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Who Speaks for the Fetus

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To speak for the fetus and to be his advocate is an appropriate assignment for a pediatrician. In keeping with the current modern trend in the relationship between obstetrician and the 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 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.

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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 since 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.

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 (1).

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 pregnancy, 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 (4). Recognizing chromosomal sex is not conclusive since the rare 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 (2). 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 followup of offspring born to mothers contracting German measles during the first 16 weeks of pregnancy showed their intelligence distribution to be normal (3). 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 (5). Since Mayer and Parkman (6) of the National Institute of Health have already reported on field trials of an apparently potent Rubella vaccine, it is likely that a vaccine will be available before the next rubella epidemic occurs, since epidemics usually occur every five to seven years. The answer to the rubella dilemma lies in this vaccine and not in therapeutic abortion.

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. Indeed, progeny studies on the rat and more recently on the baboon (7) have produced limb bud anomalies in animal fetuses almost indentical to the phocomelia seen in human beings. 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 have 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 principal as wasteful and unreasonable. It seems to me that this viewpoint derives 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* (8). 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 local states attorneys 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. 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 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 in 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 husband. 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. According to Aren and Amark, more of these women have an improvement in their mental adjustment than a deterioration of mental health. 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 (11).

One of the uninsurable risks of medical practice is that we sometimes begin to believe in the phantasies 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 percent of abortions in the United States are performed on women who are married, healthy, and living with their husbands. Ninety-five percent of the fetuses destroyed in these abortions would have been born normal. If we accept the Kinsey statistics, 88-95% of abortions are performed by technically competent doctors of medicine. 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 this state, 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 defendent liable for injuries sustained by 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 th[illegible] this regard for the quantity and [illegible]t the quality of life is a corners[illegible]ne of Western culture. I believe our [illegible]tients are served best by a medic[illegible] ethic which also holds this princip[illegible]sacred.

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