

# FRIENDS OF THE MICHAEL FUND NEWSLETTER

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## “What Little David Taught Me” An Interview with a Pro-life Geneticist

The following two-part interview with Dr. Paddy Jim Baggot by Michael Fund National Director Randy Engel is based on a series of essays by Dr. Baggot titled “God’s Children: Catholic Obstetrics and Genetics. The full text of these essays on moral alternatives in genetics can be viewed on our web site at [www.michaelfund.org](http://www.michaelfund.org). In 1997, Dr. Baggot became the first American geneticist to receive a Michael Fund grant in the United States for curative research in the field of Down syndrome.

**Mrs. Engel:** *Dr. Baggot, what unique contribution does the pro-life obstetric-geneticist bring to the field of genetics?*

**Dr. Baggot:** I think it is the belief in the inviolable personhood and dignity of the human embryo from conception. This is a given to the pro-life obstetric geneticist. Therefore abortion for any reason is rejected. He remains an advocate for both mother and child. This is in sharp contrast to the pro-abortion geneticist for whom the rights and personhood of the fetus or embryo can be neglected and for whom abortion is viewed as a means of “preventing” birth defects.

**Mrs. Engel:** *In your essay on “Non-Directive Counseling” you note the tendency of the secular utilitarian-minded geneticist to pit the interests of the mother against the child in her womb especially if prenatal diagnosis has revealed the presence of a serious disorder in the fetus.*

**Dr. Baggot:** Yes, this is true. But I think it is important to understand that the well-enshrined practice of so-called “non-directive” genetic counseling is seriously flawed.

First, to offer a mother the “option” of aborting her handicapped child is to imply approval thereof. It also reveals a bias against the affected child whom the counselor-geneticist believes, consciously or unconsciously, should not be born at all. This is hardly neutral advice!

Furthermore, by giving the pregnant patient, options only, without indicating which option is **best** for both mother and child, the genetic counselor is engaging in a fundamentally dishonest act. Certainly we would reject such an approach in other equally serious medical situations.

**Mrs. Engel:** *Can you give us an example of this?*

**Dr. Baggot:** Yes. Let me use the hypothetical example of a patient who has appendicitis. Following the principles of “non-directive” counseling his doctor gives him with two “options” which are presented as having equal merit - surgery and acupuncture. The doctor does not advise one over the other. He lets the patient freely chose his own course of treatment. The patient chooses acupuncture because it is cheaper and easier. He dies shortly thereafter of a ruptured appendix.

Was the doctor being honest in his “non-directive” counseling of his patient with appendicitis? No. The doctor certainly never would have counseled his own daughter or son in this way. For if a doctor really cares deeply about his patient he has to care about the treatment his patient chooses and attempt to steer him or her to the **best** treatment available. In this case the physician failed to do his duty and the patient died.

In the case of eugenic abortion there are two persons directly involved, mother and child, bonded by love. Therefore what the doctor does for the mother he does for the child and what he does for the child he does for

the mother. Obviously, you can't help a mother by harming her child.

**Mrs. Engel:** *It appears that the agenda of the genetic-obstetrician is often different from the mother he is counseling?*

**Dr. Baggot:** Yes. Often he may offer abortion as a way to avoid lawsuits. He may feel that eliminating babies with birth defects will help reduce the costs to society in terms of taxes, insurance costs and medical expenses. This outlook is utilitarian.

The mother on the other hand is usually concerned about her responsibilities to her child and her family, and she may fear the unknown stresses of raising a handicapped child, especially if her doctor has painted a bleak picture of her baby's prognosis. She may be worried about her ability to give her child all the care he needs and whether society will accept and appreciate her baby.

If the birth defect is lethal, she may look ahead to a painful pregnancy, followed by the tragic death of her baby, a journey of sorrow and misery. In these cases, the mother is usually pro-life about her particular baby, who moves within her abdomen, even if she is not pro-life in general. These concerns reflect a different agenda than that of the doctor whose main objective is the prevention of the birth of a child with birth defects.

**Mrs. Engel:** *What about the doctor's obligation to his fetal patient?*

**Dr. Baggot:** The traditional obligation of the doctor to advocate for his fetal patient is ignored in the mythical "non-directive" counseling process. Indeed there is an active bias against his being allowed to be born. Yet, if that child could speak, I believe he would say to the doctor, "you cannot predict my future happiness."

As a pro-life physician, I believe that every baby, no matter what his condition, has a right to maternal love. No matter how short his or her life, he deserves and has earned at least one maternal embrace after spending nine months cooped up in the womb.

I might also add that no one can predict with absolute certainty the future of any given baby. We all know babies and children who did much better than expected. The mother who chooses abortion can never really know in a definitive way that the baby would have not done better than he or she was predicted to do. The only definitive way to know the baby's true potential is to help him achieve it. This leaves the mother who aborts her affected child with the potential for poisonous self-doubts and self-recriminations. It should not be surprising then that abortion for fetal indication is so psychologically harmful to the mother, to say nothing of the significant physical complications associated with late-term abortions.

**Mrs. Engel:** *I think that this was dramatically demonstrated by the testimony of parents – both pro and*

*con – at the 1966 Congressional hearings on the ban of Partial Birth Abortion, a late-term abortion technique usually recommended for eugenic considerations, that is where the unborn child may have very serious anomalies.*

**Dr. Baggot:** Yes. In reading the public testimony of parents faced with making a decision to carry their affected baby to term or aborting their baby I was struck by the difference between both groups on a number of levels.

In the first group, the fetus was diagnosed with having a body stalk anomaly, such that the abdominal organs were outside the child's body. Despite warnings about the complications of a "horrendous" delivery and a grief too much to bear, the parents opted for delivery. "We took many beautiful pictures of him. We never had any regrets about carrying Gerard to term, giving birth to him and loving him till he died naturally." For Gerard's mother, "it is the event I am most proud of in my life."

For another mother, the diagnosis was Trisomy 18 accompanied by a large abdominal defect. Her baby lived only 45 minutes after birth but "Our lives are richer for having carried Calvin. We can live our lives without doubts or second thoughts that we did the right thing," she said. This courageous mother gave birth to five other children subsequently. This is a telling counterpoint to the mother who testified that following her partial birth abortion she suffered five miscarriages, presumably as a result of cervical incompetence due to procedure related trauma.

But perhaps the most startling testimony came from parents whose unborn child was diagnosed with a large abdominal defect and other anomalies. The prognosis appeared grim – stillbirth, a newborn death, or a possible survival after extensive surgeries. The mother chose full term delivery after which the child underwent extensive surgery and was on a respirator for six weeks. "Watching his pain and suffering was unbearable, but the courage and strength of our child was miraculous. We are now blessed by his presence with us every minute of our lives."

**Mrs. Engel:** *The child lived then?*

**Dr. Baggot:** Yes. The child survived and did well subsequently.

**Mrs. Engel:** *What about the women who underwent a partial birth abortion for eugenic indication at the recommendation of their physician or medical specialist?*

**Dr. Baggot:** I think their testimony speaks for itself.

In the first case, the baby was diagnosed at 19 weeks gestation with severe hydrocephalus and the mother was told not only that there was "no hope" for her son but that the complications of her pregnancy put her life in danger as well.

However, it is a medical fact that babies with hydrocephalus do not usually suffer intrauterine fetal

demise. In most cases these babies survive and with prompt treatment at birth have normal intelligence. As for the forecasted maternal complications, hemorrhages following uterine fetal death are uncommon, and they typically would occur more than a month after fetal death. Also, the threat of cervical and uterine lacerations from vaginal delivery could be prevented by cesarean section, a potentially safer procedure than partial birth abortion.

**Mrs. Engel:** *This also appears to be true in the second case in which the mother was informed seven months into her pregnancy that her child had severe polyhydramnios and that the presentation was breech. She was told that a partial birth abortion was her only viable choice.*

**Dr. Baggot:** With polyhydramnios, the fetal compartment is distended with fluid making the uterus much larger than the baby thus facilitating version. But even if version and vaginal delivery were not possible, cesarean section would have been safer for the mother and the parents would have gotten their one wish: to hold their live baby in their arms before she died.

**Mrs. Engel:** *Does the risk of maternal death increased when the mother is carrying a child with a severe birth disorder?*

**Dr. Baggot:** No. Generally speaking, anomalous babies rarely pose any risk to their mothers. Therefore, given the potential mortality of partial birth abortion, spontaneous vaginal delivery is the safest option for these mothers. Even a cesarean section is safer than a partial birth abortion because it permits full exposure of the uterus and all instrumentation is done under direct visualization.

As for the child in the womb, there can be no doubt which procedure is best for him. In the case of normal delivery or C-section he will have his moment of love with his parents and perhaps his siblings before he dies. With partial birth abortion, he is delivered as a breech up to his neck, an opening is created in the back of his head, and his brain matter sucked out so as to collapse his skull for delivery through the narrower cervical canal. It is hard to image a more painful or ignominious death for one's child.

**Mrs. Engel:** *And as for the mother, father, siblings and other members of the family?*

**Dr. Baggot:** With the choice of partial birth abortion, the mother's loss of her baby will forever be an immensely unforgettable, personal tragedy. It stands to reason that coupling the death of the baby with guilt, anger, self-loathing, and desolation of an abortion would compound the tragedy and probably harm the parents' marriage.

Bringing the baby to term and having a live birth, in contrast, allows a tremendous outpouring of love and emotional support from family, hospital staff, and friends. In this context, the tragedy of the baby's eventual death could be forever wedded to an unforgettable positive, rewarding and loving experience.

**Mrs. Engel:** *In reading over these "hard cases" used to justify late term eugenic abortions it appears that a second-opinion consultation with a pro-life perinatologist or obstetrician-geneticist would have enabled these women with difficult pregnancies to make a more fully informed decision in these matters of life or death. What special role can a pro-life geneticist-physician play in the counseling and obstetric management of mothers carrying babies with severe or even lethal anomalies?*

**Dr. Baggot:** First there is the need to explain to parents the diagnosis, prognosis and therapy, if any. We must review the genetics and recurrence risk. Fear of the unknown is a great burden of suffering when one's child has one or more birth defects. Accurate explanation of the situation removes the fear of the unknown. It is an important and considerable act of charity.

As a Catholic pro-life obstetric- geneticist I believe that I can perform a great service by allaying the parents' unreasonable fears and helping them to accept their child with his own uniqueness and individuality. He may have a unique and individual appearance. He may have a unique and individual vocation and he may require a unique and individual sort of love from his parents.

Guiding the parents away from despair and abortion, and toward hope and acceptance, the pro-life geneticist can prevent a disaster that would be unforgettable. Most geneticists rarely save a life. The pro-life geneticist, however, can save lives.

**Mrs. Engel:** *Was there any particular incident in your medical career that re-enforced your life-affirming philosophy?*

**Dr. Baggot:** Yes, there was one remarkable case during my training in obstetrics that taught me what I needed to know and needed to do in cases involving lethal birth defects.

I met a mother whose baby had many birth defects, such that he would die shortly after birth. I knew that I could not participate in abortion but I really did not know what would be the compassionate alternative. The way I learned what to do was what a little man taught me. His name was little David.

Prenatal ultrasound had revealed that little David had five different major anomalies that did not closely simulate any known syndrome. Abortion had been offered to the mother but she rejected the idea. It was a long and agonizing pregnancy for this young couple of modest means from a rural community. The father gave his name, David, to his first born son.

After delivery, the child was put on the ventilator for about eight hours while the pediatricians thoroughly evaluated him and his lethal birth defects were confirmed. It was expected that little David would live only about twenty minutes when taken off the ventilator. Since the child's death was expected imminently, he was brought from the

neo-natal care unit and put into his mother's arms surrounded by his father, various aunts and uncles, and grandmothers each waiting their turn to hold, kiss and love the infant.

After twenty minutes little David's cardiac and respiratory rate began to slow, but then unexpectedly returned to normal. This cycle repeated itself many times over the next twenty-four hours. Over the course of the day a long succession of near and distant relatives arrived from many corners of the state. So many, in fact, that the room could not hold them all. All got their chance to hold, kiss, and love the newborn infant until his final moments on earth. What was so remarkable was this incredible spirit of love and peace that permeated the room – an explosion of love never to be forgotten by those who were present. I knew then that I would have to attend little David's funeral.

The day of the funeral, I took a two and a half-hour drive very early in the morning through a beautiful section of the "boonies." When I got there David's mother said, "My doctor said he would come and I knew he would.

There were about 100 people at the service. A funeral home had donated little David's casket and one of his grandfathers who was a preacher gave a beautiful sermon. There were no dry eyes at the service.

Later I took the mother by the hand for a walk across the adjoining empty field. I thought back on the mistakes I made in life. For most of them there was a subsequent repair or remedy. For my life as a doctor, it was similar; someone brings me a problem, I develop a remedy. But as I looked up at the beautiful sky, and the trees below and the horizon in between, I was awed and humbled by how unchangeable and non-negotiable the outcome of death was.

I told David's mother that hers was a special and unique baby whose loss can never be replaced. No other baby would be or could be this baby. I was sorry that we shared the loss of this beautiful, incredible baby, but I told her that there was every reason to hope for the future and trust in God. As for little David it seemed that he had received more love in a day than some babies receive in a lifetime.

One would expect these young parents to be devastated by this tragic loss of their first son and they were. Yet, in their minds, and everyone's mind, the tragedy of the baby's death was ever intimately wedded to and always inseparable from the explosion of love.

**Mrs. Engel:** *What would you say was the great lesson you learned from little David as a physician?*

**Dr. Baggot:** Actually there was more than one.

First, I believe that little David helped his parents heal from their terrible, painful experience. This was evidenced by the fact that his parents, rather than eschewing another pregnancy, at least any time soon, decided to try

to conceive again just a few months later, and happily delivered their second baby by the end of a year.

Secondly, little David taught me the proper management of a baby with a lethal birth defect is usually expectant, that is, non-intervention. He taught me that there is a tremendous amount of good that can come from such management. He showed me that every baby is created for a reason, and each has a special vocation. Little David demonstrated that even a baby, who never spoke, could preach a powerful spiritual message to doctors, hospital staff, mothers, fathers, and readers.

**Mrs. Engel:** *Thank you Dr. Baggot for this remarkable story. I am sure it has touched the hearts of all the friends of The Michael Fund especially during this blessed Christmas season and I look forward to our concluding interview on curative advances in the field of genetics.*

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### **More About The Michael Fund**

The International Foundation for Genetic Research, popularly known as The Michael Fund, was created in 1978 as a prolife alternative to the March of Dimes. All contributions and memorial gifts are tax-deductible.

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