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The Two-Minus-One Pregnancy

By Ruth Padawer

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As Jenny lay on the obstetrician's examination table, she was grateful that the ultrasound tech had turned off the overhead screen. She didn't want to see the two shadows floating inside her. Since making her decision, she had tried hard not to think about them, though she could often think of little else. She was 45 and pregnant after six years of fertility bills, ovulation injections, donor eggs and disappointment — and yet here she was, 14 weeks into her pregnancy, choosing to extinguish one of two healthy fetuses, almost as if having half an abortion. As the doctor inserted the needle into Jenny's abdomen, aiming at one of the fetuses, Jenny tried not to flinch, caught between intense relief and intense guilt.

"Things would have been different if we were 15 years younger or if we hadn't had children already or if we were more financially secure," she said later. "If I had conceived these twins naturally, I wouldn't have reduced this pregnancy, because you feel like if there's a natural order, then you don't want to disturb it. But we created this child in such an artificial manner — in a test tube, choosing an egg donor, having the embryo placed in me — and somehow, making a decision about how many to carry seemed to be just another choice. The pregnancy was all so consumerish to begin with, and this became yet another thing we could control."

For all its successes, reproductive medicine has produced a paradox: in creating life where none seemed possible, doctors often generate more fetuses than they intend. In the mid-1980s, they devised an escape hatch to deal with these megapregnancies, terminating all but two or three fetuses to lower the risks to women and the babies they took home. But what began as an intervention for extreme medical circumstances has quietly become an option for women carrying twins. With that, pregnancy reduction shifted from a medical decision to an ethical dilemma. As science allows us to intervene more than ever at the beginning and the end of life, it outruns our ability to reach a new moral equilibrium. We still have to work out just how far we're willing to go to construct the lives we want.

Jenny's decision to reduce twins to a single fetus was never really in doubt. The idea of managing two infants at this point in her life terrified her. She and her husband already had grade-school-age children, and she took pride in being a good mother. She felt that twins would soak up everything she had to give, leaving nothing for her older children. Even the twins would be robbed, because, at best, she could give each one only half of her attention and, she feared, only half of her love. Jenny desperately wanted another child, but not at the risk of becoming a second-rate parent. "This is bad, but it's not anywhere as bad as neglecting your child or not giving everything you can to the children you have," she told me, referring to the reduction. She and her husband worked out this moral calculation on their own, and they intend to never tell anyone about it. Jenny is certain that no one, not even her closest friends, would understand, and she doesn't want to be the object of their curiosity or feel the sting of their judgment.

This secrecy is common among women undergoing reduction to a singleton. Doctors who perform the procedure, aware of the stigma, tell patients to be cautious about revealing their decision. (All but one of the patients I spoke with insisted on anonymity.) Some patients are so afraid of being treated with disdain that they withhold this information from the obstetrician who will deliver their child.

What is it about terminating half a twin pregnancy that seems more controversial than reducing triplets to twins or aborting a single fetus? After all, the math's the same either way: one fewer fetus. Perhaps it's because twin reduction (unlike abortion) involves selecting one fetus over another, when either one is equally wanted. Perhaps it's our culture's idealized notion of twins as lifelong soul mates, two halves of one whole. Or perhaps it's because the desire for more choices conflicts with our discomfort about meddling with ever more aspects of reproduction.

No agency tracks how many reductions occur in the United States, but those who offer the procedure report that demand for reduction to a singleton, while still fairly rare, is rising. Mount Sinai Medical Center in New York, one of the largest providers of the procedure, reported that by 1997, 15 percent of reductions were to a singleton. Last year, by comparison, 61 of the center's 101 reductions were to a singleton, and 38 of those pregnancies started as twins.

That shift has made some doctors in the field uneasy, and many who perform pregnancy reductions refuse to go below twins. After being rebuffed by physicians close to home, Jenny went online and found Dr. Joanne Stone, the highly regarded head of Mount Sinai's maternal-fetal-medicine unit. Jenny traveled thousands of miles to get there. She still resents the first doctor back home who told her she shouldn't reduce twins and another who dismissively told her to just buck up and buy diapers in bulk.

Even some people who support abortion rights admit to feeling queasy about reduction to a singleton. "I completely respect and support a woman's choice," one commentator wrote on UrbanBaby.com, referring to a woman who said she reduced her pregnancy to protect her marriage and finances. One fetus was male, the other female, and the woman eliminated the male because she already had a son. "Something about that whole situation just seemed unethical to me," the commentator continued. "I just couldn't sleep at night knowing that I terminated my daughter's perfectly healthy twin brother."

Dr. Mark Evans, an obstetrician and geneticist, was among the first to reduce a pregnancy. He quickly became one of the procedure's most visible and busiest practitioners, as well as one of the most prolific authors on the topic. Early on, Evans decided the industry needed guidelines, and in 1988, he and an ethicist with the National Institutes of Health issued them. One of their central tenets was that most reductions below twins violated ethical principles.

Two years later, as demand for twin reductions climbed, Evans published another journal article, arguing that reduction to singletons "crosses the line between doing a procedure for a medical indication versus one for a social indication." He urged his colleagues to resist becoming "technicians to our patients' desires."

The justification for eliminating some fetuses in a multiple pregnancy was always to increase a woman's chance of bringing home a healthy baby, because medical risks rise with every fetus she carries. The procedure, which is usually performed around Week 12 of a pregnancy, involves a fatal injection of potassium chloride into the fetal chest. The dead fetus shrivels over time and remains in the womb until delivery. Some physicians found reduction unnerving, particularly because the procedure is viewed under ultrasound, making it quite visually explicit, which is not the case with abortion. Still, even some doctors who opposed abortion agreed that it was better to save some fetuses than risk them all.

Through the early 1990s, the medical consensus was that reducing pregnancies of quadruplets or quintuplets clearly improved the health of the woman and her offspring. Doctors disagreed about whether to reduce those to triplets or twins and about whether to reduce triplet gestations at all. But as ultrasound equipment

improved and doctors gained technical expertise, the procedure triggered fewer miscarriages, and many doctors concluded that reducing a triplet gestation to twins was safer than a triplet birth. Going below twins, though, was usually out of the question.

In 2004, however, Evans publicly reversed his stance, announcing in a major obstetrics journal that he now endorsed twin reductions. For one thing, as more women in their 40s and 50s became pregnant (often thanks to donor eggs), they pushed for two-to-one reductions for social reasons. Evans understood why these women didn't want to be in their 60s worrying about two tempestuous teenagers or two college-tuition bills. He noted that many of the women were in second marriages, and while they wanted to create a child with their new spouse, they did not want two, especially if they had children from a previous marriage. Others had deferred child rearing for careers or education, or were single women tired of waiting for the right partner. Whatever the particulars, these patients concluded that they lacked the resources to deal with the chaos, stereophonic screaming and exhaustion of raising twins.

Evans's new position wasn't just a reaction to changing demographics. The calculus of risks had also changed. For one thing, he argued, in experienced hands like his, the procedure rarely prompted a miscarriage. For another, recent studies had revealed that the risks of twin pregnancies were greater than previously thought. They carried an increased chance of prematurity, low birth weight and cerebral palsy in the babies and gestational diabetes and pre-eclampsia in the mother. Marking what he called a "juncture in the cultural evolution of human understanding of twins," Evans concluded that "parents who choose to reduce twins to a singleton may have a higher likelihood of taking home a baby than pregnancies remaining with twins." He became convinced that everyone carrying twins, through reproductive technology or not, should at least know that reduction was an option. "Ethics," he said, "evolve with technology."

Many doctors, including some who do reduction to a singleton, dispute Evans's conclusions, pointing out that while twin pregnancies carry more risks than singleton pregnancies, most twins (especially fraternal) do just fine. Dr. Richard Berkowitz, a perinatologist at Columbia University Medical Center who was an early practitioner of pregnancy reduction, says: "The overwhelming majority of women carrying twins are going to be able to deliver two healthy babies." Though Berkowitz insists that there is no clear medical benefit to reducing below twins, he will do it at a patient's request. "In a society where women can terminate a single pregnancy for any reason — financial, social, emotional — if we have a way to reduce a twin pregnancy with very little risk, isn't it legitimate to offer that service to women with twins who want to reduce to a singleton?"

Katherine Wolkoff for The New York Times

Berkowitz gave me a short history of reduction. Perinatology's goal is to improve pregnancy outcomes, he said. Reduction began as part of that effort: losing some fetuses for the sake of others. But its role evolved into something quite different, as patients requested elective reduction to a singleton. "The only reason *we're* the ones doing that is because we're the ones who have the skills to do it, but that's not why we got those skills," he said. "It didn't start with people who conceived twins and said, 'I only want one'; it ended up with that."

Other doctors refuse to reduce below twins unless the pregnancy presents unusual medical concerns. Among them is Dr. Ronald Wapner, director of reproductive genetics at Columbia and another reduction pioneer. Sometime in the late 1990s, when Wapner practiced in Philadelphia, he received his first two-to-one request. "She said, 'Either reduce me to a singleton, or I'll end the pregnancy.' " He consulted his staff, all women, and they concluded that if a woman can choose to end a pregnancy, she can reduce from two to one. Besides, in this case, the team would be saving a fetus that would otherwise be aborted.

As word spread, a stream of patients called Wapner's office, scheduling reductions to a singleton. A few months later, after the last patient of the day left, the sonographer who had worked with Wapner for nearly 20 years stopped at his office. She told me what happened next, on condition of anonymity because she doesn't want her relatives to know everything her work entails: "I told him I just wasn't comfortable doing a termination of a healthy baby for social reasons, and that if we were going to do a lot of these elective reductions, I thought he should bring in someone else who was more comfortable. From the beginning, I had wrestled with the whole idea of doing reductions, because I was raised in the church. And after a lot of soul searching, I had decided there were truly good medical reasons to reducing higher-order multiples to twins. But I had a hard time reconciling doing reductions two to one. So I said to Dr. Wapner, 'Is this really the business we want to be in?' "

Wapner immediately called a meeting with his staff. Every one of them — the sonographer, the genetic counselors, the schedulers — supported abortion rights, but all confessed their growing unease with reductions to a singleton. "There's no medical justification in a normal twin pregnancy to reduce to one,"

Wapner said. “So we decided to allocate our resources to those who would get the most benefit. We were in the business to improve pregnancy outcomes, and those reductions didn’t fit the criteria.” He hasn’t done an elective two-to-one reduction since.

Evans estimates that the majority of doctors who perform reductions will not go below twins. Shelby Van Voris was pregnant with triplets when she discovered this for herself. After she and her husband tried for three years to get pregnant, they went to a fertility doctor near their home in Savannah, Ga. He put Shelby, then 30, on fertility drugs, and when that didn’t work, he ramped things up with injections. By then, her husband, a 33-year-old Army officer, had been deployed to Iraq. He left behind three vials of sperm, and she was artificially inseminated. “You do weird things when mortars are flying at your husband’s head,” she said. She soon found out she was carrying triplets. Frantic, she yelled at the doctor: “This is not an option for us! I want only one!”

Her fertility specialist referred her to a doctor in Atlanta who did reductions. But when Shelby called, the office manager told her that she would have to pay extra for temporary staff to assist with the procedure, because the regular staff refused to reduce pregnancies below twins. She contacted three more doctors, and in each case was told: not below two. “It was horrible,” she says. “I felt like the pregnancy was a monster, and I just wanted it out, but because we tried for so long, abortion wasn’t an option. My No. 1 priority was to be the best mom I could be, but how was I supposed to juggle two newborns or two screaming infants while my husband was away being shot at? We don’t have family just sitting around waiting to get called to help me with a baby.”

Eventually, she heard about Evans and flew to New York for the procedure. “I said, ‘You choose whoever is going to be safe and healthy,’ ” she says. “I didn’t give him any other criteria. I didn’t choose gender. None of that was up for grabs, because I had to make it as ethically O.K. for me as I could. But I wanted only one.”

She paid $6,500 for the reduction and left Evans’s office incredibly relieved. “I went out on that street with my mother and jumped up and down saying: ‘I’m pregnant! I’m pregnant!’ And then I went and bought baby clothes for the first time.”

Today, her daughter is 2½ years old. Shelby intends to tell her about the reduction someday, to teach her that women have choices, even if they’re sometimes difficult. “I am the mother of a very demanding toddler,” she says. “I can’t imagine this times two, and not ever knowing if I’d have another person here to help me. This is what I can handle. I’m good with this. But that’s all.”

Who doesn’t want to create a more certain and comfortable future for themselves and their children? The more that science makes that possible, the more it has inflated our expectations of what family life should be. We’ve come to believe that the improvements are not only our due but also our responsibility. Just look at the revolution in attitudes toward selecting egg or sperm donors. In the 1970s, when sperm donation took off, most clients were married women with infertile husbands; many couples didn’t want to know about the source of the donation. Today patients in the United States can choose donors based not only on their height, hair color and ethnicity but also on their academic and athletic accomplishments, temperament, hairiness and even the length of a donor’s eyelashes.

Sheena Iyengar, a social psychologist at Columbia Business School and the author of “The Art of Choosing,” suggests that limitless choice is a particularly American ideal. In a talk at a TED conference last year in Oxford, England, Iyengar said that “the story upon which the American dream depends is the story of

limitless choice. This narrative promises so much: freedom, happiness, success. It lays the world at your feet and says you can have anything, everything." Nevertheless, she subsequently told me, "we are in the midst of a choice revolution right now, where we're trying to figure out where the ethical boundaries should be."

Reduction is hardly the only area in which reproductive innovation has outpaced cultural consensus. Americans disagree bitterly about abortion. They also debate the ethics of egg donation, sex selection, gestational surrogacy and menopausal women being impregnated with younger women's fertilized eggs. And yet all these options are now available, at least to those who are well heeled or well insured.

The ability of women to control their fertility has created all kinds of welcome choices. "But the dark lining of that otherwise very silver cloud is that you make the choice of when to get pregnant, and so you feel really responsible for its consequences, like do you have enough money to do it well, and are you going to be able to provide your child with everything you think you ought to provide?" says Josephine Johnston, a bioethicist at the Hastings Center in Garrison, N.Y., who focuses on assisted reproduction. "In an environment where you can have so many choices, you own the outcome in a way that you wouldn't have, had the choices not existed. If reduction didn't exist, women wouldn't worry that by not reducing, they're at fault for making life more difficult for their existing kids. In an odd way, having more choices actually places a much greater burden on women, because we become the creators of our circumstance, whereas, before, we were the recipients of them. I'm not saying we should have less choices; I'm saying choices are not always as liberating and empowering as we hope they will be."

Consider the choice of which fetus to eliminate: if both appear healthy (which is typical with twins), doctors aim for whichever one is easier to reach. If both are equally accessible, the decision of who lives and who dies is random. To the relief of patients, it's the doctor who chooses — with one exception. If the fetuses are different sexes, some doctors ask the parents which one they want to keep.

Until the last decade, most doctors refused even to broach that question, but that ethical demarcation has eroded, as ever more patients lobby for that option and doctors discover that plenty opt for girls. Some patients, like Shelby Van Voris, want no part in the decision. Others say that as much as they hate the idea of choosing based on sex, if there's a choice to be made, they want to be the ones to make it.

Society judges reproductive choices based on the motives behind them. Though roughly half of Americans identify as "pro-choice" and half as "pro-life," polls also show the distinction blurs depending on why the woman is aborting. If a woman is the victim of incest or rape, or if her health is threatened, far more people — including abortion opponents — understand her choice to end the pregnancy. Support falls off if a woman aborts for financial reasons and is lowest of all if she aborts because of the fetus's sex.

Think about the common reaction to a woman who aborts because contraception failed versus a woman (and her partner) who took no precaution at all. "It changes our judgment of the moral character of the individual making the abortion decision," says Bonnie Steinbock, a philosophy professor at SUNY Albany who is on the ethics committee of the American Society for Reproductive Medicine. "In the first case, it wasn't her 'fault'; in the second, it was. It doesn't mean the careless person shouldn't have the right to an abortion, but it does mean we're going to have a very different reaction to that choice." Likewise, people may judge two-to-one reductions more harshly because the fertility treatment that yielded the pregnancy significantly increased the chance of multiples. "People may think, You brought this about yourself, so you should be willing to take some of the risk," Steinbock says.

Katherine Wolkoff for The New York Times

Women who reduce to singletons sometimes think the same thing. “Most of the two-to-one patients have gone to incredible lengths to get pregnant,” Donna Steinberg, a clinical psychologist in Manhattan who specializes in counseling infertility patients, says. “They’ve paid a lot of money and put their bodies through tremendous stress, and they’ve gotten what they wanted — and now they’re going to reduce? Outsiders think, How is that possible? And that’s also where the patients’ guilt comes from.”

It’s not only the parents who may feel guilty. Even if parents work hard to conceal it, the child may discover the full story of his or her origins, and we don’t know what feelings of guilt or vulnerability or loss this discovery might summon.

The doctors who do reductions sometimes sense their patients' unease, and they work to assuage it. "I do spend quite a bit of time going through the medical risks of twins with them, because it takes away a little bit of the guilt they feel," says Stone, the Mount Sinai doctor. Sometimes, she says, couples disagree about whether to reduce a twin pregnancy, and she encourages them to see a therapist so they can be at peace with whatever they decide.

One of Stone's patients, a New York woman, was certain that she wanted to reduce from twins to a singleton. Her husband yielded because she would be the one carrying the pregnancy and would stay at home to raise them. They came up with a compromise. "I asked not to see any of the ultrasounds," he said. "I didn't want to have that image, the image of two. I didn't want to torture myself. And I didn't go in for the procedure either, because less is more for me." His wife was relieved that her husband remained in the waiting room; she, too, didn't want to deal with his feelings.

In some ways, the reasons for reducing to a singleton are not so different from the decision to abort a pregnancy because prenatal tests reveal anomalies. In both cases, the pregnancies are wanted, but not when they entail unwanted complications — complications for the parents as much as the child. Many studies show the vast majority of patients abort fetuses after prenatal tests reveal genetic conditions like Down syndrome that are not life-threatening. What drives that decision is not just concern over the quality of life for the future child but also the emotional, financial or social difficulty for parents of having a child with extra needs. As with reducing two healthy fetuses to one, the underlying premise is the same: this is not what I want for my life.

That was the thinking of Dr. Naomi Bloomfield, an obstetrician near Albany who found out she was pregnant with twins when her first child was not quite a year old. "I couldn't have imagined reducing twins for nonmedical reasons," she said, "but I had an amnio and would have had an abortion if I found out that one of the babies had an anomaly, even if it wasn't life-threatening. I didn't want to raise a handicapped child. Some people would call that selfish, but I wouldn't. Parents who abort for an anomaly just don't want that life for themselves, and it's their prerogative to fashion their lives how they want. Is terminating two to one really any different morally?"

I was eight weeks pregnant when my husband and I, with our 2-year-old daughter in tow, visited friends who had recently had twins. Our friends, two of the most laid-back parents we knew, looked exhausted, beaten, overrun. Between their infants and their 3-year-old, it seemed someone was always hungry, howling or filling a diaper. The second my husband and I stepped into our car to drive home, we said in unintentional unison, "Thank God we're not having twins."

One week later, I began to cramp and bleed, so my midwife did an ultrasound to see if I had miscarried. The fetus was fine. It wasn't, however, alone. "Twins," the midwife announced cheerfully. My terror was instantaneous, and for the next few days, I could not seem to grab enough oxygen to breathe. Aborting half the pregnancy didn't occur to us — who knew it would even be doable? — but for a few panicky hours, we wondered if it was possible to give one up for adoption.

I was right to be afraid. Studies report enormous disruption in families with multiples, and higher levels of social isolation, exhaustion and depression in mothers of twins. The incessant demands of caring for two same-aged babies eclipse the needs of other children and the marriage. It certainly did for us. There's no doubt that life with twins and a third child so close in age has often felt all-consuming and out of control. And yet the thought of not having any one of them is unbearable now, because they are no longer shadowy fetuses but full-fledged human beings whom I love in a huge and aching way.

Plenty of infertility patients who conceive twins are ecstatic from the start about getting a two-for-one deal; some studies indicate that the majority of I.V.F. patients prefer twins. Though most doctors don't believe reduction below twins is medically justified, they do argue that it is best to avoid a multiple pregnancy from the outset. Fertility drugs and in vitro fertilization both markedly increase the chance of multiples. About 5 to 20 percent of pregnancies from fertility drugs turn out to be twins or higher, according to the American Society for Reproductive Medicine, and half of babies conceived through I.V.F. are part of a multiple pregnancy. Perinatologists and obstetricians have lobbied fertility specialists to use ovulation-inducing drugs more judiciously and to transfer fewer embryos into their patients. Over the past few years, the campaign has resulted in fewer pregnancies of triplets and up, but the number of twin pregnancies continues to climb. Clearly there is room for improvement. The problem is that for all the choices and opportunities that fertility treatments offer, there is still a lot that doctors cannot control.

A. and her partner had been together 15 years when they decided to get serious about having children. Because both women were 45, they tried to double their already slim chances by both being inseminated. They each tried it three times; nothing took. At their doctor's suggestion, they chose an egg donor in her mid-20s. Both women went through I.V.F., each with two embryos transferred. Both women got pregnant, but A. quickly miscarried. Her partner (who did not want to be identified, even by an initial) gave birth to a healthy boy, whom they adore. A. did another round of I.V.F. with frozen embryos, hoping to provide their son with a sibling. It didn't work. So when their boy was nearly a year old, both women underwent I.V.F. again. Given A.'s fertility history, the doctor predicted she had just a 5 percent chance of getting pregnant.

On their son's first birthday, both women found out they were pregnant, both with twins. Four in all. "In our wildest expectations, we never imagined being in this situation," A. said. "We both went through I.V.F. before, and we came out with one baby. We did it exactly the same way as last time, so we never expected this."

A. and her partner were sick, physically and emotionally. Because A. had already miscarried once, her doctor worried she might not carry two to term; if she reduced, the doctor said, she had a better chance of taking a baby home. The women were tempted to reduce both pregnancies, so each woman would carry one, in part to ensure that even if one miscarried, they would have at least one baby. "But we discovered that the reality of having two pregnant moms when you have a 14-month-old is insane. We've both been very ill from the pregnancies, and it's been hard to give him what he needs. At 14 months, they're inquisitive and energetic, and it was becoming harder and harder to chase him and get him up and down the slide. There were days I'd be in the bathroom throwing up, she'd be on all fours with him, and then we'd switch. We all think we can conquer the world, but then reality hits you, and you realize you have limitations."

For the sake of the boy they already had, they decided to reduce A.'s pregnancy to one, and right after that A.'s partner lost her whole pregnancy. "I don't wish this on anyone," A. says. "I'm very grateful that we had this option at our disposal, that it can be done safely and in a legal way, but it was very difficult for both of us. I still wonder, Did we choose the right one? — even though I wasn't the one who chose. That idea, that one's gone and one's here, it's almost like playing God. I mean, who are we to choose? Even as it was happening, I wondered what the future would have been if the doctor had put the needle into the other one."

The women have told no one in their families, no colleagues and only one friend.

I asked A. what would happen if she wound up losing the pregnancy after all.

"We've talked a lot about it," she said, after a bit. "I've come to realize there's only so much we can control. There's a point where you just have to let nature take its course."

Their baby is due in December.

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