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The Revenge of Conscience

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Something noteworthy is happening in the mainstream media. First, *The Los Angeles Times* ran a story that, in all its horrible brutality, attempted to defend a couple's decision to kill selected fetuses in the woman's womb by means of what is euphemistically called "selective reduction." The article was chilling in its cold honesty and grotesque morality.

Then *The New York Times* runs a pair of articles [see [first](#) and [second](#)] that deal honestly with the fact that babies are being aborted after a diagnosis of Down syndrome and other unwanted traits. As these reports indicate, 90 percent of babies identified through prenatal testing as likely to have Down syndrome are aborted. Furthermore, many ethicists and specialists refuse all efforts to draw any line at which traits are an acceptable basis for killing the fetus.

Now, *The Washington Post Magazine* publishes an extensive report on the practice of "selective reductions," taking us into the practice of Dr. Mark Evans in Manhattan. This article is not for the faint-hearted. It is, nevertheless, one of the most important articles on the dignity of human life to appear in a very long time. Why? Because it forces us to face where we have now arrived as a culture—a culture fast becoming the Culture of Death.

As Liza Mundy reports:

Selective reduction is one of the most unpleasant facts of fertility medicine, which has helped hundreds of thousands of couples have children but has also produced a sharp rise in high-risk multiple pregnancies. There is no way to know how many pregnancies achieved by fertility treatment start out as triplets or quadruplets and are quietly reduced to something more manageable. The U.S. Centers for Disease Control and Prevention, which publishes an annual report on fertility clinic outcomes, does not include selective-reduction figures because of the reluctance to report them.

The industry doesn't publish them, either. "This is a very sensitive topic," says David Grainger, president of the Society for Assisted Reproductive Technology, the membership group for IVF clinics. It's sensitive, personally, for patients, but also politically, for doctors.

Mundy, author of *Everything Conceivable: How Assisted Reproduction is Changing Men, Women, and the World*, takes us into the practice of Dr. Evans, described as "a pioneer in fetal therapy." His goal, he claims, is the delivery of a healthy baby. As Mundy reports, "In some cases, this can be achieved by treating a fetus in utero. In some cases, it is achieved by sacrificing a fetus in utero."

Dr. Evans developed the technique of inserting a tiny needle into an unborn child and then injecting potassium chloride into the fetal heart, killing the baby. He does so, he explains, because multiple pregnancies are more dangerous than pregnancies involving a single baby or twins.

As Mundy reports, Dr. Evans has attempted to define his own set of "guiding principles" in terms of the ethics of his practice. At first, he refused to take the gender of the babies into consideration. Now, he does so—allowing couples to choose to carry one boy fetus and one girl fetus, while killing the others. He also refused at first to "reduce" pregnancies from twins to single babies, because he admits that there is no danger to fetal health posed by a twin. He changed his policy on that too. When some couples want just a single child, he will now "reduce" to one.

Clearly, Dr. Evans' "guiding principles" are really "sliding principles." He is making up his ethical system as he goes along.

Mundy also introduces readers to three women seeking "reductions" from Dr. Evans. The first is identified as a woman in her 30s. She and her husband decided to go through the IVF procedure and this produced triplets. Now, she is preparing to reduce three to two.

From the report:

The fetuses were moving and waving their limbs; even at this point, approaching 12 weeks of gestation, they were clearly human, at that big-headed-could-be-an-alien-but-definitely-not-a-kitten stage of development. Evans has found this to be the best window of time in which to perform a reduction. Waiting that long provides time to see whether the pregnancy might reduce itself naturally through miscarriage, and lets the fetuses develop to the point where genetic testing can be done to see which are chromosomally normal.

Greenbaum periodically magnified one fetus and brought it into focus. She would then freeze the frame and do two things: measure the fetuses to assess their growth and see if any one is lagging; and take a "nuchal translucency," measuring the fluid behind each fetus's neck. An excess of nuchal fluid suggests a possible problem: Down syndrome, for example. They are all measuring at 11 weeks and 6 days," Greenbaum said.

"That's right," the woman said, wonderingly. "It is 12 weeks tomorrow."

So far, there was nothing anomalous about any of the fetuses. Greenbaum turned the screen toward the patient. "That's the little heartbeat," she said, pointing to the area where a tiny organ was clearly pulsing. "And there are the little hands. There's the head. The body."

"Oh, my God, I can really see it!" the patient cried. "Oh, my God! I can see the fingers!"

"Okay!" she said, abruptly, gesturing for the screen to be turned away. She began sobbing. There were no tissues in the room, so her husband gave her a paper towel, which she crumpled to her face. The patient spent the rest of the procedure with her hospital gown over her face, so she would not see any more of what was happening.

She can hide her face under a hospital gown, but she knows exactly what is happening. One of her babies is to be killed with an injection of poison.

Mundy's second woman comes to the office with her lesbian partner. This couple would eventually decide to select a girl fetus for killing, leaving them with one girl and one boy baby.

As Mundy reports:

The women were planning to eliminate two of the fetuses and keep two, which would decrease their chances of losing the entire pregnancy from 25 percent if they did nothing to 7 percent if they reduced to twins. And if they fell into the 7 percent who miscarry, this would be "despite the reduction, not because of it," Evans said. There may be some risk from the procedure itself. In 20-odd years, he estimates, a "handful" of pregnancies have miscarried shortly after his performing the reduction, and with a less experienced practitioner, the risk of procedure-caused miscarriage is higher, probably just under 1 percent. But based on the statistics, he argues, "it's almost always safer to do this than not to do it."

Jane wanted to safeguard Emma's pregnancy but was feeling some ethical qualms. "It's killing me that we're going to do this," Jane said. "I never thought I would feel that. I'm the most pro-choice person. I'm vehemently pro-choice."

The third woman came with her mother from Puerto Rico. Tests indicated that all three of her babies were girls. Since the babies were all of the same gender, and none had been found to have abnormalities, the selection of the baby to be killed had to be taken to the "next level of subtlety."

At the same time, the actual procedure is anything but subtle. Mundy describes it in cold clinical detail, referring also to sonographer Rachel Greenbaum:

Destroying a fetus requires three hands: one to hold the ultrasound transducer on the patient's belly; one to inject the needle and maneuver it into a position near the fetal heart; another to draw out the metal rod at the core of the needle and replace it with the vial of potassium chloride. Evans, who is left-handed, did all these things at various times, tools close together as he worked over the patient's belly. At points, Greenbaum assisted by holding the vial until he needed it; holding the transducer; and coaching him into position, watching on the screen and issuing directions. Evans worked for a while trying to get the needle into the right spot.

"I'm not in," he said at one point, tensely. Then he pinned C with the needle, and pushed the plunger to release the chemical. The fetus, which had been undulating and waving, went still. It would remain in the womb, while the other fetuses grew and developed.

Have we now reached a point of no moral return? Mundy's article forces us to face the fact that we have become a society that considers "selective reduction" just part of what is necessary, given the power of new reproductive technologies. We will become killers even as we become givers of life. A needle is inserted into one baby in order to kill, another needle in yet another baby in order to save.

The cold, clinical, calculating nature of the decisions reported by Liza Mundy takes us to the heart of the human problem. The essence of sin is the ambition to be as God.

The appearance of these articles, published in major American newspapers in a span of mere days, tells us something important. So does the fact that each of these articles reflects a sense of moral disquiet. Mundy reports that many women develop intense moral disquiet and persistent depression after undergoing the procedure. A source cited by Mundy explained that "psychoanalytic interviews with women who underwent [selective reduction] describe severe bereavement reactions including ambivalence, guilt, and a sense of narcissistic injury, all of which increased the complexity of their attachment to the remaining babies."

Professor J. Budziszewski of the University of Texas describes this pattern as "the revenge of conscience." God has made us so that conscience emerges even when we attempt to shut it out and hide from it. As Budziszewski explains, "We do not lack moral knowledge; we hold it down." It does not stay down.

We can hide behind euphemisms like "selective reductions," but the woman on the table knows what is happening. She can hide her face under a gown but she cannot hide from her conscience.

The same is true for Dr. Evans, and for those who read Mundy's important article. Consider just these words:

Evans prepared two syringes, swabbed Emma with antiseptic, put the square-holed napkin on her stomach. Then he plunged one of the needles into Emma's belly and began to work his way into position. He injected the potassium chloride, and B, the first fetus to go, went still.

"There's no activity there," he said, scrutinizing the screen. B was lying lengthwise in its little honeycomb chamber, no longer there and yet still there. It was impossible not to find the sight affecting. Here was a life that one minute was going to happen and now, because of its location, wasn't. One minute, B was a fetus with a future stretching out before it: childhood, college, children, grandchildren, maybe. The next minute, that future had been deleted.

A future deleted — as simple as that. This is what we have become as a society, if this is what we tolerate and accept as a necessary cost of the new reproductive technologies. Even the most enthusiastic advocate of "a woman's right to choose" must have to take a deep breath when reading these articles. Conscience will have its revenge.

