Selection Reduction in Multiple Gestation
or, It is Best Not to be a "Superior" Fetus

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"You shall not commit murder.
Ex. 20:13

A NEW TWIST IN THE ABORTION SCHEME

There is a chilling new chapter written in babies' blood beginning in perinatal medicine. I recently attended the annual meeting of the Society of Perinatal Obstetricians in Houston. At that meeting L. Lynch, et al., from Mt. Sinai Medical Center in New York, presented an abstract detailing- transabdominal reduction of 64 multifetal gestations (119 babies).[1]

This feat at 9 - 13 weeks gestation consisted of using a 20 - 22 gauge spinal needle under ultrasonic guidance with intrathoracic (intracardiac) injection of potassium iodide into the most "superior" baby(ies). The study group consisted of 22 sets of triplets, 35 sets of quadruplets, 2 sets of quintuplets, 4 sets of sextuplets, and one set of nontuplets.[2]

All pregnancies were reduced to twins except two sets of triplets. Forty-two sets have delivered with an average gestational age of 35.6 weeks.3 Twenty-two (63%) delivered before 37 weeks, 4 (11%) before 32 weeks, 7 (17%) were losses 3.5 to 10 weeks after the procedure and 22 were still pregnant.[4]

CRITICAL ANALYSIS OF THE QUESTION

Though selective reduction of pregnancies is not currently murder in the legal sense of the word, I maintain that it is murder, Biblically. Our discussion ought, therefore, to center on the Biblical prohibitions against murder, but first let's analyze the data presented above in light of what we know of multiple gestations. Williams Obstetrics (18th edition, 1989) describes the mean gestation for twins as 37 weeks, for triplets 35 weeks, and for quadruplets 29 weeks.[5] The respective natural incidences of these types of gestations are 1/250 twins, 1/63,000 triplets, and 1/15,000,000 quadruplets, using Hellin's hypothesis that each frequency is the nth power of the twinning frequency.[6] Thus we see that multiple gestations, except twinning, are relatively rare with gestational ages that are very compatible with excellent survival outcomes. Then why do we see all the triplets, quadruplets, etc.? The answer lies in the area of *in* vitro fertilization (IVF).

THE CAVALIER USE OF OVARIAN STIMULATION AND IVF

There are over 10 million infertile couples in the United States.[7] Many of them are desperate to have a child and the technology we have allows them to consider *in vitro* fertilization as an alternative. Unfortunately, the medical profession has not kept ethics at the forefront with technology. Arguments rage about what to do with excess embryos but we will not discuss those here. We seek to discuss IVF and what we should be telling our infertility colleagues.

First, let's talk about the latest data in IVF The U.S. In Vitro Fertilization Registry was established in 1987 to try to catalog what IVF was doing in this country. There are 174 clinics that participate in 40 states and the District of Columbia.[8] Their data was presented in the January issue of **Fertility and Sterility.** The data show that there were 13,647 IVF cycles (at $5 - $10,000/cycle) with 2,243 clinical pregnancies (pregnancy confirmed by positive pregnancy test and ultrasound) of which there were 2,133 babies born.[9] This number included 19% multiple births. (Remember,

the normal multiple birth rate is about 0.5%)

The most interesting data, though, are on how the pregnancy rate varied with the number of embryos transferred per cycle. The clinical pregnancy rate was 16% and the delivery rate was 12% for greater than 3 embryos transferred.[10] The clinical pregnancy rate was 22% and the delivery rate was 16% for greater than 4 embryos transferred.[11] The multiple delivery rate went from 2.8% to 4-3% respectively.[12] So, for a gain of about 4% in delivery-rate with greater than 4 embryos we more than doubled the multiple pregnancy rate.

The problem with this practice is that these are not just triplets but many times include quadruplets and above. In this study we saw 55 triplets, 8 quadruplets and 2 quintuplet pregnancies. The morbidity with greater than triplets is significant." It includes premature labor, premature rupture of the membranes, intrauterine growth retardation, premature delivery and significant morbidity and mortality due to diseases of prematurity. The differences in pregnancy rates were not statistically analyzed in this study so it is impossible to note statistical significance. The change from 12% to 16% delivery rate with greater than 4 transfers does not seem to justify the obvious ethical, medical and financial problems increased multiple gestations pose.

SO NOW WHAT?

The Scriptures tell us in Exodus 20:13 that it is wrong to murder an individual. We know from comments in Psalms 139:13, (" . . . you knit me together in my mother's womb") and Exodus 21:22 states, ("If men who are fighting hit a pregnant woman. . . But if there is serious injury, you are to take life for life . . . ") that infants in the womb are considered God's people even before they are born. To perform cold-blooded premeditated baby reduction is, Biblically, murder. What can we do as physicians? As a perinatologist I can refuse to perform such murderous reductions and strenuously oppose the adoption of such a scheme at my hospital. You, as referring physicians, can refuse to deal with hospitals and physicians who perform such tasks. Believe me when I say that as a perinatologist you live on your referrals. If you don't get referrals and get the reputation as a "baby killer" your practice will suffer. This loss hits most physicians who are not believers where they live . . . in the pocket book.

Further, we can put pressure on our gynecologic endocrinologists not to transfer more than 3 eggs at a time. We can pressure them not to superovulate individuals to make 5 10 eggs and thus create the ethical dilemma we are presently caught in. We can suggest that physicians discontinue stimulation of any menstrual cycle that appears to be producing multiple dominant follicles over 3 in number. This multiple ovulation can usually be easily predicted with ultrasound and serum estriols. If the cycle is producing excess follicles stimulation is stopped and the patient taken through another cycle for IVF This practice is expensive (Pergonal or human menopausal gonadotropins costs about $1000 an IVF course) but the peace of mind and freedom from distasteful dilemmas about "extra infants" are basically avoided.

Most of all, we can place pressure on colleagues to use their ethical sense when performing infertility procedures. Finally, we can inform our desperate infertile couples that they should carefully question their infertility specialist and see if he is willing to discontinue a cycle that produces more than three follicles and is willing to transfer only 3 or 4 embryos per cycle.

OUR CALL

Reformed Christian physicians ought to be leading the way in moral/ethical debates and confronting our colleagues about their own insensitivities to God's image in man. We should call "selective termination" by its Biblical name - murder and raise the call to end indiscriminate IVF procedures which bring rise to "selective termination."

" . . . but I will hold the watchman accountable for his blood." Ezekiel 33:6b

References

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2. *Ibid.*

3. *Ibid.*

4. *Ibid.*

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6. **Creasy and Resnick,** 2nd edition, W B. Saunders, p. 565.

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10. *Ibid.*

11. *ibid.*

12. "Williams Obstetrics, op cit., p. 650.