

## The Perinatal Hospice

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The recent debate over "partial birth" abortions, whereby the physician manipulates the infant in the womb to a breech presentation, extracts it to the shoulders, traps the skull and proceeds to murder the baby, has received much press. Estimates at the Congressional hearings regarding a bill to ban these abortions were that approximately 30,000 of these gruesome procedures occur each year, with 80% of them being purely "elective." The other 20% are ostensibly performed for the presence of fetal anomalies or to save the life of the mother.<sup>(1)</sup> In reality, these abortions ensure that the infant will not be born alive and hence given full protection under the law. Our society still collectively squirms at the calculated death of an infant outside the womb.

Since most of these partial birth abortions, or "dilatation and extractions," as proponents of the procedure prefer, are elective and not related to maternal health, attempting to defend their availability as necessary to save maternal lives is inexcusable. In the very rare circumstance where maternal life might be in danger, delivery of the infant with subsequent neonatal intensive care would result in survival of many infants at the gestational ages at which partial birth abortions are frequently performed. This leaves cases of serious or lethal fetal anomalies as potential "indications" for partial birth abortions. This situation provides an opportunity for those of us in medicine who are Christians to offer an alternative.

We propose the concept of *perinatal hospice* as that alternative.

Romans 6:23 states that "the wages of sin is death, but the gift of God is eternal life in Christ Jesus our Lord." Since we all descend from our earthly father Adam, we carry into our birth the imputed sin of our fleshly forefather and we shall all physically die. The timing of our physical death is the only variable. In Psalm 139:15-16 the psalmist speaks for us in a prayer inspired by the Holy Spirit, saying:

*My frame was not hidden from you  
when I was made in the secret place.  
When I was woven together in the  
depths of the earth,  
Your eyes saw my unformed body. All  
the days ordained for me were written  
in your book Before one of them came  
to be.*

Each of us possesses a time of physical life ordained by the Lord Himself. We do not know what that time will be. Ecclesiastes 8:8 reminds us that "no one has power over the wind to contain it; so no one has power over the day of his death." Genetic conditions and fetal anomalies severe enough to cause death occur in approximately 0.5-1% of all live births.<sup>(2,3)</sup> This translates into 3035,000 births a year in the United States, which approximates the partial birth abortion number." However, at least 80% of these abortions are not done for a fetal "indication." Many severely affected infants will die *in utero*, and most with severe chromosomal abnormalities (i.e., trisomy 13 or 18) who are born alive will die shortly after birth. Not all infants with lethal genetic conditions will die at birth, however. Many may not immediately manifest their disease

process and may live for years before succumbing to their condition as is commonly seen with Tay-Sachs disease, cystic fibrosis or Duchenne muscular dystrophy.

The real problem with partial birth abortion is that it represents an attempt by man to usurp God's authority by determining who is fit to live and what "quality of life" is appropriate for a mother or child. Perinatal hospice provides an answer to the abortionist. God remains sovereign over His universe, and if we believe His Scripture as truth, then we must never cooperate with the forces of evil at work in the abortion culture. Ephesians 5:11 demands that we "have nothing to do with the fruitless deeds of darkness, but rather expose them." We hold that the unborn child is imbued with a soul, established by God, no matter what the physical characteristics or chromosomal complement. Scripture gives us no reason to believe otherwise. God asks, "Who gave man his mouth? Who makes him deaf or mute? Who gives him sight or makes him blind Is it not I, the Lord" (Exodus 4:11). Does He not also create the anencephalic or the child with trisomy 18? Indeed, a blind man was born "so that the work of God might be displayed in his life" (John 9:3). The presence of the image of God in the unborn child clearly derives from Psalm 139, Jeremiah 1:5, and Genesis 1:26-27. Preborn children can react to the outside world in specific ways. Luke 1:39-44 reveals that John the Baptist leapt in his mother's womb when he heard Mary the mother of Jesus greet his mother, Elisabeth. Even the unborn leap for joy at the presence of the Lord! Since we serve a transcendent God as created beings with souls, we may never destroy human life created in the image of that transcendent God, except as commanded by Him. Genesis 9:5-6 makes clear that it is this image of God which gives dignity and worth to human beings, including the preborn, as the image is also in them. In this passage the law of God states: "And from each man, too, I will demand an accounting for the life of his fellow man. `Whoever sheds the blood of man, by man shall his blood be shed; for in the image of God has God made man." It is simply not our prerogative, according to God's Word, to slay the unborn. Man-made judgments about the quality of a life created in the image of God are not relevant. Only the image of God in each created human being is relevant to any judgment

regarding partial birth abortion.

As Christian physicians we clearly receive the call to be God's ambassadors within our profession. The work we do must be consistent with the guidelines set forth in His Scripture, since we represent Him. This means renewed thinking about how to approach the unborn child and the family of a child who will die in utero or live a short time ex utero.

Most terminally ill patients fear pain and abandonment.<sup>(4-6)</sup> In a similar way, the family of a terminally ill unborn child fears being shunned or abandoned. Prenatal counseling, even that which self-consciously attempts to be "non-directive," may place a tremendous burden on the family to "terminate" the pregnancy and move on. The counsel given may frequently insinuate that the infant will suffer less if it is destroyed. A curious logic indeed. We can be sure that most of the individuals infusing this attitude into their counseling would not prefer to be dead simply because someone else determined that their lives were "too painful to live" or because they were "going to die eventually anyhow." But we, to be consistent within our worldview, must provide an alternative. Hence, perinatal hospice. After all, there are, and always will be, patients who choose not to kill their unborn children who have severe chromosomal or anatomic anomalies.<sup>(7-9)</sup>

Military medicine provides a unique environment for the practice of obstetrics and gynecology, since federal law restricts the provision of abortion services except where the life of the mother is truly at risk. The surgical or chemotherapeutic treatment of an ectopic pregnancy is an obvious example of such a case. Another much rarer situation might be a patient afflicted with severe pulmonary hypertension who is dying secondary to a pregnancy. Even in these special circumstances, the provision of an abortion generally requires the agreement of at least three obstetricians, including a maternal-fetal medicine (MFM) sub specialist if possible, that the pregnancy is truly creating a significant threat to the maternal life. In addition, the input of other appropriate specialties is solicited.

Interestingly, since abortion is not an option provided in the military hospital, many parents do not choose to go outside the system to procure an abortion. This may be partially a financial decision, as a second- or third-trimester abortion can cost \$2,000-5,000, and payment is often required prior to the procedure. Perhaps more importantly, we explicitly give parents permission to consider an alternative: perinatal hospice.

In our hands the perinatal hospice includes the combined efforts of maternal-fetal medicine subspecialists, obstetricians, neonatologists, anesthesia services, labor and delivery nurses, neonatal intensive care nurses, chaplains/pastors, and social work services. Patients are given the fetal diagnosis and the expected prognosis during extensive time with the MFM staff. We participate in the ultrasound evaluation, amniocentesis if desired, birth planning, and ongoing medical management in the antepartum, intrapartum, and postpartum periods.

This supportive environment has been offered on our perinatal services since 1989, and quite frequently patients decide not to obtain an abortion for lethal fetal conditions. Parents instinctively know, in spite of the prevalent *Roe v. Wade* rhetoric, that they would be choosing to kill their baby. Most, when given the opportunity and support, will choose the better alternative of allowing God to be sovereign over their child's life. This decision is facilitated by our patients having unlimited access to care. However, even in other academic and private practice settings, financial concerns need not be prohibitive. Christian physicians must be willing to waive fees, help set up payment schedules, and assist in the establishment of a perinatal hospice.

The burden of effort in perinatal hospice resides in the antepartum counseling and preparation. Patients need to see the baby on ultrasound and be allowed to grieve. Most birth defects are not as gruesome in appearance as patients imagine. Extensive support is also provided in labor through encouragement by the nursing staff and pain relief administered by the anesthesia service. Labor management is conducted as in other labors with the exception of fetal heart rate monitoring in lethal fetal conditions such as anencephaly or trisomy 13 or 18

where an abnormal pattern is expected. Infants with conditions not expected to be lethal, such as Down's syndrome or Turner's syndrome, are managed with fetal heart rate monitoring in the same fashion as other labors.

Method of delivery is based on obstetrical indications, and the infant is handed immediately to the parents to share the baby's life. Many of these infants are stillborn, but some may live from several minutes to days. The parents are allowed to stay in the delivery suite with the child as long as they wish. We encourage dressing the baby, taking pictures of the baby, and holding of the baby by all family members, including other children if appropriate. Non-anomalous features of the baby are emphasized to the parents, such as cute hands and feet or soft skin.

Neonatologists help provide comfort for the baby as needed. The infant is kept warm and cuddled. Some may even feed. Those infants who survive for longer periods may be kept comfortable in the nursery during the postpartum period if the parents are feeling overwhelmed. Comfort measures are emphasized to the family. Parental response is overwhelmingly positive in these cases, contrary to the frequent assumptions of those who are pro-abortion. Those who allow the Lord to determine their path are much more content. They are allowed the bittersweetness of their child's birth and too-soon departure. Grief lessens as time passes, and parents rest secure in the knowledge that they did not dismember or destroy their child. Christian parents can stand with job and say, "Though he slay me, yet will I hope in him" (Job 13:15).

Let us join as Christian physicians to speak out against the despicable act of partial birth abortion. Refer parents to other pro-life physicians, and seek to counsel parents in the better way: Bearing and comforting their terminally ill fetuses.

*As you do not know the path of the  
wind  
or how the body is formed in a mother's  
womb,  
so you cannot understand the work of  
God,*

*the Maker of all things*

Amen!

(Ecclesiastes 11:5).

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All Bible quotations are from the New International Version of the Bible, 1973.