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Watson Bowes

Paul Byrne

Denis Cavanagh

William Colliton

Gerard Foye

See next page for additional authors

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True Integrity for the Maternal-Fetal Medicine Physician

Authors
Watson Bowes, Paul Byrne, Denis Cavanagh, William Colliton, Gerard Foye, Hanna Klaus, and Edmund Pellegrino

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True Integrity for the Maternal-Fetal Medicine Physician

by

Watson Bowes, Paul Byrne, Denis Cavanagh, William Colliton, Gerard Foye, Hanna Klaus, and Edmund Pellegrino

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In an article entitled"The Pro-Life Maternal-Fetal Medicine Physician", Blustein and Fleischman[1] argue that dedicated pro-life, antiabortion physicians cannot practice that subspecialty and maintain their integrity. (*authors' note*: integrity n 1: an unimpaired condition: SOUNDNESS 2: firm adherence to a code of esp. moral or artistic values[2]) They base their argument on the dominant medical moral principle of the day, patient autonomy. They also cite the legality of induced abortion. They ask: "If the job of the maternal-fetal medicine physician is to help women and their fetuses with high risk pregnancies, and if as a part of this care women do and should have the option of terminating their pregnancy, should an individual with pro-life views enter the field in the first place?"

Blustein and Fleischman suggest that the answer to this question if "No!" This paper will demonstrate the errors in their judgement. Some of the questions it will answer are: 1) To what extent can individuals with strong pro-abortion convictions practice maternal-fetal medicine without betraying their knowledge and information about the growth and development of the preborn baby? 2) How can pro-abortion maternal-fetal medicine physicians maintain their integrity when they know that there is no available treatment for the overwhelming majority of chromosomal and genetic abnormalities discovered by antenatal testing? Thus the solution offered the mother is not curing the diseases, but rather killing the intrauterine patient conceived in love. 3) How can good and studious people interested in the welfare of humankind and

humankind's ethical behavior perceive the problem from a 180 degree incorrect perspective, thus coming to wrong conclusions?

The preponderance of medical and scientific facts indicate that a new human life begins at fertilization. Arguments to the contrary are unconvincing. Even though abortion is legal in the United States throughout the entire nine months of pregnancy, the maternal-fetal specialist, all obstetricians, other physicians and informed people know that induced abortion is the killing of a preborn human being. The data on abortion rates of preborn children diagnosed as abnormal by antenatal testing are difficult to find. However, anecdotal findings suggest that the rate approximates 80%.

In our search to determine the exact data on the incidence of death selection for preborn patients diagnosed as abnormal, we did discover that such diagnoses are incorrect 5% of the time. In 1989, Hook et al[3] reported the results of an ongoing survey of rates of spontaneous death of fetuses with chromosomal abnormalities detected at second-trimester amniocentesis in which the mother did not elect abortion. Letters were sent to all laboratories known to the authors which undertook prenatal cytogenetic diagnosis. This is not a small study. There were 420 infants studied and their final diagnoses are summarized in Table 1 (p. 856) of their study. While not mentioned in the body of the article, the bottom line of the table indicates that 23 of those studied were normal. Plainly stated, this indicates that this sophisticated methodology produced a 5% false positive rate. Even if advancing technology should one day result in 100 percent accuracy for these studies, the whole undertaking remains immoral when the purpose is to locate and destroy preborn patients carrying chromosomal defects. It must be remembered that, if our conservative 80% estimate of positive studies result in induced abortion, 1680 preborn infants were terminated. Eighty-four (5%) of those babies were normal.

Clearly the result of these search and destroy technologies is eugenics, which was unanimously condemned at the Nuremberg trials among the Crimes Against Humanity. DeValres, one of the most compassionate of the judges, expressed the opinion that the tribunal would be making a statement of morality, not merely of law, and that, regardless of culpability, the crimes that had been of such enormity that anyone who had played the most remote role in their commission must be convicted.[4] Yet within this century, we are back in the business of

cleansing our race again.

It is true that in today's litigious society, it seems necessary to offer all pregnant women counseling with regard to the availability of antenatal screening, including determinations of alpha-fetoprotein. Would the enthusiastic pro-abortion maternal-fetal medicine physician (MFMP) also describe the physiologic accomplishments of the preborn patient under study in the second trimester? Would he or she also demonstrate thumb sucking and graceful swimming movements by ultrasound? Would pro-abortion MFMPs indicate the purpose of the screening, a search for neural tube defects and Down syndrome, the latter condition being one for which we have no treatment other than death selection for the preborn patient? Would they indicate that more invasive testing, amniocentesis, will be required if the results of this invasive procedure can be false positive 5% of the time? Would the dedicated pro-abortion MFMP inform the expectant mother that this false positive rate is 5 times the likelihood (1% or less) that her infant will carry a neural tube defect unless she has already delivered two infants with such a problem?[5]

It must also be remembered that the MFMP has two patients for whom she/he is the advocate and primary care giver, the preborn patient and the expectant mother. Blustein and Fleischman make no mention of the very real burdens that the amniocentesis - fetal abnormality - induced abortion scenario provides for the women involved. Several recent articles have given a glimpse of these burdens. Adler et al[6], reporting in *Science*, argue that the incidence of severe psychological responses after women have obtained "legal, non-restrictive abortions" is low. However, they note, "The more a pregnancy is wanted and is viewed as personally meaningful by the woman, the more difficult abortion may be." This is most often the case in abortions for genetic indications.

Elkins et al[7] reported on "Attitudes of Mothers of Children With Down Syndrome Concerning Amniocentesis, Abortion, and Prenatal Genetic Counseling Techniques". The study was conducted by questionnaires elicited from 300 mothers of Down syndrome infants. One hundred one responded, 40 of whom had borne children after giving birth to a child with Down syndrome. Half had an amniocentesis in subsequent pregnancies, but only half of these said that they would abort the pregnancy if Down syndrome was confirmed.

The authors report that three factors may contribute to anxiety and hostility in this population group:

1) There was a strong sense of ambivalence noted in numerous replies about the appropriateness of such procedures as amniocentesis and abortion among parents of children with Down syndrome.

2) The attitude of these mothers differed from that which may be assumed by some genetic counselors. Of the 40 women in this study who were pregnant after having a child with Down syndrome, only 10 (25%) stated that they requested amniocentesis intending to terminate the pregnancy if the results were positive for trisomy 21. This disparity of view may represent a failure to recognize the generally positive response of women to their children with Down syndrome.

3) Finally, the hostility noted may be related to the contemporary emotional discussions about abortions in general. For instance, even in this survey of a fairly homogenous advocacy group for persons with Down syndrome, 34% of the participants thought the abortion of a fetus with Down syndrome should not be allowed, whereas only 7.3% of this group thought that all women with abnormal results on amniocentesis should have an abortion.

The second area of interest investigated by Elkins et al concerned the criteria for adequate prenatal genetic counseling for people who are at high risk for a pregnancy with Down syndrome. They noted that discussions limited to the risks of the occurrence of Down syndrome, descriptions of the procedure, and risks of amniocentesis were considered adequate by only 11 (11%) of the survey participants. They add: "By contrast 86% of participants thought that initial counseling for women at high risk for Down syndrome should include positive and negative facts about Down syndrome before amniocentesis."

To learn the accuracy of this finding fully articulated, one must read"A Piece of My Mind - The Choice", by Judy Brown. M.D. (a pseudonym).[8] She details her own experience with the scenario under discussion after aborting her child and writes:

> It took several weeks to recover physically; emotional scars are still raw 2 years later...People just don't realize, my counselor said. They don't think of this as the loss of a child. It was only a few years ago that the need to mourn a miscarriage was widely accepted. For me, though, an earlier miscarriage paled in comparison with this. At least that was straightforward, and there was comfort in the fact that there was nothing I could have done to prevent it. This time, the semblance of control and heart-wrenching options magnified the pain many times over. I had chosen my pain.
>
> Perhaps in a few more years the need to share and mourn this especially complicated kind of loss will be more widely recognized. Whatever the decision, the need is great. In the meantime, I remember the words "There's a problem." And I think they apply not only to that particular pregnancy, They apply equally to technology that advances faster than our ability to comprehend the effects on the very human beings it is designed to help.

There is another problem with the conclusion of Blustein and Fleischman. As Thorp et al[9] note in their companion article in the same *Hastings Center Report*: "Patient autonomy is the overriding principle that forms the foundation of current ethical thought; autonomy places the patient in charge of her and her unborn offspring's destiny. The physician provides information, but the patient makes the ultimate decision - a choice that is impossible for others to foresee." And later they state: "Silencing dissenting *(author's note: pro-life)*opinion ultimately limits patient autonomy. If one excludes from perinatology all physicians who are pro-life, then one has expunged a goal that lies near the heart of medicine: to educate, inform, and advise. Is this in the best interest of the patient?" On the data just cited, the answer to that question os obviously, "No!"

The answer to the question, "How could Drs. Blustein and Fleischman go so wrong in their analysis?" is clearly connected to today's decline in the traditional values of Western culture. The history of this cultural change has been beautifully presented by Francis A. Schaeffer in his book, *How Should We Then Live?*[10] Schaeffer's thesis, with which we agree, is that religion has been taught in our public school systems for several decades, from the Golden Books up through the 12th Grade. That religion is secular humanism. Secular humanism teaches that man is the center of the universe rather than God. The great theophany between God and Moses on Mount Sinai when

mankind received the Ten Commandments is ruled out of young students' educational experience. There are no moral absolutes such as "Thou shalt not kill (innocent human life)". Therefore there is no criterion by which to determine what is right and what is wrong.

In such a secular humanist society, law and the principles that direct medical practice become arbitrary and socially determined rather than principled. The Roe/Doe Supreme Court decisions are examples of such laws. Medical decisions similarly become non-principled. An example of this reality is the clearly schizophrenic attitude toward life presented by the American College of Obstetricians and Gynecologists (ACOG). The ACOG leadership regularly sends excellent clinical directives to its members advising them on the care of their pregnant patients. They are advised to counsel their expectant mothers to avoid smoking and ingestion of alcohol because of the possible harm to their preborn patients. Yet these same leaders teach that it is perfectly licit to kill those same preborn babies, for whom they show such solicitude, by induced abortion if that is the mother's will. There is no logically consistent way to reconcile these two propositions.

Schaeffer indicate that if there are no moral absolutes by which to judge society, then the will of society becomes absolute. But then how do we judge a morally good from a morally pathological solution? With the moral vacuum formed by a loss of the traditional Judeo-Christian moral values, individuals or groups may easily impose substitute absolutes. These "decision makers" may be administrators, legislators, judges, physicians, lawyers, or, unfortunately, even members of organized religions. These are not evil people. They are well-educated individuals seeking solutions to genuine worldly problems. Their difficulty is that they are using unprincipled worldly wisdom. It is important to understand that we do not pass judgement on the sincerity of our confreres. What we do condemn is their thinking and actions with respect to the preborn. We perceive these to be intrinsically evil and not in the best interest of the human family.

When pressures mount on a society, the conscientious secularist reacts. Some of the pressures that can trigger a reaction are: population concerns, real or imagined shortages of food, economic breakdown and political terrorism, all of which have been experienced in recent times. A very current example is the reaction of the self-chartered Accreditation Council for Graduate Medical Education (ACGME).[11]

revised its program requirements for residency education , specifically to mandate that every Ob/Gyn residency program in the country *must* include induced abortion training, effective January 1, 1996. The ACGME does permit residents with a moral or religious objection to opt out of this experience. Thus an individual opposed to abortion in all its forms can qualify for the American Board of Obstetrics and Gynecology and ultimately become a Board-certified specialist. Under pressure from colleagues and members of Congress, the ACGME offered substitute language[12]: "No program or resident with a religious or moral objection will be required to provide training in, or to perform, induced abortions." Utilizing word games, it subsequently mandates that all Ob/Gyn training programs, including those with religious and moral objections "1) must not impede residents in their programs who do not have a religious or moral objection from receiving education and experience in performing abortion at another institution; and 2) must publicize such policy to all applicants to that residency." Manifestly this body allows institutions to forbid abortion on its own premises, but forces them to sanction it at other institutions under its aegis. This is a serious mis-reading of the ethics of moral cooperation.

Discussion

We believe that a physician's integrity is a value essential to the special practice of medicine. This is so much the case that we make it very clear to our patients that we will not participate in an abortion even if the infant in the womb were to be diagnosed as carrying a lethal abnormality. We take it to be necessary in the practice of obstetrics that standard screening tests, including screening for alpha-fetoprotein be offered as part of antenatal care. However, we stress that the mothers should be informed of the purpose of this study, which is to look for infants who have a neural tube defect or Down syndrome. Mothers should be informed that if the screening test is suspicious of an abnormality, further invasive testing with increased risks may be required. Also they should understand that, in the case of Down syndrome, there is no way to determine the severity of the problem.

If the studies confirm the presence of a trisomy 21 infant, there is unfortunately no treatment for the condition. The mothers will have to decide whether or not to carry their babies to term or end their lives.

Whatever the results, the pro-life physician cannot with integrity participate in the killing of the infant. If the woman wants an abortion she will have to seek out an abortionist. Integrity is not a problem for the physician who practices in a pro-life, anti-abortion moral framework. Physicians are to be healers, not killers.

All MFMP's and obstetricians know that the fetus is a not-yet-born human being. To state otherwise is a violation of their integrity. While the counsel to obtain an abortion might be legal, it remains, and always will remain immoral. No matter what the rationalization might be, including consequentialist arguments for the pro-abortion, anti-life MFMP's continuing in the specialty, they should realize that their own integrity, as well as the integrity of the mother, is violated when an abortion is done. To repeat, killing innocent human life by abortion may be legal today, but it remains, and always will remain immoral.

In the final analysis, it is clear that a MFMP with strong pro-life convictions can practice maternal-fetal medicine with integrity. We argue that it is physicians with pro-abortion convictions who cannot be participants in the practice of maternal-fetal medicine without betraying their integrity. We respect the attempts of MFMP's to reconcile their deeply held knowledge that a new human life begins at fertilization. With abortion, even though abortion is legal, the facts are clear: they are doing an injustice to the preborn patients, as well as to their mothers, to the profession of medicine, and to all of society.

How did all of this happen? In our view, the pathogenesis is as follows: medical technology is coming down the information highway very rapidly. Moralists need months, and sometimes years to exchange lines of argumentation before coming to a moral consensus. Then Pastor Richard John Neuhaus[13] has described the situation most accurately: "Thousands of medical ethicists and bioethicists, as they are called, professionally guide the unthinkable on its passage through the debatable on its way to unexceptionable. Those who pause too long to ponder troubling questions along the way are likely to be told that 'the profession has already passed that point.' In truth, the profession is huffing and puffing to catch up with what is already being done without its moral blessing." What the medical profession is doing is deifying technology on the assumption that if it can be done, it should be done. The elitists have turned their backs on God. However, as Abbott[14] has

pointed out: "But when God is forgotten, the creature itself grows unintelligible." The Book of Wisdom (13:1) says it this way: "For all men were by nature foolish who were in ignorance of God."

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