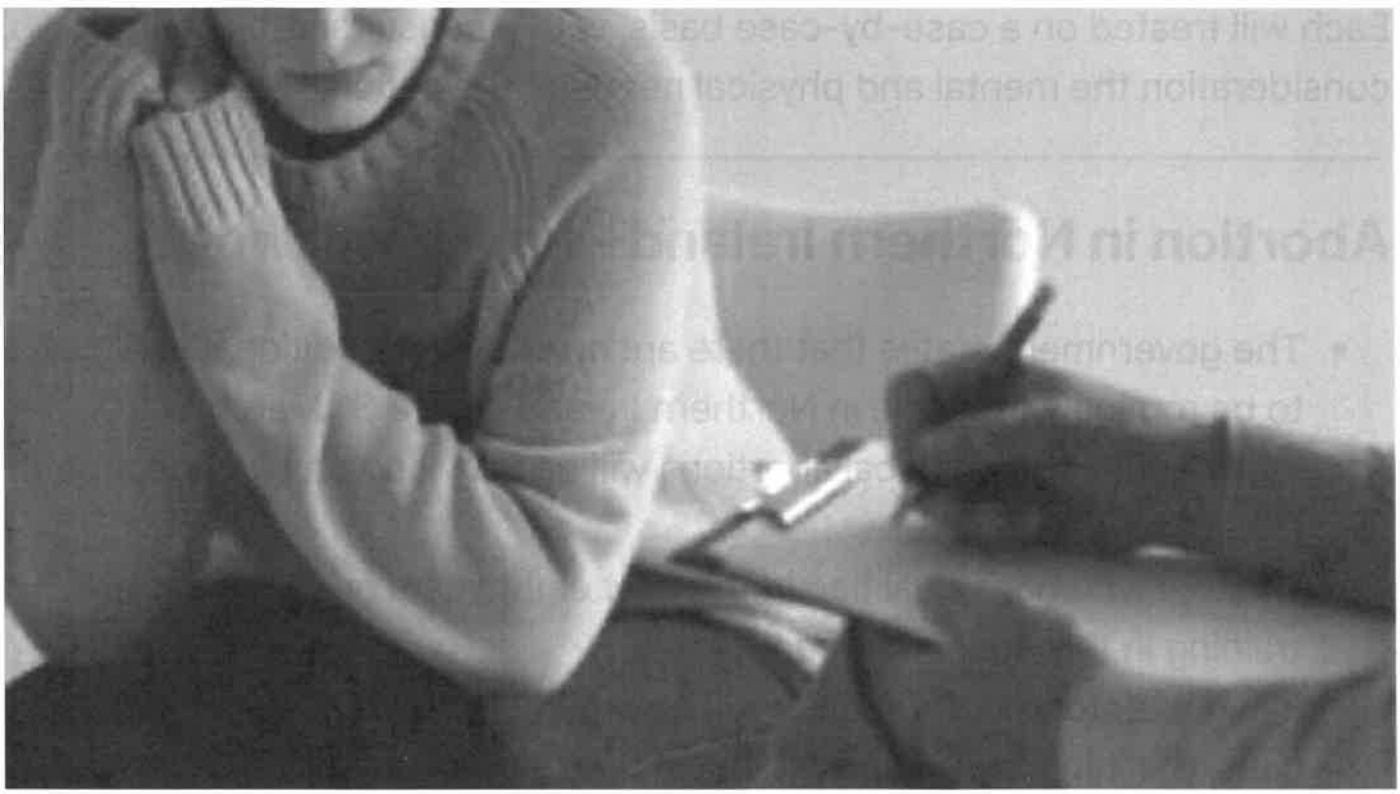
It is likely the consultant will seek a second opinion from a colleague in those cases.

This is what happened prior to 2012, when the Department of Health introduced controversial guidelines for the management of termination of pregnancy that instilled fear among some health workers.

It is estimated about 45 women a year were diagnosed with a fatal fetal anomaly in local hospitals but then had to travel elsewhere for an abortion for fear of being prosecuted.



Getty Images

Every year hundreds of women cross the Irish Sea to have pregnancies terminated

So, in 2019, Northern Ireland is reverting to practices carried out in 2012.

From now, health professionals can feel free to give information about funded services in England.

Medical services cannot be provided in a GP surgery but information should.

If a woman approaches a GP and is considering an abortion, the number for the Central Booking Service in England is expected to be made available or a call can be made to the helpline on her behalf.

Is conscientious objection allowed?

Further detail is also provided on conscientious objection.

The guidance notes that in England and Wales, the courts have found that its scope is limited to participating in a "hands-on" capacity and does not allow for objection to ancillary or administrative tasks.

That's likely to be the case in Northern Ireland, unless a consultation decides differently.

It further states "in the interim period, anyone who has a conscientious objection to abortion may want to raise this with their employer".

The guidance recognises that some women may continue to buy medical abortion pills online.

As these are prescription only, their sale and supply remains unlawful but women "will be able to seek medical assistance in Northern Ireland" if there are complications.

Health professionals, notes the guidance, will not be under any duty to report an offence.

The government said it is "imperative that health and social care professionals understand these changes and their duties under the law, if the duty comes into effect and the law changes".

It also makes clear that this supersedes guidance provided by the Department of Health in 2016.

U.S. Abortion Rates Plummet to Lowest Levels Since Procedure Became Legal

Charlie Neibergall—AP

(NEW YORK) — The number and rate of abortions across the United States have plunged to their lowest levels since the procedure became legal nationwide in 1973, according to new figures released Wednesday.

The report from the Guttmacher Institute, a research group that supports abortion rights, counted 862,000 abortions in the U.S. in 2017. That's down from 926,000 tallied in the group's previous report for 2014, and from just

over 1 million counted for 2011.

Guttmacher is the only entity that strives to count all abortions in the U.S., making inquiries of individual providers. Federal data compiled by the Centers for Disease Control and Prevention excludes California, Maryland and New Hampshire.

The new report illustrates that abortions are decreasing in all parts of the country, whether in Republican-controlled states seeking to restrict abortion access or in Democratic-run states protecting abortion rights. Between 2011 and 2017, abortion rates increased in only five states and the District of Columbia.

One reason for the decline in abortions is that fewer women are becoming pregnant. The Guttmacher Institute noted that the birth rate, as well as the abortion rate, declined during the years covered by the new report. A likely factor, the report said, is increased accessibility of contraception since 2011, as the Affordable Care Act required most private health insurance plans to cover contraceptives without out-of-pocket costs.

According to the report, the 2017 abortion rate was 13.5 abortions per 1,000 women aged 15-44 — the lowest rate since the Supreme Court's 1973 Roe v. Wade decision legalizing abortion. Following that ruling, the number of abortions in the U.S. rose steadily — peaking at 1.6 million in 1990 before starting a steady, still-continuing decline. The abortion rate is now less than half what is was in 1990.

Guttmacher noted that almost 400 state laws restricting abortion access were enacted between 2011 and 2017, but it said these laws were not the main force behind the overall decline in abortions. It said 57% of the nationwide decline occurred in the 18 states, plus the District of Columbia, that did not enact any new restrictions.

Between 2011 and 2017, the number of clinics providing abortion in the U.S. declined from 839 to 808, with significant regional disparities, the report said. The South had a decline of 50 clinics, including 25 in Texas, and the Midwest had a decline of 33 clinics, including nine each in Iowa, Michigan and Ohio. By contrast, the Northeast added 59 clinics, mostly in New Jersey and New York.

Over that period, the abortion rate dropped in Ohio by 27% and in Texas by 30%, but the rate dropped by similar amounts in states that protected abortion access, including California, Hawaii and New Hampshire.

Areas with the highest abortion rates in 2017 were the District of Columbia, New Jersey, New York, Maryland and Florida. Rates were lowest in Wyoming, South Dakota, Kentucky, Idaho and Missouri — many women from those five states go out of state to obtain abortions .

One significant trend documented in the report: people who have abortions are increasingly relying on medication rather than surgery. Medication abortion, making use of the so-called abortion pill, accounted for 39% of all abortions in 2017, up from 29% in 2014.

The report, which focuses on data from 2017, does not chronicle the flurry of sweeping abortion bans that were enacted earlier this year in several GOP-controlled states, including a near-total ban in Alabama and five bills that would ban abortion after a fetal heartbeat is detected, as early as six weeks into pregnancy. None of those bans has taken effect; their backers hope that litigation over the laws might eventually lead to a Supreme Court ruling weakening or overturning Roe v. Wade.

Guttmacher's president, Dr. Herminia Palacio, said abortion restrictions, regardless of whether they lead to fewer abortions, "are coercive and cruel by design," with disproportionate impact on low-income women.

However, the push for tougher restrictions continues. Just last week, Texas Right to Life and some allied groups urged Gov. Greg Abbott to call a special session of the Legislature to "abolish every remaining elective abortion" in the state.

The report comes amid upheaval in the federal family planning program, known as Title X. About one in five family planning clinics have left the program, objecting to a Trump administration regulation that bars them from referring women for abortions. Title X clinics provide birth control and basic health services for low-income women.

"If your priority is to reduce abortions, one of the best things you can do is make sure that women have access to high-quality, affordable and effective methods of birth control," said Alina Salganicoff, director of women's health policy for the nonpartisan Kaiser Family Foundation.

Contact us at editors@time.com.

Leana Wen: Why I Left Planned Parenthood

By Leana S. Wen July 16, 2019

This week, I left my position as the president and chief executive of Planned Parenthood.

In my farewell message to colleagues, I cited philosophical differences over the best way to protect reproductive health. While the traditional approach has been through prioritizing advocating for abortion rights, I have long believed that the most effective way to advance reproductive health is to be clear that it is not a political issue but a health care one. I believed we could expand support for Planned Parenthood — and ultimately for abortion access — by finding common ground with the large majority of Americans who can unite behind the goal of improving the health and well-being of women and children.

When the board hired me to chart this new course, I knew that it would be challenging. Few organizations, let alone organizations under constant siege, accept change easily. Indeed, there was immediate criticism that I did not prioritize abortion enough. While I am passionately committed to protecting abortion access, I do not view it as a stand-alone issue. As one of the few national health care organizations with a presence in all 50 states, Planned Parenthood's mandate should be to promote reproductive health care as part of a wide range of policies that affect women's health and public health.

Another area of contention was my attempt to depoliticize Planned Parenthood. The organization and the causes it stands for have long been in

the cross hairs of political attacks. In the last few months, seven states have passed laws banning abortion before many women even know that they are pregnant. Just this past Monday, the Trump administration announced that it would start enforcing a gag rule that would prohibit doctors and nurses working in federally funded clinics from referring patients to abortion care.

I had been leading our organization's fights against these attacks, and believe they offer even more reason for Planned Parenthood to emphasize its role in providing essential health care to millions of underserved women and families. People depend on Planned Parenthood for breast exams, cervical cancer screenings, H.I.V. testing and family planning. To counter those who associate the organization with only abortion and use this misconception to attack its mission, I wanted to tell the story of all of its services — and in so doing, to normalize abortion care as the health care it is.

For me, as a physician, it was also simply good medical care to treat the whole patient. There were already some Planned Parenthood health centers that provided full-spectrum care. In one clinic I visited, a new mother could get a checkup while her baby was vaccinated. If she was diagnosed with postpartum depression, she could receive mental health services right there, too.

With high-quality affordable health care out of reach for so many, Planned Parenthood has a duty to maximize its reach. I began efforts to increase care for women before, during and after pregnancies, and to enhance critically needed services like mental health and addiction treatment.

But the team that I brought in, experts in public health and health policy, faced daily internal opposition from those who saw my goals as mission creep. There was even more criticism as we worked to change the

perception that Planned Parenthood was just a progressive political entity and show that it was first and foremost a mainstream health care organization.

Perhaps the greatest area of tension was over our work to be inclusive of those with nuanced views about abortion. I reached out to people who wrestle with abortion's moral complexities, but who will speak out against government interference in personal medical decisions. I engaged those who identify as being pro-life, but who support safe, legal abortion access because they don't want women to die from back-alley abortions. I even worked with people who oppose abortion but support Planned Parenthood because of the preventive services we provide — we share the desire to reduce the need for abortion through sex education and birth control.

[*For a spotlight on people reshaping our politics, sign up for the On Politics newsletter.*]

There were early signs that this approach galvanized new allies and was moving the needle on public perception. Despite many shocking laws passed this year, more legislation to protect abortion access passed in 2019 than in any year in recent history. An NPR/PBS News Hour/Marist poll last month showed that support for Roe v. Wade was at the highest point in four decades.

But in the end, I was asked to leave for the same reason I was hired: I was changing the direction of Planned Parenthood.

Ultimately, my departure is not about me or the organization I continue to care deeply about. It goes beyond the movement for reproductive rights to the very ethos of our country. Can we put aside partisan differences to do what is best for the people we serve? Will the conversation continue to be dominated by a vocal minority from both ends of the spectrum, or can there

be space for those of us in the middle to come together around shared values?

I hope so. We need to stop treating those whose views differ from our own with scorn and suspicion, and instead work together to safeguard our health, our rights and our future.

Leana S. Wen (@DrLeanaWen) is an emergency physician and the former president and chief executive of Planned Parenthood Federation of America.

I Found the Outer Limits of My Pro-choice Beliefs

In an ultrasound room far from home, I discovered more than I was looking for.

Chavi Eve Karkowsky Aug 7, 2019

Dola Sun

One day about seven months ago, I was standing in a dark room in a hospital not far from Tel Aviv, performing an ultrasound on the taut belly of a woman well into her third trimester. She was 35 weeks pregnant, due in about a month. She and I felt the fetus kick, right under the ultrasound probe. "Strong one!" I said in Hebrew. She smiled. I managed to freeze a sweet picture of the bow-shaped fetal upper lip, and pressed "Print," to give to her later.

Then I measured the fetal head, snug against her pelvic bone. The numbers

on-screen suggested that it was too small. I measured it again. Still small. So I measured it again, and again, and again. Everything else in this pregnancy looked healthy: the volume of amniotic fluid, the general size of the fetus, the structure of the heart and brain. According to the woman's chart, everything had been fine, all the way through.

At that point, I needed to tell her about that small head and what it might mean for her future child's development. This is not uncommon; it's a situation I'm used to dealing with easily. But in that room, I was overcome with a strong urge not to tell her what I'd observed, because I feared where that discussion might lead. I am an American ob-gyn. In most states in my native country, third-trimester abortions are illegal or nearly inaccessible. In practice, only a handful of facilities in the entire United States perform abortions after 26 weeks for nonlethal anomalies. But here in Israel, abortion is widely available and can be offered until delivery. A subtle abnormality, such as the one I saw in that ultrasound room outside Tel Aviv, can prompt a discussion of pregnancy termination. Even at 35 weeks.

Within the American abortion debate, I am pro-choice in a concrete way. Giving women information about their pregnancies and helping them assess their options, including termination, is part of my life's work. When state legislatures in Georgia, Louisiana, and a host of other states have taken up bills to limit abortion rights, I have always known which side I am on.

But in that dark room so far from home, I was deeply uncomfortable discussing abortion with a woman 35 weeks into her pregnancy, when that fetus had no clearly lethal or debilitating problem. By then, I'd been living in Israel for about a year, and practicing medicine at a local hospital for about six months. In Israel, everything was different—perhaps including me. In that dark room, I felt lost, as I confronted the outer borders of my pro-choice beliefs.

Within obstetrics, my subspeciality is maternal-fetal medicine, or MFM. Physicians in my field care for women who face complications during their pregnancy or delivery, and we diagnose potential birth defects. I trained and practiced in the United States. A year ago, my family and I moved to Israel temporarily, for my husband's work.

I do not provide abortions, and I haven't for years. But I talk about abortion all the time, because doing so is a crucial part of the MFM job. In the United States, standard obstetric care includes a first-trimester nuchal translucency scan, as well as a second-trimester anatomy scan around 18 to 22 weeks. (In obstetrics, we measure gestational age from the pregnant woman's last menstrual period, about two weeks prior to conception. A typical pregnancy lasts 40 weeks.) Those scans are almost always normal, a cause for pictures and celebration. But ultrasounds in somewhere from 2 to 3 percent of pregnancies show fetal anomalies.

Some anomalies are mild. A short surgery will fix a cleft lip, for instance. Other anomalies are far more worrisome: a heart malformation that will require multiple surgeries in infancy; a severe thickening of the back of the neck that, while signaling no imminent threat to the fetus, hints at a serious genetic disorder. In these cases, an MFM physician will almost always recommend an amniocentesis to get cells from the pregnancy that will give a fuller diagnosis.

Any serious prenatal diagnosis requires a long counseling session, in which one question is central: Do you want to end this pregnancy? The American College of Obstetricians and Gynecologists (ACOG), which largely defines the standards of practice in the United States, holds that "the option of termination should be discussed when a genetic disorder or major structural abnormality is detected prenatally." In other words, ACOG tells doctors that we have to talk about abortion before we can continue care.

Read: The new abortion bills are a dare

When a doctor objects to abortion, ACOG guidelines say, "there should be a system in place to allow families to receive counseling about their options"—including the termination of a pregnancy—"and access to such care." This is the minimal ethical standard: A doctor who does not believe in abortion must, at the very least, point the way down that road.

I've never been that doctor. I have always discussed termination with my patients. Sometimes a patient immediately says that abortion is not an acceptable option for her, so we move on to other concerns: preparing for delivery, meeting the doctors who will be part of her baby's postnatal team, supporting her pregnancy as best we can.

Usually the discussion of abortion is longer and more wandering. At first, the patient may feel unsure of where she stands. As we talk, she may return to the subject and ask more questions. Conducting this conversation requires as much surgical skill as operating on a pregnant uterus. There is no right answer, only one that is less wrong for each patient. This is an almost impossible conversation—and one that doctors like me must have every day.

When seeing patients in the United States, doctors will initiate this conversation before 23 weeks. That is typically a patient's last opportunity to end her pregnancy—a timetable that helps explain why we generally schedule those diagnostic ultrasounds a few weeks earlier.

Key Supreme Court cases, including *Roe v. Wade* in 1973 and *Planned Parenthood v. Casey* in 1992, have built the right to abortion around the concept of fetal viability. The legal thinking goes like this: As long as a fetus cannot live independently outside a woman's body, a woman's bodily autonomy and right to privacy are the only relevant interests. Once the fetus

reaches a point when it could reasonably live outside the womb—albeit with the help of technology—the state legally has an interest in the developing pregnancy and can constitutionally limit abortion.

As medicine has advanced, viability has steadily moved earlier and earlier in a pregnancy. When I finished medical school, a fetus was deemed viable 24 weeks and zero days into a pregnancy. By the time I finished residency, the point of viability had advanced to somewhere around 23 weeks and four days—23 + 4, in medical shorthand. Today it's 23 + 0 for many institutions and creeping into 22 weeks. This doesn't mean that those babies are healthy. According to the most recent data, only 2 to 3 percent of infants born from 22 + 0 to 22 + 6 survived long enough to be discharged from the hospital, and only 1 percent lived without severe and permanent consequences of extreme prematurity.

But the U.S. legal standard for abortion hinges on reasonable viability, not healthy survival. In the phase of pregnancy before viability, abortion is protected (in theory) as a constitutional right; afterward, it can be limited by states. The future of this standard is uncertain. Anticipating a successful challenge to *Roe* in the near future, some states have already passed laws limiting abortions at earlier and earlier gestational-age thresholds, and more states are expected to follow.

Michael Wear: The abortion debate is no longer about policy

As long as *Roe* still holds, though, the sharp line it draws at the point of viability changes everything in an American ultrasound room. Suppose that I find a fetus with enlarged brain ventricles that, in rare cases, can be a sign of debilitating abnormalities. At 20 weeks, the finding would provoke the recommendation for amniocentesis; with the clock ticking, we'd want to identify any severe genetic disorders quickly. In some cases, I would warn

the patient, these tests yield diagnoses that lead some women to terminate their pregnancy.

That same finding at 32 weeks would be handled differently. Getting an abortion after viability for a lethal fetal anomaly is still technically legal in parts of the United States. Women who pursue termination under these circumstances—most often after receiving a devastating fetal diagnosis deep into a desired pregnancy—have harrowing stories of navigating the procedure alone, far from home. A patient may borrow money, sometimes tens of thousands of dollars, and fly to another state, where she may stay in a hotel for a few days. Such women talk about crossing picket lines of protesters who are screaming at them not to do what they have already spent days or weeks weeping about.

In practice, these situations are incredibly rare, likely a tiny fraction of 1 percent of all abortions in the United States. When evidence of nonlethal fetal anomalies emerges after the point of viability, there's less of a rush to reach a diagnosis, because ending the pregnancy is essentially off the table anyway. The conversation at 32 weeks is thus softer, more relaxed, and less urgent than at 20 weeks. I would discuss potential causes of those dilated ventricles and recommend some blood tests. I would mention amniocentesis. But most patients wouldn't seriously consider it, because at this point in a pregnancy, it could lead to complications, including premature labor.

Without other abnormalities, more than 90 percent of fetuses with mildly enlarged brain ventricles have normal developmental outcomes. At 32 weeks, most patients take refuge in the likelihood that the pregnancy is probably just fine. At 32 weeks, I print out those cute pictures, and that American patient leaves my office, often without tears.

Different societies navigate the landscape of moral choices in different ways. In the United States, courts have recognized a pregnant woman's autonomy over her own body, even as a potent movement led by Christian conservatives lobbies in the opposite direction. These opposing forces produce a strange outcome: Abortion is constitutionally protected as an individual right but, in much of the country, quite difficult to obtain.

Israel has struck nearly the opposite bargain. In this majority-Jewish country with deep socialist roots, abortion law has never been constructed around the idea of a woman's power over her own body, or around the value of fetal life. The basics of abortion law were passed in the 1970s, and were largely built around demographic concerns in a tiny collectivist country that, at the time, was almost continually at war. Though changes have been made, those foundational laws still prevail. In Israel, terminations of pregnancy, regardless of gestational age, must go through a committee, a va'ada. Without its assent, an abortion is officially a criminal offense. But here's the surprise: In the end, more than 97 percent of abortion requests that come before the committee are approved.

The va'ada can approve abortions for specific reasons spelled out by the law: if the woman is over 40, under 18, or unmarried; if the pregnancy is the result of rape, an extramarital affair, or any illegal sexual relationship, such as incest; if the fetus is likely to have a physical or mental defect; if continuing the pregnancy would endanger the woman's life or cause her mental or physical harm. Some of these rationales, such as rape and incest, are familiar from the U.S. abortion debate. Other justifications, such as those involving the woman's age or marital status, bespeak a certain amount of social engineering, and may strike Americans as odd matters for the law to take into account.

On paper, the va'ada system could seem very restrictive. Women still have

to jump through bureaucratic hoops, and some have told me that they lied—for instance, by saying a pregnancy was conceived in an extramarital affair—to meet the legal criteria for termination. Some women circumvent the va'ada system entirely, paying significant sums out of pocket to private doctors who perform illegal terminations. (Authorities generally look the other way.) Yet if an abortion is approved by the va'ada, it is almost always covered by the universal health-insurance system and performed in a hospital by expert physicians. In short, a process that begins by making an abortion a committee decision usually ends with a safe, timely abortion covered by public funds.

Post-viability abortions in Israel undergo a weightier approval process. After about 23 weeks of gestational age, a woman must present her case to a va'adat al, a "higher committee" with more members and more senior doctors.

Read: Malta's fledgling movement for abortion rights

Under guidelines from the Israeli Ministry of Health, many of the acceptable rationales for abortion in early pregnancy—age, extramarital affair—are no longer automatically sufficient to justify a post-viability termination. For such an abortion to be approved, a fetal anomaly must have at least a 30 percent chance of causing either moderate disability (in pregnancies of 24 to 28 weeks) or severe disability (after 28 weeks).

If a 30 percent chance strikes you as a low threshold for an abortion at this stage, you're not alone. Almost every American I've asked, whether a physician or layperson, finds that number shocking. After all, a 30 percent chance of an affected child is a 70 percent chance of an unaffected one.

In 2015, 93 percent of patients with post-viability pregnancies who applied to a va'adat al were approved. These late terminations, the overwhelming

majority of which are approved for a fetal anomaly, represent 1.7 percent of all abortions performed in Israel; in comparison, they are 0.1 percent of abortions in England and Wales, and exceedingly rare in other European countries and the United States.

In deciding whether to raise the possibility of abortion with a pregnant woman, doctors in Israel may be responding as much to the tort system as to medical reality. While Israel is less litigious than the United States overall, a landmark Israeli Supreme Court ruling in 1986 eased the way for wrongful-life and wrongful-birth lawsuits. In a wrongful-life case, a patient born with a disability seeks damages caused by a doctor's failure to offer an abortion; in wrongful-birth cases, parents are the plaintiffs. The judges who made the ruling had hoped to provide disabled patients with the financial resources necessary to live with dignity. But in the malpractice environment that ensued, the obvious way for doctors to protect themselves against lawsuits was to err on the side of counseling patients about termination.

Such lawsuits are rare elsewhere in the world. In the United States, wrongful-life and wrongful-birth cases have been restricted by legislation in many states. Anti-abortion groups that lobby for these restrictions fear that wrongful-birth lawsuits will lead doctors to recommend more abortions. More recent case law in Israel has created a more stringent legal standard, but recent statistics have shown that the number of suits continues to grow.

When termination of pregnancy is never off the table, it changes the way doctors like me practice. In the ultrasound suite, there's always a chance I'll have to initiate a traumatic conversation with a pregnant woman, no matter how far along she is.

I currently work at an Israeli hospital that doesn't provide abortions. I have many ultra-Orthodox Jewish and observant Muslim patients who don't

pursue prenatal diagnosis, and I limit their ultrasounds and counseling as their convictions dictate. But pregnancy termination comes up frequently anyway. Many of the women I see as patients come to me after receiving care from other hospitals, often with thick files in their hands. The papers inside document ultrasound after ultrasound, MRIs of the fetal brain, genetics consultations. Almost always included is the phrase *termination of pregnancy discussed*.

Read: When abortion is illegal, women rarely die. But they still suffer.

When I trace back to the original ultrasound finding that brought such a patient to me, the potential fetal anomaly it identifies is often something—an increase in amniotic fluid, say, or a mild dilation of the brain ventricles—that would seldom raise the question of abortion late in pregnancy in the United States.

Outside of the hospital, I hear similar stories from Israeli colleagues and friends. After a request on social media, I ended up with a dozen stories of patients who had discussed abortion with their doctor late in their pregnancy. Many of these cases involved clinical findings that, to my American-trained eyes, just didn't warrant it. One friend told me that, at her 37-week visit, when her fetus was measuring very small, with the fetal femur bones appearing shorter than normal, she was offered two options: She could go to the hospital either to have labor induced or to ask for a termination of her pregnancy. Same visit, same hospital, her choice. She laughs about it now, as that sweet baby nurses at her breast. When my friend was 37 weeks pregnant, though, it wasn't funny; it felt both terrifying and cruel.

In Israel, the conversation about ending a pregnancy demands to be conducted, all the time, for almost any small finding—even when it's not in

the patient's best interest, even when it's really about protecting the doctor. And that's why I was in that dark room, measuring and remeasuring that 35-week fetal head, trying to avoid what had to come next.

I was almost not brave enough to write this piece. In the United States, there are only two sides to abortion, and there is outrage on both. Anti-abortion activists will say that I'm a murderer, or an accessory to murder, because of the work I do.

I also hesitated for the opposite reason: Any time a pro-abortion-rights provider admits to any doubts, her ambivalence may be used to limit abortion care. One expert I interviewed for this piece said, "If you write how hard it is to counsel about abortions, please know this: Somewhere, someone will use that to stop women from getting the procedures that they need." After that, I couldn't write for weeks.

But there needs to be a way to talk about all the places in the middle of the abortion debate, where most Americans' beliefs actually lie.

Since arriving in Israel, I have learned that I love practicing in a country with ready access to safe abortion. I have learned that I hate the rules forcing a woman to ask a panel of strangers for permission to end her pregnancy. The committee structure is demeaning and unethical, an affront to a patient's autonomy over her own treatment.

Yet I have also learned that, in the absence of a clearly debilitating or lethal fetal abnormality, I am deeply uncomfortable with a termination of pregnancy at 35 weeks, or 32 weeks, or 28 weeks. That, it turns out, is well outside the limits of my personal pro-choice terrain. Indeed, I am uncomfortable even discussing such a termination with patients.

In my career as an obstetrician, I have cared for many pregnant women at

risk of giving birth months too soon. I've prayed with women whose water broke much too early. I have fought for the survival of fetuses on their way to being born at 24 weeks. I've delivered a lot of 28-week and 32-week and 35-week babies, and often had their parents return to me with their healthy toddlers, smiling and chubby. I know how hard women will fight for those pregnancies; I know what they are willing to risk. I won't bring up termination of pregnancy at that point—unless the alternative is worse.

Of all the American things I'm homesick for, it turns out the biggest one is *Roe v. Wade*. I miss U.S. abortion law terribly. In some part, that's because it's familiar. But it's also because the structure of American law, if practiced as constitutionally legislated, works for most patients, most of the time—ethically, emotionally, and medically. The arrangement of U.S. abortion rights means that terminations center on a woman's choice, but also that there's a point in a pregnancy when abortion is off the table, except in the most dire of circumstances. And that means there's a point in the pregnancy when everybody can relax, when we start to comfortably call the fetus a baby, when we can embrace the joy that accompanies a healthy, desired pregnancy.

In Israel, because abortion is never off the table, that relaxed time in a pregnancy never fully arrives. Telling women all their legal options is still part of my job. I am ethically required to have these difficult conversations about late abortion. I can honor that minimal obligation, though I never imagined I'd have so much trouble meeting it. When I return to the United States, what I'll take back with me is this itchy strangeness of having to figure out where I stand.

In that dark ultrasound room in the fall, I asked the patient to wipe the gel off her 35-week belly and gave her a hand to sit up. I told her what I saw: The baby's head was quite small. As the words in Hebrew left my mouth, I

could hear that I'd conjugated the verb incorrectly, and I paused. She heard my American accent and softly corrected me.

I told her, then, that I thought the head size was probably not a problem; that measuring a head is difficult, once it has already settled in the maternal pelvis; that our measurements are more unreliable near term. I mentioned gently that anything with the brain can be tricky; that sometimes these things can be serious, even debilitating; that further testing for other problems is available.

"Most people ...," I said. I paused, trying to get the words and the tone exactly right. I started again. "Most people wouldn't consider doing anything further for what I just saw, much less something serious like amniocentesis or terminating the pregnancy. But if you'd like to talk to someone who can tell you about those things, or even just take a second look at the brain, I can send you to someone else."

She was already shaking her head. "No," she said. "No, thank you." And then she asked: "Can I have that picture of the baby's face? I want to show my husband; I think she has his mouth."

I gave it to her. She smoothed the black-and-white film between her fingers, and smiled at it in her hand. And then she walked out the door.

I Asked Thousands of Biologists When Life Begins. The Answer Wasn't Popular

Published on October 16, 2019

Shortly after being awarded my Ph.D. by the University of Chicago's department of Comparative Human Development this year, I found myself in a minor media whirlwind. I was interviewed by The Daily Wire, The College Fix, and Breitbart. I appeared on national television and on a widely syndicated radio program. All of this interest had been prompted by a working paper associated with my dissertation, which was entitled *Balancing Abortion Rights and Fetal Rights: A Mixed Methods Mediation of*

the U.S. Abortion Debate.

As discussed in more detail below, I reported that both a majority of pro-choice Americans (53%) and a majority of pro-life Americans (54%) would support a comprehensive policy compromise that provides entitlements to pregnant women, improves the adoption process for parents, permits abortion in extreme circumstances, and restricts elective abortion after the first trimester. However, members of the media were mostly interested in my finding that 96% of the 5,577 biologists who responded to me affirmed the view that a human life begins at fertilization.

It was the reporting of this view—that human zygotes, embryos, and fetuses are biological humans—that created such a strong backlash. It was not unexpected, as the finding provides fodder for conservative opponents of *Roe* v. *Wade*, the 1973 case in which the U.S. Supreme Court had suggested there was no consensus on "the difficult question of when life begins" and that "the judiciary, at this point in the development of man's knowledge, [was] not in a position to speculate as to the answer."

* * *

The U.S. abortion debate has raged for generations, and remains divisive to this day. As a lawyer, mediator and researcher, I sought to assess whether there is room for compromise. I believed that such an approach could help Americans on both sides develop a shared understanding of the main issues—particularly surrounding the question of when life begins. My approach was similar to that implemented by Yale Professor Dan Kahan in his 2003 gun-control debate manifesto, in which he declared his objective as "not to take any particular position on gun control but instead to take issue with the terms in which the gun control debate is cast." I was being idealistic, yes, but this approach was not without precedent.

"This dissertation seeks to explain why the abortion debate persists and whether it can be resolved," I wrote in my dissertation's introduction. "While the U.S. Supreme Court was able to end the national segregation controversy with its holding in *Brown* v. *Board [of Education]*, the Court has twice failed to end the national abortion controversy [in the landmark Supreme Court cases of *Roe* and *Planned Parenthood* v. *Casey* in 1992]. The controversy has been resilient for decades, and it grows as some states pass laws to ban abortions throughout pregnancy, and other states legalize abortion throughout pregnancy. [T]his dissertation aims to understand whether the national controversy surrounding abortion is trivial or insurmountable."

I employed a theoretical approach that was recently codified by graduates from my department: "[A] proposal to have a synthetic approach to social psychological research, in which qualitative methods are augmentative to quantitative ones, qualitative methods can be generative of new experimental hypotheses, and qualitative methods can capture experiences that evade experimental reductionism." In practice, this meant going back and forth between qualitative and quantitative methods, leading in-person mediations with small groups, reviewing literature, and conducting surveys of Americans and the experts whose opinions they respected. My research timeline was roughly as follows, with each step being guided by what I already had learned from the previous steps:

- I led discussions between pro-choice and pro-life law students. Little progress was made because both sides were caught up with the factual question of when life begins.
- I surveyed thousands of Americans using Amazon's MTurk service. I found that most Americans believe that the question of "when life begins" is an important aspect of the U.S. abortion debate (82%); that most believe Americans deserve to know when a human's life begins in

order to give informed consent to abortion procedures (76%); and that most Americans believe a human's life is worthy of legal protection once it begins (93%). Respondents also were asked: "Which group is most qualified to answer the question, 'When does a human's life begin?'" They were presented with several options—biologists, philosophers, religious leaders, Supreme Court Justices and voters. Eighty percent selected biologists, and the majority explained that they chose biologists because they view them as objective experts in the study of life.

- I consulted with biologists, including a female University of Chicago Ph.D. genetics student; a female University of Chicago Ph.D. graduate; and a male professor—the biology expert in my department, who later served on my dissertation committee.
- I reviewed aggregated lists of biologists' views in this area, studied the opinions of experts who testified before a 1981 Senate Committee on a Human Life Amendment, and the 2005 South Dakota Abortion Task Force. I also reviewed polls of Americans' views on the question of when life begins.
- Since these sources suggested the most common view was that a human's life begins at fertilization, I designed a survey to understand biologists' assessment of that view. I emailed surveys to professors in the biology departments of over 1,000 institutions around the world.
- As the usable responses began to come in, I found that 5,337 biologists (96%) affirmed that a human's life begins at fertilization, with 240 (4%) rejecting that view. The majority of the sample identified as liberal (89%), pro-choice (85%) and non-religious (63%). In the case of Americans who expressed party preference, the majority identified as Democrats (92%).

These data were not as surprising as some might imagine. Philosophers

such as Peter Singer and Judith Jarvis Thomson have outlined abortion defenses that recognize a fetus' humanity, while also rejecting the argument that fetuses have rights, or arguing that a pregnant person's right to abort supersedes a fetus' right to life. Unfortunately, that did not stop some academics from being angered by the very idea of being asked about the ontogenetic starting point of a human's life. Some of the e-mails I received included notes such as:

- "Is this a studied fund by Trump and ku klux klan?"
- "Sure hope YOU aren't a f^%$#ing christian!!"
- "This is some stupid right to life thing...YUCK I believe in RIGHT TO CHOICE!!!!!!!"
- "The actual purpose of this 'survey' became very clear. I will do my best to disseminate this info to make sure that none of my naïve colleagues fall into this trap."
- "Sorry this looks like its more a religious survey to be used to misinterpret by radicals to advertise about the beginning of life and not a survey about what faculty know about biology. Your advisor can contact me."
- "I did respond to and fill in the survey, but am concerned about the tenor of the questions. It seemed like a thinly-disguised effort to make biologists take a stand on issues that could be used to advocate for or against abortion."
- "The relevant biological issues are obvious and have nothing to do with when life begins. That is a nonsense position created by the antiabortion fanatics. You have accepted the premise of a fanatic group of lunatics. The relevant issues are the health cost carrying an embryo to term can impose on a woman's body, the cost they impose on having future children, and the cost that raising a child imposes on a woman's financial status."

Given those responses, one might suspect that I had asked loaded questions such as: "Since the human life cycle begins at conception, isn't abortion tantamount to *murder*?" But I didn't. I asked an open-ended question to ensure that respondents were able to fully express their views on when life begins. Moreover, I asked respondents to assess the following elements of the view that "a human's life begins at fertilization":

- "The end product of mammalian fertilization is a fertilized egg ('zygote'), a new mammalian organism in the first stage of its species' life cycle with its species' genome."
- "The development of a mammal begins with fertilization, a process by which the spermatozoon from the male and the oocyte from the female unite to give rise to a new organism, the zygote."
- "A mammal's life begins at fertilization, the process during which a male gamete unites with a female gamete to form a single cell called a zygote."
- "In developmental biology, fertilization marks the beginning of a human's life, since that process produces an organism with a human genome that has begun to develop in the first stage of the human life cycle."
- "From a biological perspective, a zygote that has a human genome is a human because it is a human organism developing in the earliest stage of the human life cycle."

After assessing the above statements and answering an essay question, the respondent biologists were then told that the survey "relates to the controversial public debate surrounding abortion." It was at this point in the procedure that I received hostile responses, some of which are excerpted above.

In my dissertation, I proposed three possible motivations for these hostile

reactions:

- *Motivated Reasoning*: Respondents experience cognitive dissonance when they recognize that their view of a fetus as a human complicates their political convictions in regard to abortion policy.
- *Cultural Cognition*: Respondents fear that public recognition of the scientific views they are expressing could lead to *other* people supporting abortion restrictions.
- *Identity-Protective Cognition*: Respondents fear that expressing their views may serve to estrange them from pro-choice liberals, on whom they might rely for social, emotional, or financial support.

I understand the subject of my research might have political ramifications. But, as neuroscientist Maureen Condic has noted, "establishing by clear scientific evidence the moment at which a human life begins is not the end of the abortion debate. On the contrary, that is the point from which the debate begins." Yet the reception to my research suggests that many are going to ignore my findings out of fear of political repercussions.

I have concluded that one of the biggest reasons the abortion debate can't be bridged is mistrust. I think this is primarily due to the stakes being so high for both sides. One side sees abortion rights as critical to gender equality, while the other sees abortion as an epic human rights tragedy—as over a billion humans have died in abortions since the year 2000.

Despite the one-sided stance of the majority of 2020 presidential candidates, my research indicates that Americans on both sides agree that the nation's abortion laws should both ensure some abortion access while also providing some protections for humans in the womb. Indeed, I found that a majority of both pro-choice and pro-life Americans supported a compromise that restricted access after the first trimester of pregnancy, as

described at the outset of this essay. This combination of policies is quite similar to the law of the land in many of the most socially liberal countries of Europe, which tend to balance abortion rights with fetal rights.

In my research, I was not advocating for such a compromise. However, advancing my own preferred outcome was not the point of my academic project. My goal was to use my training to establish common ground, learn whether a compromise was possible, and report on the most likely form such a compromise might take. An important takeaway is that both sides do agree on the arbiters of the question of when life begins.

While the justices in *Roe* could not answer the difficult question of when life begins, the U.S. Supreme Court might well revisit this question in the future. The Court can trust the uncensored viewpoints of biologists and acknowledge that scientific experts affirm the view that a human's life begins at fertilization—even if some would prefer that this fact be hidden from view.

Steve Jacobs Tweets at @drstevejacobs.

Featured image: Stop Abortion Bans Rally, St. Paul, Minnesota, May 21, 2019.

The Anti-Theology of the Body

John Paul II and The Ethics of the Body

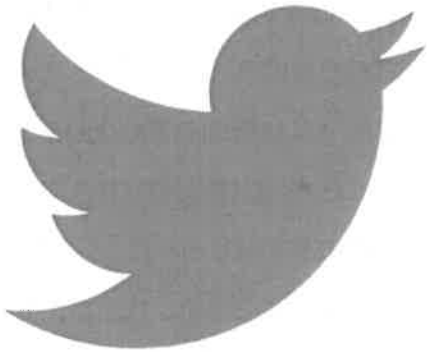
> *John Paul II's legacy reaches across many domains of human life. He was a religious shepherd for Catholic believers, a moral leader during the Cold War and after, and a truly modern philosopher who did not accept all the assumptions of modernity. His writings are significant not just for Catholics but for everyone, and not just in the theological realm but in the ethical realm.* The New Atlantis *asked two leading thinkers—Eastern Orthodox theologian David B. Hart and Lutheran theologian —to consider the significance of John Paul II's* Theology of the Body *for bioethics and beyond.*

David Bentley Hart

To ask what the legacy of John Paul II's ***Theology of the Body*** might be for future debates in bioethics is implicitly to ask what relevance it has for current debates in bioethics. And this creates something of a problem, because there is a real sense in which it has none at all — at least, if by "relevance" one means discrete logical propositions or policy recommendations that might be extracted from the larger context of John Paul's teachings so as to "advance the conversation" or "suggest a middle course" or "clarify ethical ambiguities." Simply said, the book does not offer arguments, or propositions, or (thank God) "suggestions." Rather, it enunciates with extraordinary fullness a complete vision of the spiritual and corporeal life of the human being; that vision is a self-sufficient totality, which one is free to embrace or reject as a whole. To one who holds to John Paul's Christian understanding of the body, and so believes that each human being, from the very first moment of existence, emerges from and is called towards eternity, there are no negotiable or even very perplexing issues regarding our moral obligations before the mystery of life. Not only is

every abortion performed an act of murder, but so is the destruction of every "superfluous" embryo created in fertility clinics or every embryo produced for the purposes of embryonic stem cell research. The fabrication of clones, the invention of "chimeras" through the miscegenation of human and animal DNA, and of course the termination of supernumerary, dispensable, or defective specimens that such experimentation inevitably entails are in every case irredeemably evil. Even if, say, research on embryonic stem cells could produce therapies that would heal the lame, or reverse senility, or repair a damaged brain, or prolong life, this would in no measure alter the moral calculus of the situation: human life is an infinite good, never an instrumental resource; human life is possessed of an absolute sanctity, and no benefit (real or supposed) can justify its destruction.

In a wider sense, though, I would want to argue that it is precisely this "irrelevance" that makes John Paul's theology truly relevant (in another sense) to contemporary bioethics. I must say that what I, as an Eastern Orthodox Christian, find most exhilarating about the *Theology of the Body* is not simply that it is perfectly consonant with the Orthodox understanding of the origins and ends of human nature (as indeed it is), but that from beginning to end it is a text awash in the clear bright light of uncompromising conviction. There is about it something of that sublime indifference to the banal pieties and prejudices of modernity that characterizes Eastern Orthodoxy at its best. It simply restates the ancient Christian understanding of man, albeit in the somewhat phenomenological idiom for which John Paul had so marked a penchant, and invites the reader to enter into the world it describes. And at the heart of its anthropology is a complete rejection — or, one might almost say, ignorance — of any dualism between flesh and spirit.



It is something of a modern habit of thought (strange to say) to conceive of the soul — whether we believe in the soul or not — as a kind of magical essence or ethereal intelligence indwelling a body like a ghost in a machine. That is to say, we tend to imagine the relation between the soul and the body as an utter discontinuity somehow subsumed within a miraculous unity: a view capable of yielding such absurdities as the Cartesian postulate that the soul resides in the pituitary gland or the utterly superstitious speculation advanced by some religious ethicists that the soul may "enter" the fetus some time in the second trimester. But the "living soul" of whom scripture speaks, as John Paul makes clear in his treatment of the creation account in Genesis, is a single corporeal and spiritual whole, a person whom the breath of God has awakened from nothingness. The soul is life itself, of the flesh and of the mind; it is what Thomas Aquinas called the "form of the body": a vital power that animates, pervades, and shapes each of us from the moment of conception, holding all our native energies in a living unity, gathering all the multiplicity of our experience into a single, continuous, developing identity. It encompasses every dimension of human existence, from animal instinct to abstract reason: sensation and intellect, passion and reflection, imagination and curiosity, sorrow and delight, natural aptitude and supernatural longing, flesh and spirit. John Paul is quite insistent that the body must be regarded not as the vessel or vehicle of the soul, but simply as its material manifestation, expression, and occasion. This means that even if one should trace the life of the body back to its most primordial principles, one would still never arrive at that point where the properly human vanishes and leaves a "mere" physical organism or aggregation of inchoate tissues or ferment of spontaneous chemical reactions behind. All of man's bodily life is also the life of the soul, possessed of a supernatural dignity and a vocation to union with God.

The far antipodes of John Paul's vision of the human, I suppose, are to be

found at the lunatic fringe of bioethics, in that fanatically "neo-Darwinist" movement that has crystallized around the name of "transhumanism." A satirist with a genius for the morbid could scarcely have invented a faction more depressingly sickly, and yet — in certain reaches of the scientific community — it is a movement that enjoys some real degree of respectability. Its principal tenet is that it is now incumbent upon humanity to take control of its own evolution, which on account of the modern world's technological advances and social policies has tragically stalled at the level of the merely anthropine; as we come to master the mysteries of the genome, we must choose what we are to be, so as to progress beyond *Homo sapiens*, perhaps one day to become beings — in the words of the Princeton biologist Lee Silver — "as different from humans as humans are from...primitive worms" (which are, I suppose, to be distinguished from sophisticated worms). We must seek, that is to say, to become gods. Many of the more deliriously visionary of the transhumanists envisage a day when we will be free to alter and enhance ourselves at will, unconstrained by law or shame or anything resembling good taste: by willfully transgressing the genetic boundaries between species (something that we are already learning how to do), we may be able to design new strains of hybrid life, or even to produce an endlessly proliferating variety of new breeds of the post-human that may no longer even have the capacity to reproduce one with the other. (For those whose curiosity runs to the macabre, Wesley Smith's recent ***Consumer's Guide to a Brave New World*** provides a good synopsis of the transhumanist creed.)

Obviously one is dealing here with a sensibility formed more by comic books than by serious thought. Ludicrous as it seems, though, transhumanism is merely one logical consequence (if a particularly childish one) of the surprising reviviscence of eugenic ideology in the academic, scientific, and medical worlds. Most of the new eugenists, admittedly, see their solicitude for the greater wellbeing of the species as suffering from none of the distasteful authoritarianism of the old racialist eugenics, since all they advocate (they say) is a kind of elective genetic engineering — a bit

of planned parenthood here, the odd reluctant act of infanticide there, a *soupçon* of judicious genetic tinkering everywhere, and a great deal of prudent reflection upon the suitability of certain kinds of embryos — but clearly they are deluding themselves or trying to deceive us. Far more intellectually honest are those — like the late, almost comically vile Joseph Fletcher of Harvard — who openly acknowledge that any earnest attempt to improve the human stock must necessarily involve some measures of legal coercion. Fletcher, of course, was infamously unabashed in castigating modern medicine for "polluting" our gene pool with inferior specimens and in rhapsodizing upon the benefits the race would reap from instituting a regime of genetic invigilation that would allow society to eliminate "idiots" and "cripples" and other genetic defectives before they could burden us with their worthless lives. It was he who famously declared that reproduction is a privilege, not a right, and suggested that perhaps mothers should be forced by the state to abort "diseased" babies if they refused to do so of their own free will. Needless to say, state-imposed sterilization struck him as a reasonable policy; and he agreed with Linus Pauling that it might be wise to consider segregating genetic inferiors into a recognizable caste, marked out by indelible brands impressed upon their brows. And, striking a few minor transhumanist chords of his own, he even advocated — in a deranged and hideous passage from his book ***The Ethics of Genetic Control*** — the creation of "chimeras or parahumans...to do dangerous or demeaning jobs" of the sort that are now "shoved off on moronic or retarded individuals" — which, apparently, was how he viewed janitors, construction workers, firefighters, miners, and persons of that ilk.

Of course, there was always a certain oafish audacity in Fletcher's degenerate driveling about "morons" and "defectives," given that there is good cause to suspect, from a purely utilitarian vantage, that academic ethicists — especially those like Fletcher, who are notoriously mediocre thinkers, possessed of small culture, no discernible speculative gifts, no records of substantive philosophical achievement, and execrable prose styles — constitute perhaps the single most useless element in society. If

reproduction is not a right but a social function, should any woman be allowed to bring such men into the world? And should those men be permitted, in their turn, to sire offspring? I ask this question entirely in earnest, because I think it helps to identify the one indubitable truth about all social movements towards eugenics: namely, that the values that will determine which lives are worth living, and which not, will always be the province of persons of vicious temperament. If I were asked to decide what qualities to suppress or encourage in the human species, I might first attempt to discover if there is such a thing as a genetic predisposition to moral idiocy and then, if there is, to eliminate it; then there would be no more Joseph Fletchers (or Peter Singers, or Linus Paulings, or James Rachels), and I might think all is well. But, of course, the very idea is a contradiction in terms. Decisions regarding who should or should not live can, by definition, be made only by those who believe such decisions *should* be made; and therein lies the horror that nothing can ever exorcise from the ideology behind human bioengineering.

Transhumanism, as a moral philosophy, is so risibly fabulous in its prognostications, and so unrelated to anything that genomic research yet promises, that it can scarcely be regarded as anything more than a pathetic dream; but the *metaphysical* principles it presumes regarding the nature of the human are anything but eccentric. Joseph Fletcher was a man with a manifestly brutal mind, desperately anxious to believe himself superior to the common run of men, one who apparently received some sort of crypto-erotic thrill from his cruel fantasies of creating a slave race, and of literally branding others as his genetic inferiors, and of exercising power over the minds and bodies of the low-born. And yet his principles continue to win adherents in the academy and beyond it, and his basic presuppositions about the value and meaning of life are the common grammar of a shockingly large portion of bioethicists. If ever the day comes when we are willing to consider a program, however modest, of improving the species through genetic planning and manipulation, it will be exclusively those who hold such principles and embrace such presuppositions who will determine

what the future of humanity will be. And men who are impatient of frailty and contemptuous of weakness are, at the end of the day, inevitably evil.

Why dwell on these things, though? After all, most of the more prominent debates in bioethics at the moment do not actually concern systematic eugenics or, certainly, "post-humanity," but center upon issues of medical research and such matters as the disposition of embryos who will never mature into children. It is true that we have already begun to transgress the demarcations between species — often in pursuit of a medical or technological benefit — and cloning is no longer merely a matter of speculation. But even here issues of health and of new therapeutic techniques predominate, and surely these require some degree of moral subtlety from all of us. Am I not, then, simply skirting difficult questions of practical ethics so as to avoid allowing any ambiguity to invade my Christian absolutism? Perhaps. But it seems to me that the metaphysics, dogma, and mysticism of "transhumanism" or Fletcherite eugenics hide behind, and await us as the inevitable terminus of, every movement that subordinates or sacrifices the living soul — the life that is here before us, in the moment, in all its particularity and fragility — to the progress of science, of medicine, or of the species. That is to say, I dwell upon extremes because I believe it is in extremes that truth is most likely to be found. And this brings me back to John Paul II's theology of the body.

The difference between John Paul's theological anthropology and the pitilessly consistent materialism of the transhumanists and their kith — and this is extremely important to grasp — is a difference not simply between two radically antagonistic visions of what it is to be a human being, but between two radically antagonistic visions of what it is to be a god. There is, as it happens, nothing inherently wicked in the desire to become a god, at least not from the perspective of Christian tradition; and I would even say that if there is one element of the transhumanist creed that is not wholly contemptible — one isolated moment of innocence, however fleeting and imperfect — it is the earnestness with which it gives expression to this

perfectly natural longing. Theologically speaking, the proper destiny of human beings is to be "glorified" — or "divinized" — in Christ by the power of the Holy Spirit, to become "partakers of the divine nature" (II Peter 1:4), to be called "gods" (Psalm 82:6; John 10:34-36). This is the venerable doctrine of "*theosis*" or "deification," the teaching that — to employ a lapidary formula of great antiquity — "God became man that man might become god": that is to say, in assuming human nature in the incarnation, Christ opened the path to union with the divine nature for all persons. From the time of the Church Fathers through the high Middle Ages, this understanding of salvation was a commonplace of theology. Admittedly, until recently it had somewhat disappeared from most Western articulations of the faith, but in the East it has always enjoyed a somewhat greater prominence; and it stands at the very center of John Paul's theology of the body. As he writes in ***Evangelium Vitae***:

> Man is called to a fullness of life which far exceeds the dimensions of his earthly existence, because it consists in sharing the very life of God. The loftiness of this supernatural vocation reveals the greatness and the inestimable value of human life even in its temporal phase.

John Paul's anthropology is what a certain sort of Orthodox theologian might call a "theandric" humanism. "Life in the Spirit," the most impressive of the texts collected in the *Theology of the Body*, is to a large extent an attempt to descry the true form of man by looking to the end towards which he is called, so that the glory of his eschatological horizon, so to speak, might cast its radiance back upon the life he lives *in via* here below. Thus, for John Paul, the earthly body in all its frailty and indigence and limitation is always already on the way to the glorious body of resurrection of which Paul speaks; the mortal body is already the seed of the divinized and immortal body of the Kingdom; the weakness of the flesh is already, potentially, the strength of "the body full of power"; the earthly Adam is already joined to the glory of the last Adam, the risen and living Christ. For the late pope, divine humanity is not something that in a simple sense lies beyond the

human; it does not reside in some future, post-human race to which the good of the present must be offered up; it is instead a glory hidden in the depths of every person, even the least of us — even "defectives" and "morons" and "genetic inferiors," if you will — waiting to be revealed, a beauty and dignity and power of such magnificence and splendor that, could we see it now, it would move us either to worship or to terror.

Obviously none of this would interest or impress the doctrinaire materialist. The vision of the human that John Paul articulates and the vision of the "transhuman" to which the still nascent technology of genetic manipulation has given rise are divided not by a difference in practical or ethical philosophy, but by an irreconcilable hostility between two religions, two metaphysics, two worlds — at the last, two gods. And nothing less than the moral nature of society is at stake. If, as I have said, the metaphysics of transhumanism is inevitably implied within such things as embryonic stem cell research and human cloning, then to embark upon them is already to invoke and invite the advent of a god who will, I think, be a god of boundless horror, one with a limitless appetite for sacrifice. And it is by their gods that human beings are shaped and known. In some very real sense, "man" is always only the shadow of the god upon whom he calls: for in the manner by which we summon and propitiate that god, and in that ultimate value that he represents for us, who and what we are is determined.

The materialist who wishes to see modern humanity's Baconian mastery over cosmic nature expanded to encompass human nature as well — granting us absolute power over the flesh and what is born from it, banishing all fortuity and uncertainty from the future of the race — is someone who seeks to reach the divine by ceasing to be human, by surpassing the human, by destroying the human. It is a desire both fantastic and depraved: a diseased titanism, the dream of an infinite passage through monstrosity, a perpetual and ruthless sacrifice of every present good to the featureless, abysmal, and insatiable god who is to come. For the Christian to whom John Paul speaks, however, one can truly aspire to the divine only

through the charitable cultivation of glory in the flesh, the practice of holiness, the love of God and neighbor; and, in so doing, one seeks not to take leave of one's humanity, but to fathom it in its ultimate depth, to be joined to the Godman who would remake us in himself, and so to become *simul divinus et creatura*. This is a pure antithesis. For those who, on the one hand, believe that life is merely an accidental economy of matter that should be weighed by a utilitarian calculus of means and ends and those who, on the other, believe that life is a supernatural gift oriented towards eternal glory, every moment of existence has a different significance and holds a different promise. To the one, a Down syndrome child (for instance) is a genetic scandal, one who should probably be destroyed in the womb as a kind of oblation offered up to the social good and, of course, to some immeasurably remote future; to the other, that same child is potentially (and thus far already) a being so resplendent in his majesty, so mighty, so beautiful that we could scarcely hope to look upon him with the sinful eyes of this life and not be consumed.

It may well be that the human is an epoch, in some sense. The idea of the infinite value of every particular life does not accord with instinct, as far as one can tell, but rather has a history. The ancient triumph of the religion of divine incarnation inaugurated a new vision of man, however fitfully and failingly that vision was obeyed in subsequent centuries. Perhaps this notion of an absolute dignity indwelling every person — this Christian invention or discovery or convention — is now slowly fading from our consciences and will finally be replaced by something more "realistic" (which is to say, something more nihilistic). Whatever the case, John Paul's theology of the body will never, as I have said, be "relevant" to the understanding of the human that lies "beyond" Christian faith. Between these two orders of vision there can be no fruitful commerce, no modification of perspectives, no debate, indeed no "conversation." All that can ever span the divide between them is the occasional miraculous movement of conversion or the occasional tragic movement of apostasy. Thus the legacy of that theology will be to remain, for Christians, a

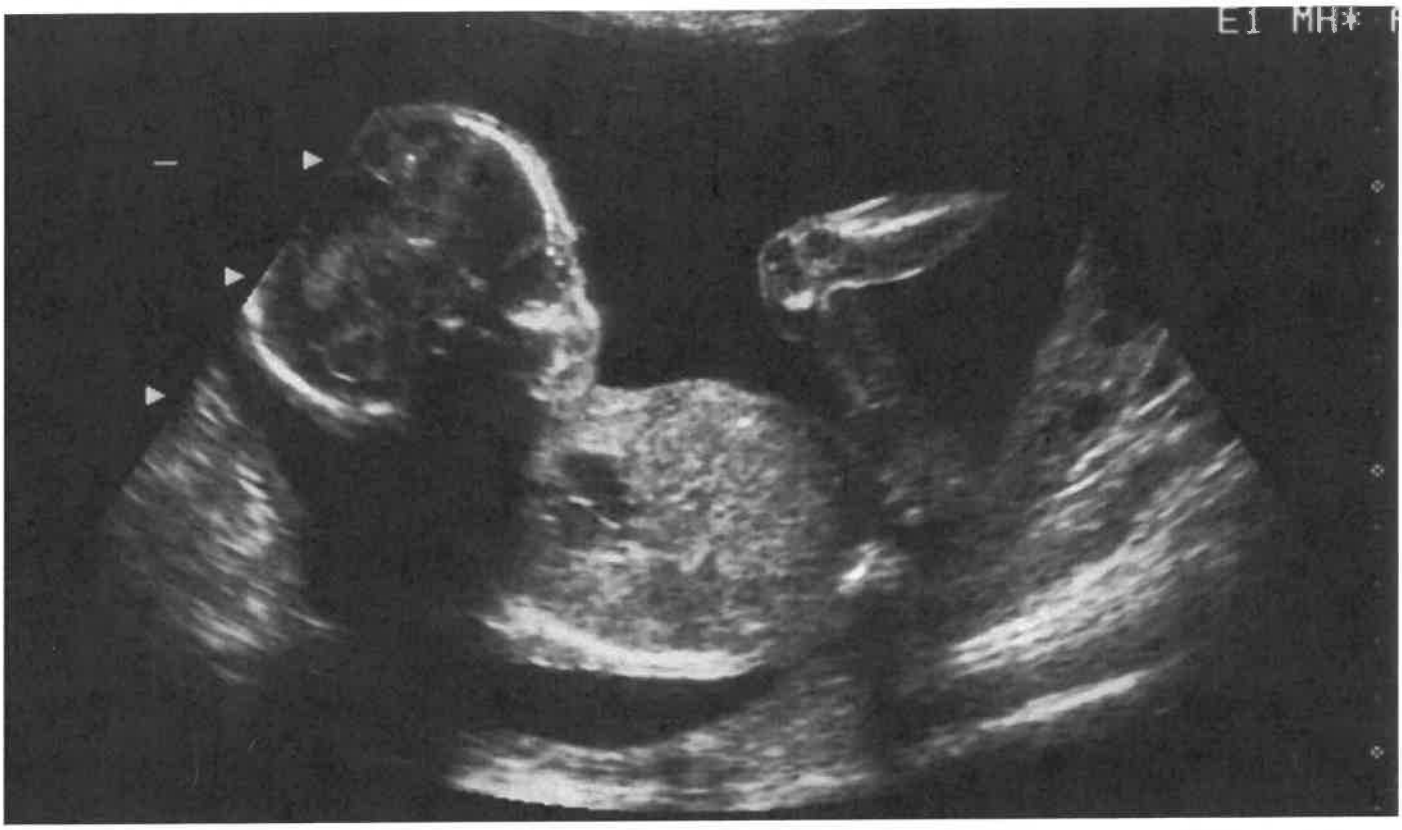
monument to the grandeur and fullness of their faith's "total humanism," so to speak, to remind them how vast the Christian understanding of humanity's nature and destiny is, and to inspire them — whenever they are confronted by any philosophy, ethics, or science that would reduce any human life to an instrumental moment within some larger design — to a perfect and unremitting enmity.

David B. Hart *is an Eastern Orthodox theologian and author of* **The Beauty of the Infinite**.

David B. Hart, "The Anti-Theology of the Body," *The New Atlantis*, Number 9, Summer 2005, pp. 65-73.

When Abortion Suddenly Stopped Making Sense

Frederica Mathewes-Green January 22, 2016 9:00 AM



(Photo: Suzanne Tucker/Dreamstime)

Abortion won the day, but sooner or later that day will end.

At the time of the *Roe v. Wade* decision, I was a college student — an anti-war, mother-earth, feminist, hippie college student. That particular January I was taking a semester off, living in the D.C. area and volunteering at the feminist "underground newspaper" *Off Our Backs*. As you'd guess, I was strongly in favor of legalizing abortion. The bumper sticker on my car read, "Don't labor under a misconception; legalize abortion."

The first issue of *Off Our Backs* after the *Roe* decision included one of my movie reviews, and also an essay by another member of the collective criticizing the decision. It didn't go far enough, she said, because it allowed states to restrict abortion in the third trimester. The Supreme Court should

not meddle in what should be decided between the woman and her doctor. She should be able to choose abortion through all nine months of pregnancy.

But, at the time, we didn't have much understanding of what abortion *was*. We knew nothing of fetal development. We consistently termed the fetus "a blob of tissue," and that's just how we pictured it — an undifferentiated mucous-like blob, not recognizable as human or even as alive. It would be another 15 years of so before pregnant couples could show off sonograms of their unborn babies, shocking us with the obvious humanity of the unborn.

We also thought, back then, that few abortions would ever be done. It's a grim experience, going through an abortion, and we assumed a woman would choose one only as a last resort. We were fighting for that "last resort." We had no idea how common the procedure would become; today, one in every five pregnancies ends in abortion.

Nor could we have imagined how high abortion numbers would climb. In the 43 years since *Roe v. Wade*, there have been 59 million abortions. It's hard even to grasp a number that big. Twenty years ago, someone told me that, if the names of all those lost babies were inscribed on a wall, like the Vietnam Veterans Memorial, the wall would have to stretch for 50 miles. It's 20 years later now, and that wall would have to stretch twice as far. But no names could be written on it; those babies had no names.

We expected that abortion would be rare. What we didn't realize was that, once abortion becomes available, it becomes the most attractive option for everyone *around* the pregnant woman. If she has an abortion, it's like the pregnancy never existed. No one is inconvenienced. It doesn't cause trouble for the father of the baby, or her boss, or the person in charge of her college scholarship. It won't embarrass her mom and dad.

Abortion is like a funnel; it promises to solve all the problems at once. So

there is significant pressure on a woman to choose abortion, rather than adoption or parenting.

A woman who had had an abortion told me, "Everyone around me was saying they would 'be there for me' if I had the abortion, but no one said they'd 'be there for me' if I had the baby." For everyone around the pregnant woman, abortion looks like the sensible choice. A woman who determines instead to continue an unplanned pregnancy looks like she's being foolishly stubborn. It's like she's taken up some unreasonable hobby. People think, If she would only go off and do this one thing, everything would be fine.

But that's an illusion. Abortion can't really "turn back the clock." It can't push the rewind button on life and make it so she was never pregnant. It can make it easy for everyone *around* the woman to forget the pregnancy, but the woman herself may struggle. When she first sees the positive pregnancy test she may feel, in a panicky way, that she has to get rid of it as fast as possible. But life stretches on after abortion, for months and years — for many long nights — and all her life long she may ponder the irreversible choice she made.

This issue gets presented as if it's a tug of war between the woman and the baby. We see them as mortal enemies, locked in a fight to the death. But that's a strange idea, isn't it? It must be the first time in history when mothers and their own children have been assumed to be at war. We're supposed to picture the child attacking her, trying to destroy her hopes and plans, and picture the woman grateful for the abortion, since it rescued her from the clutches of her child.

If you were in charge of a nature preserve and you noticed that the pregnant female mammals were trying to miscarry their pregnancies, eating poisonous plants or injuring themselves, what would you do? Would you think of it as a battle between the pregnant female and her unborn and find ways to help those pregnant animals miscarry? No, of course not. You would immediately think, "Something must be really wrong in this

environment." Something is creating intolerable stress, so much so that animals would rather destroy their own offspring than bring them into the world. You would strive to identify and correct whatever factors were causing this stress in the animals.

The same thing goes for the human animal. Abortion gets presented to us as if it's something women want; both pro-choice and pro-life rhetoric can reinforce that idea. But women do this only if all their other options look worse. It's supposed to be "her choice," yet so many women say, "I really didn't have a choice."

I changed my opinion on abortion after I read an article in *Esquire* magazine, way back in 1976. I was home from grad school, flipping through my dad's copy, and came across an article titled "What I Saw at the Abortion." The author, Richard Selzer, was a surgeon, and he was in favor of abortion, but he'd never seen one. So he asked a colleague whether, next time, he could go along.

Selzer described seeing the patient, 19 weeks pregnant, lying on her back on the table. (That is unusually late; most abortions are done by the tenth or twelfth week.) The doctor performing the procedure inserted a syringe into the woman's abdomen and injected her womb with a prostaglandin solution, which would bring on contractions and cause a miscarriage. (This method isn't used anymore, because too often the baby survived the procedure — chemically burned and disfigured, but clinging to life. Newer methods, including those called "partial birth abortion" and "dismemberment abortion," more reliably ensure death.)

After injecting the hormone into the patient's womb, the doctor left the syringe standing upright on her belly. Then, Selzer wrote, "I see something other than what I expected here. . . . It is the hub of the needle that is in the woman's belly that has jerked. First to one side. Then to the other side. Once more it wobbles, is tugged, like a fishing line nibbled by a sunfish."

He realized he was seeing the fetus's desperate fight for life. And as he watched, he saw the movement of the syringe slow down and then stop. The child was dead. Whatever else an unborn child does not have, he has one thing: a will to live. He will fight to defend his life.

The last words in Selzer's essay are, "Whatever else is said in abortion's defense, the vision of that other defense [i.e., of the child defending its life] will not vanish from my eyes. And it has happened that you cannot reason with me now. For what can language do against the truth of what I saw?"

The truth of what he saw disturbed me deeply. There I was, anti-war, anti–capital punishment, even vegetarian, and a firm believer that social justice cannot be won at the cost of violence. Well, this sure looked like violence. How had I agreed to make this hideous act the centerpiece of my feminism? How could I think it was wrong to execute homicidal criminals, wrong to shoot enemies in wartime, but all right to kill our own sons and daughters?

For that was another disturbing thought: Abortion means killing not strangers but our own children, our own flesh and blood. No matter who the father, every child aborted is that woman's own son or daughter, just as much as any child she will ever bear.

We had somehow bought the idea that abortion was necessary if women were going to rise in their professions and compete in the marketplace with men. But how had we come to agree that we will sacrifice our children, as the price of getting ahead? When does a man ever have to choose between his career and the life of his child?

Once I recognized the inherent violence of abortion, none of the feminist arguments made sense. Like the claim that a fetus is not really a person because it is so *small*. Well, I'm only 5 foot 1. Women, in general, are smaller than men. Do we really want to advance a principle that big people have more value than small people? That if you catch them before they've reached a certain size, it's all right to kill them?

What about the child who is "unwanted"? It was a basic premise of early feminism that women should not base their sense of worth on whether or not a man "wants" them. We are valuable simply because we are members of the human race, regardless of any other person's approval. Do we really want to say that "unwanted" people might as well be dead? What about a woman who is "wanted" when she's young and sexy but less so as she gets older? At what point is it all right to terminate her?

The usual justification for abortion is that the unborn is not a "person." It's said that "Nobody knows when life begins." But that's not true; everybody knows when life — a new individual human life — gets started. It's when the sperm dissolves in the egg. That new single cell has a brand-new DNA, never before seen in the world. If you examined through a microscope three cells lined up — the newly fertilized ovum, a cell from the father, and a cell from the mother — you would say that, judging from the DNA, the cells came from three different people.

When people say the unborn is "not a person" or "not a life" they mean that it has not yet grown or gained abilities that arrive later in life. But there's no agreement about which abilities should be determinative. Pro-choice people don't even agree with each other. Obviously, law cannot be based on such subjective criteria. If it's a case where the question is "Can I kill this?" the answer must be based on objective medical and scientific data. And the fact is, an unborn child, from the very first moment, is a new human individual. It has the three essential characteristics that make it "a human life": It's alive and growing, it is composed entirely of human cells, and it has unique DNA. It's a person, just like the rest of us.

Abortion indisputably ends a human life. But this loss is usually set against the woman's need to have an abortion in order to freely direct her own life. It is a particular cruelty to present abortion as something women want, something they demand, they find liberating. Because *nobody* wants this. The procedure itself is painful, humiliating, expensive — no woman "wants"

to go through it. But once it's available, it appears to be the logical, reasonable choice. All the complexities can be shoved down that funnel. Yes, abortion solves all the problems; but it solves them inside the woman's body. And she is expected to keep that pain inside for a lifetime, and be grateful for the gift of abortion.

Many years ago I wrote something in an essay about abortion, and I was surprised that the line got picked up and frequently quoted. I've seen it in both pro-life and pro-choice contexts, so it appears to be something both sides agree on.

I wrote, "No one wants an abortion as she wants an ice cream cone or a Porsche. She wants an abortion as an animal, caught in a trap, wants to gnaw off its own leg."

Strange, isn't it, that both pro-choice and pro-life people agree that is true? Abortion is a horrible and harrowing experience. That women choose it so frequently shows how much worse continuing a pregnancy can be. Essentially, we've agreed to surgically alter women so that they can get along in a man's world. And then expect them to be grateful for it.

Nobody wants to have an abortion. And if nobody wants to have an abortion, why are women doing it, 2800 times a day? If women doing something 2,800 times daily that they don't want to do, this is not liberation we've won. We are colluding in a strange new form of oppression.

* * *

And so we come around to one more March for Life, like the one last year, like the one next year. Protesters understandably focus on the unborn child, because the danger it faces is the most galvanizing aspect of this struggle. If there are different degrees of injustice, surely violence is the worst manifestation, and killing worst of all. If there are different categories of innocent victim, surely the small and helpless have a higher claim to

protection, and tiny babies the highest of all. The minimum purpose of government is to shield the weak from abuse by the strong, and there is no one weaker or more voiceless than unborn children. And so we keep saying that they should be protected, for all the same reasons that newborn babies are protected. Pro-lifers have been doing this for 43 years now, and will continue holding a candle in the darkness for as many more years as it takes.

I understand all the reasons why the movement's prime attention is focused on the unborn. But we can also say that abortion is no bargain for women, either. It's destructive and tragic. We shouldn't listen unthinkingly to the other side of the time-worn script, the one that tells us that women want abortions, that abortion liberates them. Many a post-abortion woman could tell you a different story.

The pro-life cause is perennially unpopular, and pro-lifers get used to being misrepresented and wrongly accused. There are only a limited number of people who are going to be brave enough to stand up on the side of an unpopular cause. But sometimes a cause is so urgent, is so dramatically clear, that it's worth it. What cause could be more outrageous than violence — fatal violence — against the most helpless members of our human community? If that doesn't move us, how hard *are* our hearts? If that doesn't move us, what will ever move us?

In time, it's going to be impossible to deny that abortion is violence against children. Future generations, as they look back, are not necessarily going to go easy on ours. Our bland acceptance of abortion is not going to look like an understandable goof. In fact, the kind of hatred that people now level at Nazis and slave-owners may well fall upon our era. Future generations can accurately say, "It's not like they didn't know." They can say, "After all, they had sonograms." They may consider this bloodshed to be a form of genocide. They might judge our generation to be monsters.

One day, the tide is going to turn. With that Supreme Court decision 43

years ago, one of the sides in the abortion debate won the day. But sooner or later, that day will end. No generation can rule from the grave. The time is coming when a younger generation will sit in judgment of ours. And they are not obligated to be kind.

Seeing the crucified Christ in my wife's C-section

I see love incarnate in suffering flesh, a body bearing a body in pain for love.

The doctors, midwives, and nurses act in perfect concert toward a single goal: bring this child into the world, and keep her mother in it. They don't ask whether the procedure is elective or necessary, whether the parents have made a responsible decision, whether Mom spanks or Dad's got a job, whether this is One Too Many in a world of finite resources, whether we'd considered all our options some months before. Their goal is: *Get this baby out and present her to her mother.*

My role is simply to witness these things. And all I see is Christ. Christ is visible in this room. Servants of life serve my wife and daughter. They image Christ's undying aid to the least of these. In attending to the one on the cross and the one she bears, they attend to Christ himself. The life they midwife into this world is somehow his life too, has life because of his life, shares in life because he is life itself. In the truest cliché we have, they are doing the Lord's work.

I see Christ here, and I see his mother. Christ is himself our mother, and so is Mary. For the church is Christ's body, birthed into being at the cross; yet the church is also our mother, figured by Mary, standing beneath her exalted, suffering Son, who gives to her his beloved disciple, and in him all others, to be her children. Mary, all-holy virgin, is therefore both (as Dante put it) the daughter of her son and the mother of all his children.

From the beginning, Mary knew the painful road that stretched out before

her. Counting the cost, she said yes. In her we recognize our own yes, the yes and amen of Christ in whom all the promises of God come true. For the saints in glory, Dante said, Mary is "the noon-time torch of love." For mortals here below, she is "the clearest fountain of their living hopes."

At the Church of the Annunciation in Nazareth, in the cave where it is said that Gabriel first spoke to the mother of God, on the altar it reads: *verbum caro hic factum est*. There is a time and a place of the Word's tabernacling among us, and it isn't in Bethlehem in a manger. Incarnation begins in the temple of Mary's womb. *Fiat mihi*, "be it done to me," is the start of Christ's work of salvation, and in her reply all the replies of Mary's children have their source and strength. Her faith is the faith of all God's children, the hinge of Israel's history and the turn of the ages; through Mary's consent, Abraham's trust in God finds its consummation in Gethsemane, where Abraham's son submits to God's will with the bloody anguish of labor's final hours.

No wonder, then, that when I look at my wife's outstretched arms, I see Christ, and Mary, and Christ again. I see them, I see him, because I see love incarnate, unconquerable love in suffering flesh. This body bears a body in pain for love. Christ bore our sins in his body on the tree; by his wounds we have been healed (1 Peter). The archetype of maternal love is nothing less than the passion of the God-man: a human being willingly giving himself over to suffering for the beloved; the author of life becoming the author of salvation, creating anew what death had sought to snuff out. As the cross is a curse that saves, so childbirth's pains are a curse that nevertheless gives life.

For in the economy of grace, neither curse is the final word. Another Eve has come, and in her Son both curses are exhausted, undone from within. Love still hurts here below, and love's pain will last so long as this world

endures. Love outbids such suffering even now, though, as Christ's countless daughters, sisters, and mothers bear witness. He makes himself known through them, as he did to me, through my wife and our daughter. It is a mystery altogether humbling, certainly to those of us reduced to being onlookers. The only fitting response is dumbstruck awe, followed by the sacrifice of praise.

A version of this article appears in the print edition under the title "Birth on a cross."

Baby Food, Bassinets and Talk of Salvation: Inside an Evangelical Pregnancy Center

By Elizabeth Dias Aug. 23, 2019

NEWPORT, Tenn. — Wendy Ramsey began her day as she often does, in the cool basement of Lincoln Avenue Baptist Church. It was a Thursday, and her first client was coming at noon. She flipped on the fluorescent lights.

Racks of infant, toddler and maternity clothes neatly lined the waiting area. Formula and baby food were on the shelf, free for anyone who came. A flier for a local domestic violence shelter was taped to the cinder-block wall, one of its tabs ripped off.

A whiteboard in her office listed her prayer requests: for her clients, for their salvation and for new babies.

"We are very open about what we do here — I guess more so, what we do not do here," she said. "We are not a medical facility, we do not perform abortions and we do not refer for abortions. You can see the form right there."

Options, a small nonprofit at Lincoln Avenue Baptist Church, provides peer counseling, baby supplies and social services referrals to pregnant women and parents of young children.Audra Melton for The New York Times

She pointed to the sign-in clipboard. The disclaimer was printed in bold and all caps.

Ms. Ramsey runs Options Pregnancy Help Center, a small evangelical Christian nonprofit that provides peer counseling, baby supplies and social services referrals to pregnant women and parents of young children.

The June morning was quiet, the opposite of the anti-abortion protests she used to attend. Protests alone, she had come to think, were "not how Jesus handled anything." She remembered a Bible story of Jesus welcoming an outcast woman — people like the pregnant women and new mothers she now spends her days trying to help.

"If we want to be pro-life, we have to want more than legislation," she said. "It just can't begin and end there."

Under President Trump, the anti-abortion movement has more power than it has wielded in decades. Roe v. Wade is in the cross-hairs. Nine states have drastically curbed abortion rights in the past few months. Alabama banned nearly all abortions, including in cases of rape or incest.

In Tennessee, conservative lawmakers are pushing a so-called heartbeat bill, which would ban abortion weeks into a pregnancy.

But in this eastern part of the state, a rural and conservative region of cherished religious values, the abortion debates in Washington, in statehouses and on cable news can seem distant.

Here, the front line of the anti-abortion movement is a woman working out of a church basement.

A third of people in Cocke County, which includes Newport, are below the poverty line. The Tennessee Department of Health says it ranks 94th out of 95 counties in health outcomes, which measure length and quality of life.Audra Melton for The New York Times

'My heart is for women'

Options is one of more than 2,700 anti-abortion pregnancy centers across the country. It is affiliated with Care Net, one of the three largest networks of such centers in the United States, whose home page calls for action against "the pro-choice Left," which it says "publicly defends infanticide."

NARAL Pro-Choice America calls pregnancy center activists "anti-choice extremists" who "lie to and mislead women to prevent them from considering abortion." Planned Parenthood clinics, like one in Memphis, report that pregnancy center volunteers try to lure women away from their

doors with gift bags or protest vigils.

"All of that is directed at shaming patients who come for abortions, and stigmatizing abortion, which is a part of health care," said Aimee Lewis, a vice president for Planned Parenthood of Tennessee and North Mississippi. "They are fake clinics."

Options, like many independent anti-abortion pregnancy centers, is not a licensed medical clinic. But unlike some centers, it does not pretend to be. Volunteers do not force women to hear fetal heartbeats or show them gruesome photos of aborted fetuses. Women are informed that the volunteers are not professional counselors. The vast majority who come have already decided to have their babies.

Instead, the mission is to assure women they can handle the challenges to come, no matter the obstacles; the center helps them find jobs, emotional support or even a place to shower.

Michelle Jones, 33, first came to Options last summer, when her youngest was 4 months old. Her husband had lost his job, and she wasn't working. A few months later, she went to an Options-sponsored dinner to hear local bank representatives talk about how to build credit. Now, she meets often with a mentor and is going back to school.Audra Melton for The New York Times

"The job is to not just say, 'Hey, this is a real life inside of you, you need to save it.' That's not going to accomplish anything," Ms. Ramsey, 31, said. "It is to get her to see that whatever she thinks is too big for her to handle, she can actually handle it."

A third of the people in Cocke County, which includes Newport, are below the poverty line. The Tennessee Department of Health says that it ranks 94th of 95 counties in health outcomes, which measure length and quality of life, and that nearly half of children under 5 do not live in two-parent homes. The nearest abortion clinic is 50 miles away.

Nationwide, about a quarter of women who had abortions said their main reason was that they could not afford to have a baby, according to a 2005 study by the Guttmacher Institute. Half of the women who had abortions in 2014 lived in poverty.

"Circumstances don't make a woman what she is," Ms. Ramsey said. "My heart is for women to know their worth," she said, "that they have a purpose, and that life is not too hard or extreme for them to meet the purpose that they want to do."

"I just don't know this is a war we are going to win politically," she went on. "I wish people could just think people, not power. What is the good for the people?"

'How can we help them?'

Ms. Ramsey's first client arrived, almost eight months pregnant. She was 19 and worried about being a first-time mother. Ms. Ramsey asked what success looked like to her, and popped in a breastfeeding DVD to go over ways to hold a baby.

The videos are part of a Christian curriculum designed for anti-abortion pregnancy centers. When a client comes to Options, she watches a short video, does some homework reflecting on the day's topic and then earns "Baby Bucks," points she can trade for clothes, supplies, cribs — anything in the donation stockpile.

"We have to do a pregnancy test to start giving her stuff," Ms. Ramsey explained between clients, otherwise "things get traded and sold."

Down the hall, Brier Smart, 22, and her boyfriend finished a Bible study session. She dragged a pile of free infant clothes to the couch and began to

fold each onesie while he played with their 7-month-old.

Brier Smart and Kevin Fowler playing at home with their son, Kaysen. They receive support from Options, including free infant clothes.Audra Melton for The New York Times

They had been coming since she was 30 weeks pregnant. When the Health Department reduced their son's formula allotment with the Women, Infants and Children supplemental nutritional assistance program, they were grateful Options could help out.

Newport, a city of about 6,800, was getting a little better, Ms. Smart said. There was the updated movie theater and pool at the park. But many people they knew from school were now addicted to drugs — particularly methamphetamine. Grandparents were left raising children.

Ms. Ramsey stood in her office, reflecting on her mission. She could remember only three times when a client said she had come to Options thinking about abortion.

"I don't ever look at a baby and think, 'This is going to make this girl's life way worse,'" she said. "When I see people that are living in poverty, I don't look at it like, those people shouldn't have a kid because they aren't going to take care of it. I look at it as, 'Those people aren't in a good situation; how can we help them be in a better situation, with or without a kid?'"

She finds truth in the critique by many who support abortion access that their opponents do not care about life beyond birth. "All we want is the baby to be born, and then we are not going to give the parents any kind of tools to take care of it," she said of many others in the anti-abortion movement. "We are not going to come alongside them, we are just going to feel like we won."

"Circumstances don't make a woman what she is," Ms. Ramsey said.Audra Melton for The New York Times

'A sense of pride in family'

The last client left for the day, and Ms. Ramsey drove toward Cocke County High School, where she graduated in 2006 before attending Bible college in Knoxville. There, she dreamed of moving to India to fight human trafficking, and even refused to wear shoes for a month to protest global poverty.

Last summer, a leadership club at the high school volunteered to serve dinner at the annual Options fund-raising banquet. It seemed that the whole town showed up: the local judge, the dentist, nurses, a pediatrician, the state representative. Together they raised $35,000 to refurbish a donated house so Options could move out of the church basement, a move set for later this summer.

This night, Ms. Ramsey met with teachers, health care providers, law enforcement and other community leaders to brainstorm how to get all the county's children ready for kindergarten.

She sat down next to Alicia Dalton, who runs Newport Pediatrics.

"We are all pretty much in the same room together all the time," Ms. Dalton said, "all working together to meet the same needs."

"People take pride in being able to provide for their families," Mayor Crystal Ottinger of Cocke County said. "They can't always do that for whatever reason: unemployment, disability, it may be drugs."Audra Melton for The New York Times

Together the group discussed how to increase day care opportunities, make transportation accessible for people without cars and educate parents about nutrition. They had a refrain: "The community owns the problem, the community solves the problem."

"People take pride in being able to provide for their families," the county

mayor, Crystal Ottinger, said a few days later. "They can't always do that, for whatever reason: unemployment, disability, it may be drugs. I'm not going to sugarcoat it, we are rural Appalachia. But they still have a sense of pride in family here."

It is a reason she thinks Options works: People have to earn points and take classes, not simply take free stuff. "The more people that Options can help, the more likely they are to give back," she said.

Ms. Ramsey said her work was about helping women and their babies, but she also had an underlying hope: that they would commit their lives to Jesus. She offers extra points for Baby Bucks if they go to church. "I can't lie," she said. "Ultimately, I just don't think that there can be an abundant life without Jesus. If they say that's manipulative and a secret tactic, then I will not apologize for it."

"I will tell you," she went on. "We have girls that don't go to church, that don't do the Bible studies. I give them as much as anybody else. And I love them as much."

The nearest abortion clinic to Newport, a town of about 6,800 people, is 50 miles away.Audra Melton for The New York Times

'He will set a path for me'

The morning after the meeting, Ms. Ramsey set out in a white minivan. Many of her clients do not have cars, so she picks them up.

She knows Newport's streets by heart: past the Food City Gas 'N Go, along the railroad tracks, by the women's jail, where she volunteers every other Thursday, to the bridge dotted with baskets of fuchsia-colored blossoms. She crossed.

This was the side where she grew up, first in the gray trailer and then in the house where her mother lives.

She looked out at the dark clouds growing over the Smoky Mountains in the distance and pulled into a driveway. She prayed silently and then knocked on the door.

A young woman stepped out, about five months pregnant. Jennifer Campbell, 30, was born here, too. Her parents divorced when she was 8, she moved in with her grandparents and then her father died in a motorcycle accident. Things spiraled downhill, from an abusive relationship to opiates and meth. Her two children were taken into state custody. She spent time in jail, and without a home.

And then, she said, she prayed to God.

Jennifer Campbell visiting Options when she was about five months pregnant. She was in jail when she first met Ms. Ramsey.Audra Melton for The New York Times

"I got pregnant during the time that I prayed," she said. "He blessed me with another chance of being a mom, and I did not want to mess this up."

Now, she is sober. She goes to the doctor for prenatal care. She met Ms. Ramsey when she was in jail and heard she offered baby supplies. She said she had never considered having an abortion.

"I know that since God has blessed me with this child, he will set a path for me," she said.

They pulled up to the church's back door and went in.