A doctor's decision

Erin Stock
(https://dailynorthwestern.com/staff/?writer=Erin%20Stock)
January 18, 2006

The man in thin blue scrubs stood facing about 50 future doctors in their second year at Northwestern's Feinberg School of Medicine. Dr. Scott Moses occasionally tugged at the skin under his chin, where his full face was tinted by stubble. He asked the students to tell him what an abortion was.

"Terminating a pregnancy," a student volunteered. Moses, who has been a guest lecturer for this class for seven years, wrote the student's suggestion on the whiteboard in a hurried scribble: "terminate preg."

"Killing a baby," someone said flatly. Two students sitting against the back wall laughed. Moses quickly responded, "The

Latest Stories
(https://dailynorthwestern.com/category/lateststories/?list)

Women's Soccer: Northwestern toggling through its frontline options
(https://dailynorthwestern.com/2018/10/12/lat soccer-northwestern-toggling-through-its-frontline-options/)
October 12, 2018

Proposed elimination of Station 4, EFD personnel leads to backlash
(https://dailynorthwestern.com/2018/10/12/top stories/proposed-elimination-of-station-4-efd-personnel-leads-to-backlash/)
October 12, 2018

Amid scandal in the Catholic Church, CaSA holds candlelight vigil for survivors
(https://dailynorthwestern.com/2018/10/12/top stories/amid-scandal-in-the-catholic-church-casa-holds-candlelight-vigil-for-survivors/)
October 12, 2018

Meet the 2018 Homecoming Court
(https://dailynorthwestern.com/2018/10/12/lat the-2018-homecoming-court/)
October 12, 2018

VIEW ALL
(https://dailynorthwestern.com/category/lateststories/?list)

fancy word we're going to use for that is 'feticide.'"

A third student threw out, "Evacuation of the uterus." A fourth: "Family planning." The students watched, without taking notes, as Moses compiled the horizontal list on the board.

Outside the walls of McGaw 2-322 on the Chicago Campus, a block over on East Superior Street, is Prentice Women's Hospital – one of the premiere health care centers for women in the country. At 1:15 p.m. on a Monday in November, as Moses lectured the second-years in "Profession of Medicine," chances were good that a woman was terminating her pregnancy nextdoor. Or was she killing her baby? Moses asked the students to figure out how they saw abortion. He probed the gray areas.

Podcasting

To listen to the reporters tell their stories, listen to a podcast here (https://www.dailynorthwestern.com/vnews/display.v/ART/2006/0

"If you're an abortion provider, and someone comes back for a seventh one, is that different than someone who comes and weeps on your doorstep, who says, 'This is the absolute worst thing that has happened, and I'll never do it again'?"

Moses paused.

"It's not different for the fetus," he said.

BEYOND THE CLASSROOM

Suppose there is a future patient who wonders why her period is late, or who notices her breasts swell and curses herself for missing her birth control pill, or who is distressed when the condom breaks. She could be your best friend, your roommate, that girl who sits next to you in class, even you. She might consider abortion. Her doctor might not.

The 1973 Roe V. Wade verdict did not only give women the right to choose, Moses told the class.

He rattled off the ruling quickly. "For the stage prior to

approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."

It is future obstetrician-gynecologists, some of whom were sitting in McGaw 2-322 that day, who have to find a way to define their own ethical parameters in providing abortions. The point has become more significant as the number of abortion providers in the United States falls, even as the surgery remains in high demand. The number of abortion providers in the country decreased 11 percent between 1996 and 2000, according to the Alan Guttmacher Institute. At current rates, the nonprofit organization, which researches sexual and reproductive health issues, estimates about one in three women will have an abortion before age 45.

The choice facing future physicians is not as simple as deciding whether to perform abortions. If they will not offer the procedure, will they refer their patients to someone who will? Or if they do perform them, will they provide selective abortions, where a woman decides to end a pregnancy because the fetus has some undesirable characteristic, such as a genetic disability?

The American Medical Association doesn't offer much guidance. The organization's ethical code only says that it does not prohibit physicians from providing them, as long as they do not violate the law.

Moses felt strongly that he wanted to be trained how to do abortions up until viability, which is when a fetus can live outside the uterus – usually around 24 weeks. Fetal anomalies and genetic disabilities, such as Down syndrome, typically are not recognized until the second trimester. He also never wanted to be in a position where he could not save the life of a woman. But it took him years, and hundreds of religious and philosophical texts, to determine his limits.

The students he lectured probably had not decided into what field of medicine to go, let alone dissected the moral nuances of performing an abortion. Their training so far had been talking about the ethics and politics of abortion.

NU's medical program offers more abortion training than most, according to the national organization Medical Students for

Choice. The group surveyed 67 programs, including NU's. It found that NU is one of less than 20 percent of programs surveyed that have any clinical information about abortion required in their first- and second-year curricula.

The future of abortion is here, in the halls of NU. One day, some of these students might meet women who want to receive the most controversial medical procedure in the country. And they will have a decision to make.

WEIGHTY DECISIONS

Anne Ruble, a third-year NU medical student probably going into obstetrics-gynecology, saw an abortion for the first time when she was 24. Ruble was couch-ridden with mono in November of 2000 and she spent her days in front of the television while politicos argued over who would make a better president. She swore to herself that if George W. Bush beat Al Gore, she would go work at Planned Parenthood, an organization that advocates abortion rights and offers reproductive services.

The staff worried Ruble would faint during that first surgery. They planned a way to remove her discreetly without upsetting the patient. It never got that far. Ruble is not the type to get squeamish.

Ruble, now 29, cannot even remember how she felt about it that first time, except that it did not make her feel bad. She has helped in about 500 abortions since then, and the only time she was upset was when the patient was in emotional or physical pain. What was removed from the uterus just looked like blood, about enough blood to fill half of a urine sample cup.

Ruble does not consider what she saw in the jar to be a baby. She does not think of it as a baby in the second trimester either, even though fetal parts are identifiable.

She would consider it a baby, however, if a female patient came to her for a maternity visit and not an abortion after five weeks of pregnancy. Ruble would be happy for her.

"People feel comfortable making decisions based on the fetus, for the fetus," she explained. "I just don't."

This idea does not make sense to Katie Benzmiller, who co-directs Medical Students for Life at NU. The fetus, Benzmiller

directs Medical Students for Life at NU. The fetus, Benzmiller believes, is also a patient. It has rights.

As a second-year student, she has at least another year and a half to decide what field of medicine she will go into, but she is leaning toward pediatrics. A Roman Catholic, Benzmiller does not believe abortion is good for a patient. She would never recommend it, even if it is legal.

“For me, it’s like smoking is legal, but would you ever advise your patient to smoke?” she said.

Her stance on abortion is the same even in cases where the fetus is known to have a genetic disability. Last week Benzmiller and her group hosted a talk by Kristi Kirschner, the medical director for the Women with Disabilities Center and the director of the Disability Ethics Center, programs sponsored by the Rehabilitation Institute of Chicago.

Students on both sides of the issue candidly discussed their concerns: Is it moral to discontinue a pregnancy because the child has a high chance of having cystic fibrosis, a disease that leads to life-threatening lung infections? What traits are appropriate to consider for selective abortion?

“To eliminate someone completely because of the idea that they may suffer in their life” is
not right, Benzmiller said after Kirschner’s talk, explaining that everyone is going to suffer in some way. “There’s so much in life we want to control but can’t.”

TWO EVILS

Lyjia Strachan is fairly confident she will have no problem giving patients medical abortions, with drugs such as Mifeprex, which is taken at home to end a pregnancy no more than nine weeks along. The fourth-year NU medical student probably will perform surgical abortions within the first trimester as well, but she is not so sure about second-trimester abortions.

After 12 weeks of gestation the procedure becomes more difficult. Technically, the embryo is now a fetus and its larger size means the operation is harder for the doctor and more dangerous for the patient. More training is required.

Morally, the arguments do not change. If someone believes life

begins at conception, it is killing at six weeks and killing at six years. If someone uses viability as the measuring stick, an abortion in the second trimester would not change anything.

Still, for some it can feel different.

“I didn’t necessarily feel particularly sad. I was just like, I don’t know,” Strachan paused, talking about when she saw a second-trimester abortion for the first time. “It’s the same as giving chemotherapy – you’re hurting someone, but you’re helping someone.”

She focused on the task at hand, like a good doctor. But she said later, “It was quite an odd, surreal experience, but you know, that was her decision, and I have to rely on that.”

Kye Ye wrote about his first experience seeing an abortion in a journal entry that later became an essay second-years read in “Profession of Medicine.” The fourth-year medical student supported abortion rights at the time, and still does. But what he saw surprised him.

It looked like a skinned frog, he wrote. At first it looked like “an amorphous blob of bloody mess,” he continued, but then he saw the doctor pick out the 11-week-old fetus – a small translucent body with two arms and legs. One half of the head and the jaw were still intact. There was a torn off section of ribs. He had no idea it would be so human-like.

It didn’t make abortion wrong. It made it tragic. When an undesired pregnancy occurs, it either ends in an unwanted child or in an abortion. Both options are profoundly tragic, he wrote, and perhaps in some cases one is worse than the other. Being raised by parents who scorn your existence leads to social and developmental problems that can be devastating, he thought. It’s the lesser of two evils.

COMPREHENSIVE DECISIONS

David Eisenberg, a third-year resident at Northwestern Memorial Hospital, regularly performs abortions. He had just gotten off work after doing four abortions one day in November – three of them were second-trimester abortions, performed because of congenital abnormalities. The fourth abortion was for a woman with heart disease whose life would be threatened by carrying a pregnancy to term.

Eisenberg does not think there is an ethical difference between first- and second-trimester abortions. He does not remember being upset about seeing an abortion after 12 weeks.

“By then I had seen a lot in medicine. I had seen gunshot wounds, I had seen surgeries, I had seen blood and gore, so I think I was desensitized at that point,” Eisenberg said.

Performing abortions is essential to providing patients comprehensive care in their reproductive lives, he said.

“It’s really remarkable to have the experience of walking out of a delivery, where it’s the happiest day for everyone in the room, and walking into your clinic and hearing a woman say, ‘I don’t know what I’m going to do, my life is over.’ And being able to say, ‘No, it’s not. You have a choice,'” he said. “‘You can have your life back.'”

THE TEST

Moses, who had questioned medical students about abortion, will not forget his first one. The 39-year-old patient started crying in front of him. She had a 12-year-old child, was divorced and in a bad relationship with a man she really liked. The condom broke. Moses cried a bit with her, talked to her for 45 minutes and had no idea what he would do. He was trained in abortion. Would he use it?

The doctor stepped out of the room. He realized that in order to give his patient comprehensive care he would need to do the abortion. So he did. He thought about it afterward, as he still does every time, maybe once or twice a month.

Moses told the students that day in McGaw 2-322 that it comes down to the “red-faced test.” If you can stand up in a room of your peers and say what you did without shame, then your decision was not wrong. He tells his patients that you have to go from thinking about what the perfect answer is to thinking about what the best answer is.

Moses is one of three who perform abortions in his group of seven doctors. That day in November, he told his students he will only provide an abortion after 12 weeks if there is some sort of fetal anomaly. Or if the patient was raped. O if she is a teenager.

His face did not flush.

Reach Erin Stock at estock@northwestern.edu.

Comments