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WHEN ABORTION BECOMES BIRTH: A DILEMMA OF MEDICAL ETHICS SHAKEN BY NEW ADVANCES

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A woman went to Beth Israel Medical Center in Manhattan for an abortion. When it was done, the doctors told her she had just given birth to a daughter.

The child, though seriously brain-damaged, was saved by new techniques of caring for extremely premature infants, and the techniques get better every year. The number of children surviving abortions is still tiny, and their chances of leading healthy lives are still small, but they are posing extraordinarily troubling problems for doctors and hospital administrators.

In effect, medical technology has leaped beyond both the law on abortion and the assumptions of medical ethics. At many hospitals, policies have been thrown into turmoil.

Doctors are grappling with whether a child born as a result of an abortion should be given the same extraordinary care as one born of a miscarriage. Hospital ethics committees are confronting the question of whether late abortions should be moved out of operating rooms and into the obstetrical wings holding the latest life-saving equipment. Women requesting late abortions at some hospitals are being told that a fetus born alive will be given all chances to survive. 'One of Our Most Difficult Areas'

"The area of late abortions is one of our most difficult areas," said Dr. Alan Rosenfield, acting director of obstetrics and gynecology at Columbia-Presbyterian Medical Center. "There are no easy answers, given our technology now."

In its landmark 1973 decision, the United States Supreme Court upheld a woman's right to abortion until the point of fetal viability and said that point was generally at about 28 weeks after conception. In New York State, the law allows abortions through the 24th week of pregnancy. But a decade of advances in medical science have made it possible to sustain the lives of infants earlier - as early as 23 weeks.

Live births after abortions are still extremely rare. Of the more than 160,000 abortions performed in 1982 in New York, there were 18 live births, according to statistics maintained by the State and City Health Departments. No statistics are maintained nationwide.

Dealing With a Possibility

But the very possibility - a possibility most hospitals are reluctant to discuss openly - has stirred internal hospital discussions of when and how abortions are performed, whether late pregnancies should be screened for defects, and what specific procedures should be taken if a child is born live.

And there are difficult new legal issues. When an abortion becomes a birth, it is unclear who must decide what procedures are in the infant's best interest or who is financially responsible.

Because infants born of abortion are injured in the abortion process, legal scholars are asking whether it would be possible for such a seriously injured infant to make a claim of "wrongful life" against a hospital.

Differing Approaches To the Problem

Policies vary dramatically.

Some hospitals are now only performing elective abortions until the 20th week - a point where it is still impossible to sustain fetal life - except in cases where a fetus has been determined to suffer from major defects.

Others, refusing to make even that exception, are declining to perform amniocentesis, the genetic screening of the amniotic fluid surrounding the fetus. The test is generally recommended for women over the age of 35 and undergone by countless others to detect fetal abnormalities.

Some hospitals are switching to an abortion procedure that eliminates any possibility that a fetus might live.

Warnings to the Families

At still others, families are routinely being advised that an abortion may result in a live birth.

"We have to warn the families," said Dr. Hugh R. Barber, chief of obstetrics and gynecology at Lenox Hill Hospital in Manhattan, where abortions are performed until the legal limit of 24 weeks. "You have to tell them there is a slight possibility the fetus may live."

Dr. John Parente, director of obstetrics and gynecology at the Bronx-Lebanon Hospital Center, said that amniocentesis is not available there and that the hospital did not want to do late abortions.

"It's an emotional problem," he said. "We just don't want to do it."

"We decided to cut back to 20 weeks," said Dr. Fritz Fuchs, professor and former chairman of the department of obstetrics and gynecology at New York Hospital-Cornell Medical Center, where an exception is made for major defects. "In this manner, we have avoided getting into any difficulties with the law."

Fear Inspires Caution

The subject is rife with emotion and debate. Much of the discussion is taking place behind closed doors for fear of publicity and lawsuits.

Told about the subject of this article, many doctors declined to return telephone calls. In one case, the director of obstetrics at a major New York hospital spoke in detail of an aborted infant's survival last year and the traumatic impact this event had on the hospital's staff. The next day, he called back to deny the incident had ever occurred.

The questions of when abortions should be performed, by what method, and what kinds of infants should be saved are answered differently by different physicians.

While publicly the great majority of hospitals agree that any infant who survives an abortion or miscarriage should be kept alive, doctors acknowledge privately that this practice varies widely from hospital to hospital.

Circumstances of Procedure

"It's necessary to remember that these days abortion is done on request and therefore not a procedure you undertake in the interest of the fetus," said Dr. Gordon W. Douglas, the chief of obstetrics and gynecology at New York University Medical Center, where abortions are performed only until the 20th week of pregnancy except in cases of fetal abnormality.

"What most of us try to do is to try to remain within the law and not generate problems for anyone," Dr. Douglas said. "The hospital requires any live fetus to be given full supportive services and full resuscitation regardless of prognosis. But the delivery of a living fetus carries no guarantee of a surviving adult of any competence."

Complicating the problem for doctors at many hospitals are advances that have been made in detecting defects long before birth. Many of these procedures, including amniocentesis and sonography, cannot be performed until relatively late in the pregnancy, so often decisions about such abortions are made just at the edge of fetal viability.

Working at Cross Purposes

"It makes us all schizophrenic," said Dr. Richard Hausknecht, an associate clinical professor of obstetrics and gynecology at Mount Sinai Hospital who specializes in high risk pregnancies. "Nowadays we are asked to terminate a pregnancy that in two weeks doctors on the same floor are fighting to save."

Very premature infants, with low birth weight, suffer from myriad problems. Recent advances have helped prevent lung collapse in these tiny infants and have made it possible to nourish them with new formulas.

Nevertheless, serious handicaps persist. The cost of producing a survivor from a fetus of less than 28 weeks' gestation - whether it is a result of an abortion or of natural miscarriage - can run into the tens of thousands of dollars, not including medical costs from later complications of premature birth.

Three Methods Of Abortion

Much debate concerns the method by which late abortions are performed. Generally, there are three methods.

Injecting saline into the amniotic sac to induce labor in the mother is still the most commonly used procedure in late abortions. While it generally results in fetal death, it has been associated with harmful side effects in women and doctors have increasingly turned to the use of prosteglandin in late abortions.

Prosteglandin is a substance that also induces labor, but it does not poison the fetus. Of all abortion methods, prosteglandin - while believed to be the safest for women by some doctors - is also the most likely to result in a live birth.

The third and most controversial of the methods is dilation and evacuation. Known as D and E, it involves dismembering the fetus while still in the womb, which eliminates any possibility of live birth. It is a relatively new procedure in late abortions, and is generally believed to be among the safest for women and the least psychologically painful. However, it is also generally considered the most traumatic for doctors and staff.

The suction and curettage method, in which the cervix is dilated and the fetus is extracted through a suction tube, is generally applicable only in the early stages of pregnancy. New Procedure Is Gaining

According to the Centers for Disease Control in Atlanta, the use of dilation and evacuation in second- trimester abortions has increased greatly in recent years, as more physicians have learned to perform the procedure and it has gained in acceptance.

Division abounds among gynecologists about who is willing to perform late abortions and by what method.

"I think every obstetrician struggles with this and makes his mind up what his threshold is," said Dr. David Grimes, a gynecologist with the division of reproductive health at the center in Atlanta. "Some do it until 12 weeks. Some will do it until 24."

"It would not be worth it to me to take even a small risk to the mother's life to avoid possibility of a live birth," said Dr. Bruce Young, director of maternal-fetal medicine at New York

University Medical Center, where the policy also is to perform abortions until the 20th week of pregnancy except in cases of fetal deformities. The method of choice at New York University Medical Center is the use of prosteglandin. 'The Best Way I Know How'

"A woman comes to me for a late abortion and I do it the best way I know how," said Dr. E. Wyman Garrett, an obstetrician in Newark who is among a growing number of physicians who have developed expertise in performing D and E's through the 24th week of pregnancy.

He said he prefers this method because it is safer for the woman and because it avoids the agonizing decision of what to do when an child is born alive - a situation he confronted only last year.

In that instance, Dr. Garrett performed a saline abortion on a young woman at University Hospital in Newark. The infant that emerged weighed about 1 pound 10 ounces and was alive. It was born Jan. 13 and died April 29 after developing meningitis.

"I do D and E's because I think it is safer," said Dr. William Rashbaum, a gynecologist affiliated with Beth Israel who also specializes in this method. "It is a horrible procedure. Staff burnout is a major problem. But are you functioning in the interests of taking care of your staff or taking care of your patients?"

Theories Founder On Reality

A serious problem physicians confront in performing late abortions is the gap between abstract theories on fetal viability and the realities of medical practice.

In the case of the fetus born alive during an abortion at Beth Israel, for example, the infant was believed to have been only 22 weeks in gestation, but it was in fact 25 or 26 weeks, according to one doctor.

"The baby turned out to be older than we thought," the doctor said. Beth Israel officials said that the infant suffered extensive brain damage but would not discuss the incident further.

Pregnancy due dates, dates of conception and fetal viability are still uncertain areas. They depend on the skills of the doctor, the technical currentness of the hospital and individual development of the child. Method of Determining Age

When a woman in the second trimester of pregnancy approaches a physician for an abortion, she is asked to undergo a sonogram, which produces an image of the fetus. It is the best - though still far from perfect - way for doctors to determine gestational age, since recollections about last menstrual periods are highly imprecise.

The age is estimated by measuring the diameter between two points on the fetus's skull. In theory, the wider the diameter, the older the fetus. But accuracy depends on the machinery used and on the skill of the technician using it. Congenitally small children make estimations of fetal age even more difficult.

"Sonograms are very subjective," said Jeffrey Karaban, a sonographer at one of the largest abortion clinics in New York City, the Eastern Women's Center in Manhattan, where 8,000 abortions are performed a year. "Certainly there are a lot of bad sonograms done. We have patients come from seemingly reputable places and yet their sonograms don't jibe with what we see."

Viability is even more difficult to assess. Once a highly premature infant is born - either as a result of abortion or of miscarriage - its gestational age is determined by how much it weighs and a number of other physical characteristics: the condition of its eyes, the state of its skin, how much cartilage it has developed in its ears. This, too, is highly subjective. Characteristics of Fetus

A 24-week fetus physically appears to resemble a child, but its lungs and brain are still not fully developed, nor are its eyelids open.

If a decision has been made to resuscitate the baby, a mask may be placed over its mouth and nose and a needle placed through its navel to measure blood pressure and body chemistry. The baby is then weighed and further examined to determine whether to continue treatment.

Some doctors do not believe an infant is "viable," and thus a subject for the most advanced and aggressive treatment, if it is seriously deformed or has been determined to have less than a 20 percent chance of survival. Other doctors will try to save any infant with a heart beat.

"I have never been called to deal with such a case, but if I were, I would vigorously treat that baby," said Dr. John Driscoll, director of the neonatal intensive care unit at Columbia-Presbyterian. "If the baby was anomalous, there would be a whole other set of dilemmas. If I were asked about a Down's syndrome baby, I believe everything should be done. I differ with some people's thoughts about quality-of-life issues."

The underlying question that many doctors ask in confronting these difficult medical problems is why late abortions are still necessary, given the availability of contraceptives and the comparative ease with which abortions can now be obtained.

Indeed, over the past 10 years, elective abortions have been performed at progressively earlier stages of pregnancy nationwide, and the great majority are now carried out within the first trimester.

Of the 1.6 million abortions performed in the United States in 1980 - the last available figure from the Centers for Disease Control in Atlanta - more than 90 percent were done within the first 12 weeks. Only about 13,000 - less than 1 percent of all abortions performed nationwide - were performed on women pregnant more than 21 weeks.

According to statistics compiled by the Centers for Disease Control, the largest group of these women is between the ages of 15 and 19. Indication of Pregnancy

Many of these are believed to be unwed teen-agers who do not know they are pregnant until they feel the baby kick. Quickening - as fetal movement is called - usually first occurs between the 17th and 20th weeks of pregnancy. About 10 percent of all second-trimester abortions - less than 1 percent overall - are performed on women who have discovered they are carrying infants with serious defects.

Amniocentesis is usually performed during the 14th through 16th weeks of pregnancy. Results take at least three to four weeks, so that a woman choosing to abort a fetus with birth defects may not be able to do so until the 17th or as late as the 20th week of pregnancy. If there are problems with culturing the fluid, it may have to be performed even later.

In an article to be published by the Georgetown University Law Journal next June, Nancy K. Rhoden, assistant professor of law at Ohio State University in Columbus, points out that advances in neonatology may have made the Supreme Court's *Roe v. Wade* decision obsolete. **New Cutoff Point Suggested**

Miss Rhoden suggests an arbitrary cutoff point of 20 weeks or the halfway mark of pregnancy as a new limit for abortions, with exceptions to be made for women who have found through amniocentesis that their offspring have serious defects.

But as legal scholars, ethicists and others continue to dissect this complicated subject, hospitals and physicians are trying to cope with the human drama of what is appropriate and what is not, whether abortions should now be carried out in the obstetrical wings of hospitals where fetuses can be monitored or whether neonatologists should be present at abortions where a live birth is a possibility.

"Social policy makes the late abortion issue worse," said **Dr. Phillip Stubblefield**, chief of obstetrics and gynecology at Mount Auburn Hospital in Cambridge, Mass., and an associate professor at Harvard Medical School. "Doing an abortion at 28 weeks is indefensible. I would draw a line at 24." The only exception he would make would be to save the life of the mother.

"But there should be a middle ground," he added. "Some abortions are necessary. What we should do is try to streamline the system so that help can be gotten earlier."

"What are the chances of a 24-week fetus to have a normal life?" asked Dr. William Caspe, the director of pediatrics at Bronx-Lebanon Hospital. "Probably small. Can they survive in terms of their heart and lungs? Yes. In terms of brain survival we are not there. And so a number of us have great qualms about what to do to a teeny tiny baby. For medical and legal reasons, we need to resuscitate. Some feel comfortable at that. Some don't.

"As a society, you shouldn't want us to do that. But as society, you give us no choice."

photos of Drs. Fritz Fuchs, William Rashbaum, John Driscoll and Jeffrey Karaban; chart of pregnancy and abortion timetables