The Sanctity of Human Life and Ectopic Pregnancies[1]

Dr. J. Alan Branch

Some of my most frustrating and maddening moments as a professor of Christian Ethics have come when uninformed ministerial students have made false claims about the viability of ectopic pregnancies. I have prepared this set of notes for preachers training for ministry. My goal is to help you understand that an ectopic pregnancy ***will not come to term.*** **If left untreated, an ectopic pregnancy will rupture, the baby will die (if not already dead), and the mother will bleed profusely and possibly die**. To be as blunt as I possibly can, these notes are intended to end ignorance among Baptist preachers about this topic.

I. What is an Ectopic Pregnancy?

An ectopic pregnancy is a major medical emergency that occurs when the baby implants in the wrong place.

A. Defined

An ectopic pregnancy, also known as an eccyesis, occurs with the baby implants in an abnormal place instead of in the uterus. The most common site of ectopic implantation is the Fallopian tube. Other sites for ectopic implantation include the abdomen, ovary, or the cervix. These secondary sites are less common than the Fallopian tubes and they are associated with higher mortality. The higher mortality is because it is more difficult to detect an ectopic pregnancy in these locations and also due to the massive bleeding that can result

[1] I have taken most of the medical information directly from the extremely helpful McGill University Gynecology page available at http://sprojects.mmi.mcgill.ca/gynecology/anatmain.htm. It is not my attempt to present this as original academic research, rather my purpose is to present accurate information for ministerial students who might not otherwise attempt to comprehend this complicated issue. As a matter of intellectual integrity, I state again that I do not claim originality for the descriptions of ectopic pregnancy in this handout.

if a rupture occurs at these sites. Josie L. Tenore of Northwestern University describes the medical dangers associated with the rupture of an ectopic pregnancy and says:

> Because none of these anatomic sites can accommodate placental attachment or a growing embryo, the potential for rupture and hemorrhage always exists. A ruptured ectopic pregnancy is a true medical emergency. It is the leading cause of maternal mortality in the first trimester and accounts for 10 to 15 percent of all maternal deaths.[2]

Evangelical physician Megan Best amplifies the dangers of an ectopic pregnancy and says, "[In and ectopic pregnancy] the embryo implants outside the uterus (usually in the fallopian tube), ***where the baby will not survive***. It is a serious situation that is potentially fatal for the mother and requires urgent treatment."[3]

B. Where do Ectopic Pregnancies Occur?

1. Fallopian tube

Approximately 97% of ectopic pregnancies occur in the Fallopian tube, of which 80% occur in the ampulla region of the tube. About 10% occur in the isthmus region and about 5% in the infundibulum region. Only about 3% occur in the interstitial portion of the Fallopian tube. In rare cases ectopic pregnancies occur in the ovary, the cervix, or in the abdomen. Although these non-tubal ectopic pregnancies are infrequent, they represent nearly 20% of deaths due to ectopic pregnancies. This high danger to life at these

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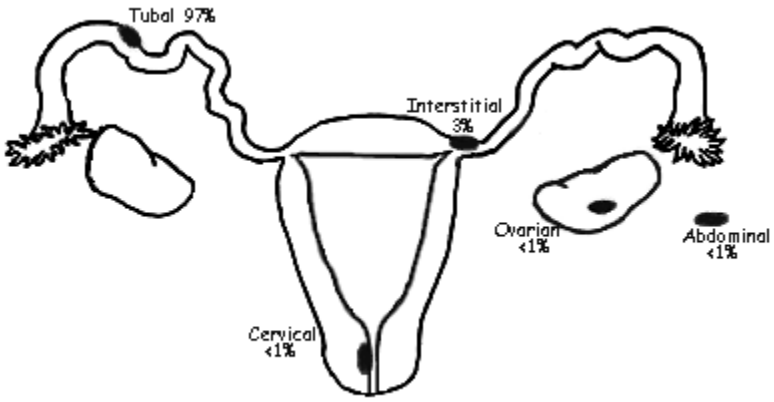
[2] Josie L. Tenore, "Ectopic Pregnancy," *American Academy of Physicians News and Publications*, accessed November 16, 2007, *I*http://www.aafp.org/afp/20000215/1080.html.

[3] Megan Best, *Fearfully and Wonderfully Made: Ethics and the Beginning of Human Life* (Kingsford, NSW: MatthiasMedia, 2012), 302. Emphasis added. Brest goes on to comment that the grief associated with an ectopic pregnancy is compounded in many cases because it will be more difficult for the woman to become pregnant in the future. This is because parts of one of her fallopian tubes will be damaged.

locations likely results from massive bleeding when these pregnancies rupture.



Sites and incidence of ectopic pregnancies

2. The Cervix

Most cervical pregnancies occur after a sharp uterine curretage. More than half of the women with a cervical pregnancy need treatment by hysterectomy. Even if a hysterectomy is not performed, the prognosis for future fertility is poor.

3. The Abdominal Cavity

Most abdominal pregnancies occur after the embryo first implants in the Fallopian tube, after which it is expelled from the fimbrial opening of the tube and then implants in the abdomen. An unusual type of abdominal pregnancy may implant in the spleen or liver, which causes massive lethal bleeding in the abdomen.

4. The Ovaries

Most medical literature suggests ovarian pregnancies account for about 3% of all ectopic pregnancies.[4]

Uncommonly, an ectopic and a uterine (normal) pregnancy may both occur at the same time. This is termed a heterotopic pregnancy and occurs in 1-3% of pregnancies following in-vitro fertilization. Such a circumstance might be more common after drug induced ovulation because multiple ovulations can be more likely to occur. When using IVF, the incidence of heterotopic pregnancy increases with the number of embryos transferred into the uterus.

Some ectopic pregnancies resolve without medical intervention.[5] Essentially, this means the baby dies and a miscarriage of some sort occurs.

II. How Many Ectopic Pregnancies?

A. Estimated Number

Ectopic pregnancies occur at a rate of about 1-2% of pregnancies and can occur in any sexually active woman of reproductive age. There is a marked increase in the number of ectopic pregnancies as age increases, with 6.6 per 1,000 pregnancies in women aged 15 – 24 and 21.5 per 1,000 pregnancies in women aged 35-44. There is a higher incidence of ectopic pregnancy among women who have had more than one pregnancy.

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[4] Jayeeta Roy and Anindita Sinha Babu, "Ovarian Pregnancy: Two Case Reports," *Australasian Medical Journal* (August 1, 2013): 408.

[5] Tenore says between 68 – 77 percent resolve without intervention.

B. Risk Factors Related to Ectopic Pregnancies

Damage to the fallopian tubes from pelvic inflammatory disease, previous tubal surgery, or a previous ectopic pregnancy is strongly associated with an increased risk for ectopic pregnancy. Minor risk factors include a history of cigarette smoking, an age over 35, and multiple sexual partners over a lifetime.[6]

1. Previous Ectopic Pregnancies

The most significant risk factor related to ectopic pregnancy is a prior history of an ectopic pregnancy: more simply, if a woman has had one ectopic pregnancy, she is at a higher risk for having a second ectopic pregnancy compared to the general population.

2. Previous Ectopic Pregnancies and IVF

There also seems to be a higher rate of ectopic pregnancies in In Vitro Fertilization (IVF) patients who have had a previous ectopic pregnancy.[7] Ovarian ectopic pregnancies account for about 3% of all ectopic pregnancies when women conceive naturally and about 6% of all ectopic pregnancies where women are using some form of assisted reproduction technology.[8] Women who have had previous ectopic pregnancies and who take fertility drugs to induce multiple ovulations are also at a higher risk for ectopic pregnancies.

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[6] Kurt T. Barnhart,"Ectopic Pregnancy," *The New England Journal of Medicine* 361.4 (July 2009): 379.
[7] "Previous Tubal Pregnancy Increases Risk of Repeated Ectopic Pregnancies," *Fertility Weekly* April 20, 2009, 4.
[8] R.L. Joseph and L.M. Irvine, "Ovarian Ectopic Pregnancy: Aetiology, Diagnosis, and Challenges in Surgical Management," *Journal Of Obstetrics And Gynecology: The Journal Of The Institute Of Obstetrics And Gynecology* 32.5 (July 2012): 472.

3. Damaged Fallopian Tubes

Any disruption or damage to the normal architecture of the Fallopian Tubes increases one's risk of having an ectopic pregnancy. The Fallopian Tubes can be damaged by congenital defects, infections, tumors, or scarring from surgery. A reversal of a tubal ligation is also associated with higher risks for ectopic pregnancies.

4. Ectopic Pregnancy and Sexually Transmitted Infections (STI)

An increase in the prevalence of STIs is associated with increasing numbers of ectopic pregnancies. During recent decades the incidence of ectopic pregnancies has been steadily increasing concomitant with increased STI rates and associated salpingitis (an inflammation of the Fallopian tubes). Undetected STIs in women often lead to Pelvic Inflammatory Disease (PID). PID can lead to infection and corresponding damage of the Fallopian tubes. When the Fallopian tubes become infected, normal transport of the fertilized egg to the uterus becomes more difficult, making an ectopic pregnancy more likely. The statistical incidence of ectopic pregnancy has also risen due to an improved ability to detect ectopic pregnancies. How does Salpingitis contribute to ectopic pregnancy? Salpingitis can fuse together the folds in the Fallopian tubes. These folds are naturally found lining the inside of the tube. This narrows the inside of the tube such that sperms can travel normally through it, but the embryo cannot. Secondly, the embryo can be trapped in blind pockets formed by adhesions inside the tube (adhesions are abnormal joining between organ parts, which usually form after damage to organs). Salpingitis contributes to about 50% of first-time ectopic pregnancies.

C. Other Causes

In most of the remaining first-time ectopic pregnancies (accounting for about 40%), the cause is undetermined. One theory is that in some women the fertilized ovum travels more slowly in the Fallopian tube, so that at time of implantation (7 days after fertilization) the embryo is still in the Fallopian tube and not the uterus as it should be. Instead of implanting in the uterus as is normal, it implants in the Fallopian tube. A possible cause for this slowing down of travel is a hormonal imbalance. There is also evidence that indicates smoking can increase a woman's chance of an ectopic pregnancy. Josie Tenore states, "Cigarette smoking has an independent and dose-related effect on the risk of ectopic pregnancy. Cigarette smoking is known to affect ciliary action in the nasopharynx and respiratory tract. A similar effect may occur within the fallopian tubes."[9] Another theory is that ectopic pregnancies occur because of an abnormality of the embryo, such as an incorrect number of chromosomes.[10] Chromosomal abnormalities may interfere with the embryos ability for normal transport within the Fallopian tube. Some ectopic pregnancies can be due to a mother's birth defect within her own fallopian tubes, endometriosis, complications of a ruptured appendix, or scarring caused by previous pelvic surgery.

TABLE 1
Risk Factors for Ectopic Pregnancy

Strong evidence for association
Pelvic inflammatory disease
Previous ectopic pregnancy

[9] R.L. Joseph and L.M. Irvine, "Ovarian Ectopic Pregnancy: Aetiology, Diagnosis, and Challenges in Surgical Management," 472.
[10] Normally every cell has 23 pairs of chromosomes, and 1 X and 1 Y chromosome; these chromosomes carry the person's complete genetic material, which should be the same in each cell.

Endometriosis
Previous tubal surgery
Previous pelvic surgery
Infertility and infertility treatments
Uterotubal anomalies
History of in utero exposure to diethylstilbestrol
Cigarette smoking

Weaker evidence for association
Multiple sexual partners
Early age at first intercourse
Vaginal douching

D. Signs of Ectopic Pregnancy

Abdominal or pelvic pain and vaginal bleeding in the first trimester are the most common presenting symptoms of ectopic pregnancies.[11] An examination by medical personnel confirms the diagnosis.

III. Treatment of Ectopic Pregnancies

Ectopic pregnancies have to be ended in order to save the mother's life. Ectopic pregnancies can be treated via surgical procedures or by using medications. Some ectopic pregnancies resolve without any medical treatment.[12] Ectopic pregnancies cannot continue to term (birth), so the baby must be removed to save the mother's life.[13] When medical interventions are used, usually there

[11] Sahoko H. Little and Pamela G. Rockwell, "Ectopic Pregnancy: Zero in on these Lab and Imaging Clues," *The Journal of Family Practice* 61.11 (November 2012): 678.
[12] All information in this section is from Kurt T. Barnhart, "Ectopic Pregnancy," *The New England Journal of Medicine* 361.4 (July 2009): 384 – 385.
[13] "Ectopic Pregnancy," from *MedLine Plus Medical Encyclopedia*, Electronic Resource available at http://www.nlm.nih.gov/medlineplus/ency/article/000895.htm. (Accessed November 16, 2007).

are two procedures, one using drugs and one using a surgical procedure. The most common drug used with ectopic pregnancies is methotrexate, a folic acid antagonist that is metabolized in the liver and excreted in the kidney. Methotrexate inhibits the synthesis of purines and pyrimidines. Thus, it interferes with DNA synthesis and cell multiplication. Rapidly dividing cells are most vulnerable to methotrexate. Surgically, a laparoscope is used to abort the ectopic pregnancy.

According to the American Association of Pro-life Obstetricians and Gynecologists, "By the time an ectopic pregnancy has been discovered (usually by 7 to 8 weeks gestation) the embryo has died in the majority of cases. . . . In a small number of cases a living embryo can be observed in the ectopic pregnancy. Unfortunately, this embryo will die in the near future if observation is continued, and the mother's life remains in imminent danger from a life-threatening hemorrhage, before and after the death of the embryo."[14]

A. Surgical

Surgical treatment may involve removing the affected fallopian tube (salpingectomy) or dissecting the ectopic pregnancy with conservation of the tube (salpingostomy). Laparoscopy is effective and is the preferred surgical approach. Laparoscopy is a surgery that uses a thin, lighted tube put through a cut (incision) in the abdomen. If the mother has extensive intraperitoneal bleeding or other problems, a Laparotomy may be needed. A Laparotomy is involves a large incision through the abdominal wall in order to gain access to the abdominal cavity.

[14] American Association of Pro-life Obstetricians and Gynecologists, "What is the AAPLOG's Position on Treatment of Ectopic Pregnancy?," July 9, 2010, https://aaplog.org/what-is-aaplogs-position-on-treatment-of-ectopic-pregnancy/.

B. Pharmaceutical

Methotrexate can be administered via injection for ectopic pregnancies. There are both single-dose and multi-dose regimens. The single-dose requires fewer visits and is more commonly used, but it is associated with a higher rate of treatment failure. Methotrexate stops cell growth and dissolves existing cells.[15]

Randomized trials have shown that a multi-dose methotrexate treatment has a very slightly higher success rate than surgical treatment. On the other hand, a single-dose methotrexate treatment has a much lower success rate than surgical removal of the ectopic pregnancy.

IV. Hydatidiform mole / Molar Pregnancy

A. Definition

A molar pregnancy — also known as hydatidiform mole — is a noncancerous (benign) tumor that develops in the uterus. A molar pregnancy starts when an egg is fertilized, but instead of a normal, viable pregnancy resulting, the placenta develops into an abnormal mass of cysts.[16] A molar pregnancy has the appearance of a large and random collection of grape-like cell clusters. Perhaps 1 in 1,000 pregnancies in the U.S. are molar pregnancies.

A hydatidiform mole is formed when an egg which has somehow lost its nucleus is fertilized. In about 80% of hydatidiform moles, an empty egg is fertilized by one sperm, and the haploid sperm genome is copied to create a diploid genome. In about 20% of

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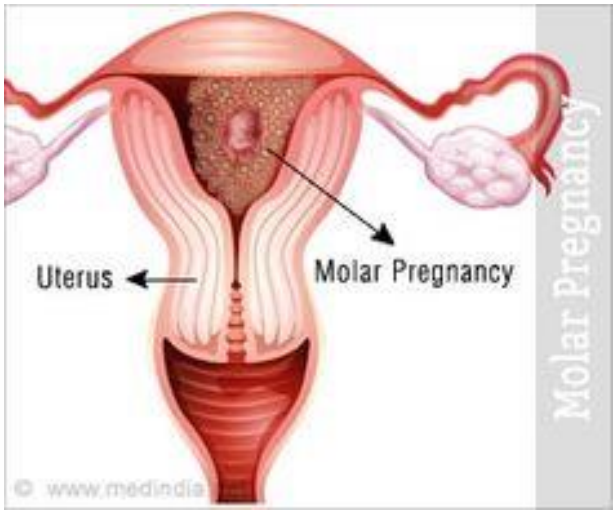
[15] The Mayo Clinic, "Ectopic Pregnancy," May 22, 2018, https://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/diagnosis-treatment/drc-20372093.

[16] The Mayo Clinic, "Diseases and Conditions: Molar Pregnancy," accessed August 5, 2016, http://www.mayoclinic.org/diseases-conditions/molar-pregnancy/basics/definition/con-20034413. Molar Pregnancies may also be known as gestational trophoblastic disease (GTD).

the cases, the empty egg is fertilized simultaneously by two sperm. In both cases the fertilized egg has the correct number of chromosomes (46), but all the DNA came from the father. Because of this, no baby develops.[17] In other rare cases, there are 23 chromosomes from the mother, but two sets of chromosomes from the father. The embryo has 69 chromosomes instead of 46. The baby will not live.

There are two basic types of molar pregnancies: Complete and Partial. Complete molar pregnancies have only placental parts. There is no baby within the placenta. In partial molar pregnancies, there is a baby within the placenta, but it has severe birth defects and will soon be overcome by the rapidly growing abnormal mass. The baby is often "incomplete." The baby will die.

Tragically, when a molar pregnancy develops, a pregnancy test will show that a woman is pregnant. The woman will gain weight as in a normal pregnancy and have morning sickness, often quite worse than normal. However, when the sonogram is performed, all that is seen is a mass that looks like a cluster of grapes.



[17] Nessa Carey, *The Epigenetics Revolution* (New York: Columbia University Press, 2012), 120.

B. Moral Response

Most molar pregnancies will end spontaneously ("miscarry") and the expelled tissue will appear grape-like. The baby will not come to term. If not treated, a molar pregnancy can be dangerous to the woman. It sometimes can cause a rare form of cancer. If molar tissue is still growing in the uterus, it can cause a condition called persistent GTD. About 1 in 5 women has this condition after a molar pregnancy, usually after a complete molar pregnancy. Persistent GTD can be treated with hysterectomy or chemotherapy. Chemotherapy is medicine used to treat cancer. In rare cases, a mother may get a cancer-causing form of GTD called choriocarcinoma. This condition is treated with several kinds of cancer medicines.[18]

If a molar pregnancy is detected, an abortion is performed. In most cases there is no embryo. In rare cases when there is an embryo, the baby will not live and the mother may develop a serious disease.

V. Moral Response to Ectopic Pregnancies

I am pro-life. I oppose abortion on demand. But an ectopic pregnancy is a different moral situation than abortion for mere convenience.

A. Roman Catholicism and Ectopic Pregnancies

Catholics United for the Faith summarizes the Roman Catholic Approach to an Ectopic Pregnancy:

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[18] March of Dimes, "Molar Pregnancy," last reviewed May, 2014; accessed August 5, 2016; http://www.marchofdimes.org/complications/molar-pregnancy.aspx.

> A mother facing a tubal pregnancy risks imminent rupture of the fallopian tube. While the doctor would opt for the least risk and expense to the mother, all the options presented to her involve terminating the pregnancy. The mother, however, must respect both her life and that of her child.
>
> There is no treatment available that can guarantee the life of both. The Church has moral principles that can be applied in ruling out some options, but she has not officially instructed the faithful as to which treatments are morally licit and which are illicit. Most reputable [Roman Catholic] moral theologians . . . accept full or partial salpingectomy (removal of the fallopian tube), as a morally acceptable medical intervention in the case of a tubal pregnancy.[19]

In a nuanced approach, Roman Catholic moralists want to avoid directly participating in an abortion. Instead, their approach is to view the fallopian tubes as infected. The goal is to treat the infected area of the fallopian tube, which means the section containing the baby is removed. However, in Roman Catholic thought, the principle of double effect is utilized. This means that the death of the baby comes as an unavoidable side effect of treating the woman's infected fallopian tubes. The result is that Roman Catholics do not believe that the woman has sinned by availing her self to a salpingectomy.

B. Evangelicals and Ectopic Pregnancies

1. Dr. Branch's Response to Uniformed Ministerial Students

Because I have heard uninformed seminary students make unfounded statements about the viability of ectopic pregnancies, I emphasize the following quote from the Feinbergs: "With ectopic pregnancies, the baby develops outside the uterus, and even if the

[19] "Ectopic for Discussion: A Catholic Approach to Tubal Pregnancies." An electronic resource available at http://www.cuf.org/Faithfacts/details_view.asp?ffID=57. (Accessed November 6, 2008).

mother is willing to sacrifice her own life, the baby will still die. So, unless the baby's life ends, both mother and baby will die."[20] An ectopic pregnancy will not survive to full term. The pregnancy will rupture and the woman will bleed profusely and die unless she gets medical help.

I suspect some of my ministerial students are overly optimistic about the viability of ectopic pregnancies because of extremely rare reports of a child that survived some sort of ectopic pregnancy. For example, it is with great caution that I mention an article in 2013 the *Journal of the Turkish-German Gynecological Association* which reported an extraordinary case in which a pregnant woman came to an emergency room complaining of abdominal pain. Upon examination, it was discovered that she was carrying a baby at 34 weeks gestation in an *ovarian pregnancy*. Due to the fast work of the physicians, the child was delivered alive (immediately). Sadly, the baby died at day four. The mother also had to have surgery because of bleeding at the site of the pregnancy.[21] But this case is so amazingly rare because the pregnancy had a viable placenta attached to the ovary. Again, the baby died soon after birth and the mother urgently needed surgery to stop bleeding after the baby was delivered. If the baby had implanted in the fallopian tubes, the location of the vast majority of ectopic pregnancies, the pregnancy would certainly have ruptured much sooner.

As I said above, I mention this case with caution and I hesitated putting in my notes. Why? Because when ectopic pregnancies are the issue, some of my students have the bad habit of not reading with precision and forming poorly conceived opinions based on one scrap of information. Or, to use a cliché, they try to hold a mountain by a thread. Yet, I have had the tragic experience of reading "research

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[20] John Feinberg and Paul Feinberg, *Ethics for a Brave New World*, 2nd ed. (Wheaton: Crossway, 2010), 138.

[21] Elif Meseci, et al, "A 34-Week Ovarian Pregnancy: Case Report and Review of Literature," *Journal of the Turkish-German Gynecological Association* 14.4 (December 2013): 246 – 249.

papers" (and I use the term "research" quite loosely here) authored by ministerial students who have found some odd, rare case such as this Turkish woman and then concluded Christians are wrong to end ectopic pregnancies. My point is these scenarios are terribly, terribly rare. In this case, the mother was in imminent danger and would have died without medical treatment. It is imprudent and rash for ministerial students to over-generalize from astoundingly rare cases and thus assume all ectopic pregnancies are in some way "viable." They are not: Again, the baby will not come to term, the pregnancy will rupture, and the mother will bleed profusely.

On one occasion, a student submitted a paper in which he argued it is wrong to terminate an ectopic pregnancy. I wrote "F" on his paper, explained his errors, and asked him to re-write, which he did. The student's re-write accurately summarized the dangers of ectopic pregnancies and the fact they are not viable; the professor was delighted with the re-submission and assumed learning had occurred. But I was wrong: the student learned nothing. After the semester, the student indicated to MBTS that I had wrongly given him an "F" because we disagreed on a "grey area" and a point "under debate." He had re-submitted his paper to placate me, but had not changed his mind.

This event deeply saddened me at several levels, but I have two specific causes for concern. First, the student was completely wrong: ectopic pregnancies are not a "grey area" among Evangelicals. The student was being obdurate and was completely at odds with all facts of medical science, rejected the consensus of Southern Baptist physicians and ethicists, and lacked the compassion necessary for a Christian minister. Second, the student demonstrated an unteachable spirit. Instead of admitting, "Wow, I was wrong," he stubbornly adhered to his own wrong-headed, foolish, ill-informed, ignorant, heartless, and dangerous moral stance.

I have been teaching at MBTS since 2001 and over the years I have had **five** different students attempt to argue that ectopic pregnancies are viable and it is sin for a woman to end an ectopic pregnancy. I want to be as blunt as possible: This moral stance is grounded in ignorance and arrogant pride. **Any student who tries to argue that ectopic pregnancies are viable and it is wrong for a woman to end an ectopic pregnancy will receive an automatic F for the entire paper regardless of the quality of the rest of their work. There will be no opportunity to re-write or re-submit.**

2. Ectopic Pregnancies: The Southern Baptist Definition for "Health of the Mother" Concerns

In context of the abortion debate, when most evangelicals refer to concerns about the health of the mother, they in fact have the very narrow case of an ectopic pregnancy in mind. In contrast, pro-choice advocates tend to equivocate and use the term "mother's health" to mean both an ectopic pregnancy in one breath and the broader issues of emotional and financial concerns in the next sentence. For our purposes here, I refer to the health of the mother as a concern in the very narrow and specific cases of an ectopic pregnancy or cases where the mother has cancer and her life is in danger.

Ministerial students should understand that an ectopic pregnancy is dangerous for a woman and her life is in fact threatened. *Both* the life of the mother and the child are precious to God. An ectopic pregnancy presents a moral dilemma because if the mother attempts to take the pregnancy to term, she will most likely die. If an abortion is performed to save the mother's life, the child dies. How do we resolve this dilemma? I find the advice of conservative evangelical authors John and Paul Feinberg to be most helpful here. Referring to the specific case of imminent danger to the physical life of the mother in relation to cancer or an ectopic pregnancy, they say:

> Still, we believe there are principles that justify taking the baby's life in these case. One [principle] is that if it is possible to do good to someone else without endangering or harming oneself, one is obligated to do so; otherwise there is no obligation. As applied to these kinds of cases, this rule means the mother is not morally required to give up her life to save that of the baby. . . . The other principle . . . that justifies taking the fetus's life is that one is not morally responsible for failing to do what could not be done or for doing what one could not fail to do. That is, one is not guilty for failing to do something if one is not free to do it. In this case, it is not possible for the mother to save both her life and that of the baby. Therefore, she is not morally culpable if she doesn't do both.[22]

Living in a fallen world, an ectopic pregnancy presents one of the rare instances when there is a genuine dilemma. I have a deep conviction that no sin has occurred if a woman has an abortion in these tragic cases. A strong pro-life resolution affirmed by the SBC in 1989 reflects a position similar to the Feinbergs and concludes with this sentence, "Be it finally resolved, That we do reaffirm our opposition to legalized abortion and our support of appropriate federal and state legislation and/or constitutional amendment which will prohibit abortion except to prevent the imminent death of the mother."[23]

I also want to include an extensive quote from the late Dr. Bill Cutrer, an obstetrician who served on the faculty of Southern Baptist Theological Seminary:

> I still receive calls about ectopic (tubal) pregnancies, that is, pregnancies in which the zygote implants outside the womb. Doctors have advised surgery to remove the pregnancy, and

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[22] John S. Feinberg and Paul D. Feinberg, *Ethics for a Brave New World*, 139 - 140.
[23] The Southern Baptist Convention, "Resolution on Laws Regulating Abortion." www.sbc.net. (Accessed November 16, 2009).

> the mother is often torn about the implications of this procedure as an abortion. Some well-meaning pastoral advisors have added to the problem by suggesting that the baby can be "moved" or that the baby might "migrate" and be all right. At this moment, we have no way to achieve such movement; the ectopic pregnancy still represents a great risk to the mother's life. Women die in the United States today because of undiagnosed ectopic pregnancies that rupture. The mother bleeds to death before surgical intervention can save her. We must be accurate in our understanding if we are going to advise people in the medical arena. Our zeal for the life of the baby must not dampen an informed zeal for the life of the mother. *Pastors and well-meaning Christian friends can give bad advice based on wrong information or faulty understanding.*[24]

In a 2020 statement on Ectopic Pregnancies, the American Association of Pro-Life OB/GYNs says, "There are currently no possible re-implantation techniques for ectopic embryos."[25] Again, I too have heard uninformed ministerial students make unsubstantiated claims about the viability of an ectopic pregnancy. Southern Baptists have reflected awareness that in cases where an ectopic pregnancy is involved, the mother's life is in danger, and have repeatedly acknowledged the need to protect a mother's physical life from imminent danger of death. A 1980 pro-life resolution stated, "Be it finally resolved, that we favor appropriate legislation and/or a constitutional amendment prohibiting abortion except to save the life of the mother."[26] A strongly worded pro-life resolution passed by the SBC meeting in New Orleans in 1982 stated,

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[24] William R. Cutrer, "A Physician's Perspective," in *The Reproductive Revolution: A Christian Appraisal of Sexuality, Reproductive Technologies, and the Family* (Grand Rapids: Eerdmans, 2000), 21. Emphasis in the original.

[25] American Association of Pro-Life Obstetricians and Gynecologists, "Practice Bulletin 9: Ectopic Pregnancy," March 12, 2020, https://aaplog.org/wp-content/uploads/2020/03/Practice-Bulletin-9-Ectopic-Pregnancy.pdf.

[26] "Resolution on Abortion," The Southern Baptist Convention, June 1980. http://www.sbc.net/resolutions/amResolution.asp?ID=19. (Accessed January 30, 2014).

"Be it finally resolved, that we support and will work for appropriate legislation and/or constitutional amendment which will prohibit abortions except to save the physical life of the mother, and that we also support and will work for legislation which will prohibit the practice of infanticide."[27] The same idea was repeated in another pro-life resolution affirmed by the SBC in 1989: "Be it finally resolved, that we do reaffirm our opposition to legalized abortion and our support of appropriate federal and state legislation and/or constitutional amendment which will prohibit abortion except to prevent the imminent death of the mother."[28] The wording of these resolutions makes perfectly clear that Southern Baptists reject the broad definition of "life of the mother" as articulated in *Doe* v. *Bolton*, but have narrow understanding related to imminent, physical danger – such as an ectopic pregnancy. As a person deeply committed to the sanctity of human life, I plead with my students to remember that we also believe in the sanctity of the life of the mother. An ectopic pregnancy is a tragic circumstance presented by living in a fallen world. Again, in an ectopic pregnancy, the baby will not come to term, the pregnancy will rupture, and the mother will bleed profusely and possibly die.

Last updated December 11, 2019

[27] "Resolution on Abortion and Infanticide," The Southern Baptist Convention, May 1982. http://www.sbc.net/resolutions/amResolution.asp?ID=20. (Accessed January 30, 2014).
[28] "Resolution on Laws Encouraging the Regulation of Abortion," The Southern Baptist Convention, June 1989. http://www.sbc.net/resolutions/amResolution.asp?ID=23. (Accessed January 30, 2014).