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THE HUMANITY OF THE UNBORN CHILD

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MY POSITION is to speak for the fetus and to be his advocate. This is an appropriate assignment for a pediatrician and in keeping with the current trend in the relationship between obstetrician and pediatrician; the obstetrician now recognizes that he is responsible for two patients, the mother and her unborn child.

To consider the fetus not to be a separate person but merely a part of the mother has not been tenable since the sixteenth century when Arantius showed that the maternal and fetal circulations were separate—neither continuous nor contiguous. The genetic material of this separate human embryo is certainly unique, determinative and complete. It is certainly alive since it possesses that hallmark of life—the ability to reproduce dying cells. It can be distinguished at any stage of development from any other non-human species. Once implanted, it requires only time and nutrition. Only two possible futures are open to it. It can become a live human being or a dead human fetus.

An editorial in *California Medicine* poses the life and death issues of abortion in their proper perspective:

Since the old ethic has not yet been fully displaced, it has been necessary to separate the idea of abortion from the idea of killing, which continues to be socially abhorrent. The result has been a curious avoidance of the scientific fact, which everyone really knows, that human life begins at conception and is continuous whether intra or extrauterine until death. The very considerable semantic gymnastics which are required to rationalize abortion as anything but taking a human life would be ludicrous if they were not often put forth under socially impeccable circumstances.¹

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¹ Editorial, *CALIFORNIA MEDICINE* 113:3 (1970).

Let us trace the typical pregnancy as it relates to the question of abortion. The average woman will not suspect she is pregnant until her menstrual period is missed and overdue by about a week. By this time, she is three weeks pregnant and the embryo's heart is already beating. She can confirm her pregnancy after six weeks of gestation by a biological test. By six weeks, all organ systems are present and functioning in the unborn child. Most abortions are performed between the eighth and the twelfth week of pregnancy. At eight weeks of pregnancy, we have a functioning nervous system. If you stroke the upper lip of an eight week fetus, it will flex its neck. This is a confirmation of reflex activity and a functional nervous system. Furthermore, an electroencephalographic tracing done at eight weeks will show brain waves essentially the same as the newborn infant and not substantially different from the brain waves of a mature adult. By twelve weeks the fetus will squint, swallow and suck his thumb. More importantly, he will withdraw from a painful stimulus or, in other words, he perceives pain. When abortion is done at twelve weeks, it is done by the method of dilatation and curettage. That is, the neck of the womb is opened up and the fetus removed in pieces by a sharp curet. When such a procedure is done, there is little doubt that the fetus, in fact, feels what is done to it. Between the sixteenth and the twentieth week, the preferred abortion procedure would be hysterotomy. A small Caesarean section is done and the fetus removed intact. Such a procedure at this stage almost always results in a live birth by the criteria established internationally for the definition of a live birth. In New York, for example, when a

hysterotomy is performed at twenty weeks, the law requires that the operating surgeon first fill out a birth certificate² and *after all signs of life subside*, that he then fill out a death certificate. It is obviously ludicrous to suggest that life did not exist when a birth has been certified by a legal document and equally ludicrous to suggest that abortion does not result in death when the State requires the confirmation of a death by a death certificate. The New York City Health Department does admit to the report of twenty-six such live births (as confirmed in a Chicago Tribune expose by Ron Kotulak³). One of the live births actually survived and has survived and has now been adopted. Between twenty and twenty-four weeks gestation, the preferred method of abortion is by the saline amniocentesis or "salting out" method. This procedure is accompanied by a high risk of complications. The New York State Health Department reported complications as occurring in 30-33% of women who had abortions by salting-out during the first four months of the New York law.⁴ The procedure consists in the injection of a 20% salt solution into the womb. The purpose of this injection is to kill the baby. He usually has a few convulsive movements prior to death and labor occurs spontaneously a short time later with the expulsion of a dead fetus. One instance was reported in which the saline was injected into the amniotic sac of only one of a pair of fraternal twins (because the

² N.Y. PUB. HEALTH LAW § 4130. (1954).

³ Chicago Tribune, Dec. 18, 1970, at —.

⁴ Preliminary Report. New York Abortion Law, July 1-Sept. 30, 1970. New York State Department of Health.

diagnosis of twins had not been made). When labor occurred, twins were born; one of which was dead and the other (un-injected) twin was alive. We have photographs of fetuses in various stages of development which further confirm the fact that abortion procedures are not performed on "amorphous cell masses" or "blobs of protoplasm" as some abortion lobbyists have suggested. No abortion in history has ever been performed on a "fertilized egg" because the woman does not even know she is pregnant at this point. What we as a society must really face up to, in the push toward abortion on demand, is the fact that developed, anthropomorphic human beings are to be sacrificed to achieve allegedly desirable societal goals. There is a serious question as to whether these goals are even achieved, but the means proposed for their achievement must be clearly understood. The public must comprehend that the real issue is whether any woman at any time, for any reason (or for no reason) should be allowed to terminate her pregnancy. Since the vast majority of Americans reject the principle abortion on demand (77% are opposed according to a recent study⁵); we can safely presume that they would reject any legislative proposal which was clearly recognizable as espousing demand abortion.

The consensus of the American people regarding abortion for various medical indications is another matter. The principle of "therapeutic abortion" is not overwhelmingly rejected by the American people. In most instances, however, the

portrayal of the true issues involved in therapeutic abortion has been distorted or oversimplified.

The incidence of abortions done in hospitals to preserve the mother's life, to preserve the mother's health, and for psychiatric indications have all decreased in the past twenty years. The only type of abortion which has increased during that time is the abortion done for the so-called "fetal indication." The use of this term is in itself a misnomer. One cannot justify an abortion on the basis of a fetal indication since no fetus has ever survived an abortion. The justification for such an abortion must then be either a form of euthanasia to spare the child a life with handicaps or for the purpose of saving the parents the happenstance of having an abnormal child, or to provide for the termination of an unwanted pregnancy.

There is no evidence to indicate that the infant with congenital anomalies would rather not be born, since he cannot be consulted and no one really represents him when the abortion decision is made. There is evidence that handicapped persons do value life after they are born, since the incidence of suicide among handicapped persons is apparently lower than that of the general population.⁶

Fetal indications are more accurately parental indications, then, and are based on a reluctance on the part of parents to accept a certain mathematical risk that an infant will be abnormal. Every preg-

⁵ Blake, *Abortion and Public Opinions*, THE 1960-1970 DECADE SCIENCE. 171:540 (1971).

⁶ Hellegers, A. E., *A Doctor Looks at Abortion*. Edward Douglas White Lecture. Georgetown University Law School (1966).

nancy, of course, carries with it the risk of the birth of an infant with congenital anomalies. The risk is never zero percent. It must be stated that the risk involved in *no* presently recognized maternal hazard would support a program of routine abortion. There is no accurate and safe method of recognizing the abnormal embryo in utero during the period when an abortion could be done. Trying to do a karyotype during the first trimester carries an excessive risk of terminating the pregnancy or producing fetal damage.⁷ Recognizing chromosomal sex is not conclusive since the sex-linked disorders now recognized are principally sex-linked recessives. What, then, are the risks involved, and do they justify the consideration of termination of the life of the fetus? In the situation of maternal rubella during the first trimester, modern prospective, virologically controlled studies indicate that no more than 10-20% of infants will be at risk.⁸ Even a figure of 20% would have to include such anomalies as remediable cardiac defects, tonal hearing loss and intrauterine growth retardation. When one talks of severe life-blighting congenital anomalies due to German measles, he is talking about cataracts and mental retardation. The risk of an infant suffering one of these calamities is much less than 20%. In fact, an eleven year prospective follow-up of offspring born to mothers contracting German measles during the first sixteen weeks of

pregnancy showed their intelligence distribution to be normal.⁹ The risk of an infant being born with any type of congenital anomaly is much less in any non-epidemic year than it is during a rubella epidemic.¹⁰ Since Mayer and Parkman,¹¹ of the National Institute of Health, have already produced and marketed an effective and potent rubella vaccine, it is likely that we can use this vaccine to prevent the next rubella epidemic, since epidemics usually occur every five to seven years. The answer to the rubella dilemma lies in this vaccine and not in therapeutic abortion. Rh incompatibility, once one of the leading fetal indications for therapeutic abortion, is no longer mentioned. I predict that in 2-3 years rubella will go the same route as Rh disease.

The problem of teratogenic drug ingestion would also seem irrelevant in this context. Thalidomide was not on the American market. It is unlikely that a drug with such a teratogenic capability could pass the progeny study requirements now made mandatory by the Food and Drug Administration. Progeny studies require testing to provide a drug safe for pregnant women and their unborn children. Indeed, thalidomide progeny studies on the rat and more recently on the baboon¹² have pro-

⁷ Macintyre, March of Dimes Symposium on Birth Defects; *quoted in* 8 MEDICAL WORLD NEWS. 82, Jan. 27, 1967.

⁸ Sheridan, M.D. *Final Report of a Prospective Study of Children Whose Mothers had Rubella in Early Pregnancy.* 2 BRIT. MED. J. 536 (1964).

⁹ Sever, et al. *Rubella Epidemic 1964: Effect on 6,000 Pregnancies.* 110 AM. J. DIS. CHILD. 395 (1965).

¹⁰ Siegel & Greenberg, *Fetal Death, Prematurity and Malformations After Maternal Rubella.* 262 NEW ENG. J. MED. 389 (1960).

¹¹ Mayer & Parkman, *Clinical Trial of an Experimental Rubella Virus Vaccine,* 69 J. PED. 893 (1966).

¹² Axelrod & Hendricks, Southwest Foundation

duced limb bud anomalies in animal fetuses almost identical to the phocomelia seen in human beings. Thus, if progeny studies had been required in Europe, the dangers of thalidomide could have been recognized before marketing the drug. The thalidomide tragedy was, in a sense, iatrogenic and, therefore, deserving of our profession's utmost concern and compassion. In keeping with noblest medical traditions is the work of Dr. Gustav Hauberg of the Anna Stift rehabilitation school in Hanover, Germany. In this institution, a team of orthopedists, social workers, and teachers has been engaged in the developing of abilities of thalidomide-damaged children so that, despite their heavy handicaps, they will still value life. Mental and psychological development has been normal, in most cases, and higher education potential is attributed to most. Thus even such a poignant situation as the birth of 7,000 phocomelics can have its positive aspect when medical resources are properly mobilized. The best preventative against the recurrence of such a tragedy is the basic reluctance of obstetricians to give any new drugs to pregnant women.

It is difficult to formulate a therapeutic principle which would apply to the various situations posed by exposure to drugs or disease. If the principle is that it is better for eight or nine normal babies to die than for one or two abnormal babies to be born, then I must say that I reject this principle as wasteful and unreasonable. It seems to me that this viewpoint derived from a cult of perfection which says that life is not

worth living unless it is free of handicaps. That *vita* is not *vita* unless it is *La Dolce Vita*.¹³ Experience in working with handicapped children would suggest that human nature frequently rises above its impediments and that, in Shakespeare's words, "Best men are molded out of faults and, for the most, become much more the better for being a little bad."

Certainly the entire medical profession, not just abortion law revisionists, has compassion for victims of forcible rape and incest. There is a question, however, as to the true dimensions of this problem. Studies on human fertility would suggest that not too many pregnancies are likely to result from a single act of forcible rape. I am informed, by the Chicago state's attorney's office that their staff could not recall a single incident of such a pregnancy in an experience covering about nine years of prosecutions for rape. If such a pregnancy were to occur, there is no scientific evidence that psychological trauma would be prevented, unaffected, or intensified by compounding the shame of rape with the possible guilt of abortion. In the case of statutory rape, there is likewise a question as to the relevance of therapeutic abortion. These pregnancies are not the results of ignorance or contraceptive failure. According to a recent North Carolina study, 95% of pregnant unmarried teenagers know how to obtain and use contraceptives. Teenage girls who become pregnant are largely a group characterized by social isolation and alienation from their parents. Frequently, they look forward to the birth

for Research and Education. Report quoted in 72 MEDICAL TRIBUNE. 3 (1966).

¹³ Byrn, *The Anatomy of Abortion Reform*, 4 REPORT 21 (1966).

of the infant as a further loneliness compensation and, therefore, do not present themselves for therapeutic abortion consideration. Incestuous pregnancy is no less a difficult problem. Many such pregnancies are not recognized or admitted until physically obvious and beyond the time when abortion would be possible. Many cases of alleged incest will fail of recognition because the victim or her mother will shrink from the financial ruin involved in accusing the father or the social ruin involved in convicting a brother. In 1966, there were only twelve indictments for incest entered in Cook County and only a fraction of these involved pregnancies to which therapeutic abortion would have related under any law.

Much is made of the appeal to prevent the birth of unwanted children. It seems to me that there is a confusion involved here which results from the failure to distinguish between the unwanted child and the unwanted pregnancy. In fifteen years of experience with the parent-child relationship, I have very rarely encountered a mother who asked to be rid of her child once she had taken it home from the nursery. I have encountered many mothers, pregnant with their third or fourth child who undergo a kind of panic which requires the sympathetic support of their family doctor and their husbands. According to Hoerck, 75% of women who were refused abortion under the Swedish system, went on to have their babies and were happy with them.¹⁴ According to Aren and

Amark, more of these women have an improvement in their mental adjustment than a deterioration of mental health.¹⁵ I wonder if we really want a situation like that in Denmark, for example, where the principal indications for abortion are: (1) the stress syndrome of housewives, (2) symptoms of insufficiency, and (3) impending exhaustion.¹⁶

One of the uninsurable risks of medical practice is that we sometimes begin to believe in the fantasies of our patients. Patients may ascribe god-like qualities to us, but I doubt that they will approve of our acting them out. The notion that a physician should be allowed to perform any abortion he chooses within the framework of the physician-patient relationship is a unique and unprecedented request for any profession. Does the lawyer ask that since law is his specialty, laws should be left to his conscience? Does the educator suggest that his position as an educator entitles him to decide when prayer should occur in public schools? A doctor may know how to do an abortion; he does not necessarily know when it should be done, or if it should be done at all.

Ninety-two percent of abortions are performed for social reasons, not medical. Physicians are not equipped by training to handle such requests. A large percentage of abortions in the United States are performed on women who are married,

¹⁴ Hoerck, cited by Asplund, *Discussion of Swedish Abortion Experience*, 11 BULL. SLOANE HOSP. 77 (1965).

¹⁵ Aren & Amark, *The Prognosis of Granted but not Performed Legal Abortions*, ACTA PSYCH. NEUR. SCANDANAVIAN SUPP. 99 (1955).

¹⁶ Hoffmeyer, *Medical Aspects of the Danish Legislation on Abortion*, 17 W. RES. L. REV. 529 (1965).

healthy, and living with their husbands. Ninety-five percent of the fetuses destroyed in these abortions would have been born normal, if allowed to go to term. If we accept the Kinsey statistics, 88-95% of abortions are performed by technically competent doctors of medicine.¹⁷ What do we expect to gain, then, from changing the law?

It seems to me that we have a good law in Illinois. When physicians throughout the state were asked, through the Illinois Medical Journal, to report cases where the present law had worked to the detriment of the physical or mental health of the mother by depriving her of a needed abortion, *no such cases were reported*. During the past five years, in Illinois, we have had five maternal deaths due to septic criminal abortion, an average of one a year. This must be close to an irreducible minimum. If the law is changed to allow for a vast increase in the number of abortions performed, there will be many more lives lost and these will be the lives of unborn children. The mortality is 100% for them. Most states recognize that the unborn child does have rights under the law. A mother may sue for the support of her unborn child or may hold a defendant liable for injuries sustained of her unborn child as a result of accident or assault. An unborn child may share in an inheritance

or workmen's compensation benefits. A pregnant woman convicted of a capital crime may not be executed until after her baby is born. The Constitution, in the fifth amendment, provides that no person shall be deprived of life without due process of law. It is certainly a matter of pause for the medical profession to decide whether two doctors in agreement, or even an "Abortion Committee," constitutes due process.

It seems ironical that when we have established a National Institute of Child Health which specifically directs its attention to child development from the time of conception, and while tens of millions are being spent by various national foundations to improve the lot of the unborn, that we should see in this day a movement for more liberal "fetal indications" for abortion.

If you ask me, therefore, to speak for the fetus, then speak for him I will. I speak for him intact or deformed. I speak for him wanted or unwanted. Yes, and I speak for him be he illegitimate or high-born. I am for life and the preservation of life. I believe that any life is of infinite value and that this value is not significantly diminished by physical or mental defect or the circumstances of that life's beginning. I believe that this regard for the quantity, as well as the quality of life, is a cornerstone of Western culture. I believe our patients are served best by a medical ethic which also holds this principle sacred.

¹⁷ Kinsey, *in* ABORTION IN THE UNITED STATES, 54.