## "A Baby for Mary"

by Blaine Paxton Hall, PA-C

Now that Mary had finally delivered her baby, we were nervously wondering how she'd react the first time she saw it.

Mary's room was easily seen from the nurses' station; she was lying under a thick, slate-blue quilt that she'd drawn up under her arms. Her large hands were relaxed and folded across her chest. Mary's husband was seated beside her, his forearms resting on the bed's siderails. On the edge of his chair, he was leaning toward her, but she was gazing the other way, out toward us, watching the comings and goings at the semicircular counter. We busily avoided her gaze but she kept calling, "Are they bringing him soon?"

We thought Dr. Childs, the pediatrician, was stalling. There was even some talk that the doctors wouldn't let her see the baby. And we wondered how she'd react to that because she'd been asking to hold the baby ever since the cesarean section, first thing this morning.

Mary had known for nearly three months that she was carrying a physically and mentally defective baby. At 16 weeks, Dr. Richie, the obstetrician, had scanned Mary's abdomen by ultrasound to confirm gestational age. Quite unexpectedly, he'd noticed enlargement of the fetal kidneys. And knowing that hydronephrosis was part of the syndrome of several types of chromosomal abnormalities, Dr. Richie had whisked Mary and her husband off to a geneticist.

Dr. Harrington had recommended amniocentesis, the procedure by which the cells of the amniotic fluid (and, therefore, the cells of the fetus, are examined). Soon thereafter, Dr. Harrington, a tall, slender man in a brown tweed suit, met Mary and her husband at the door of his wood-paneled office. A medical student accompanied Mary and her husband to Dr. Harrington's—for the learning experience, which he'd shared with us later:

"Mr. and Mrs. Tanner. Please. Please come in." Dr. Harrington gestured toward a cavernous leather couch, then moved gracefully to the wing-back chair alongside his impressive oak desk. Elegantly occupying the chair, he peered intently at them and began slowly, smoothing his bearded chin with his palm. "The results show that your baby has Trisomy 13."

Mary and her husband looked blankly at each other and then back at Dr. Harrington. He continued pensively. "Trisomy 13 is, as we say, a chromosomal abnormality. You see, within every single cell in your body are 23 pairs of chromosomes. Chromosomes contain exact and specific instructions for the development of the fetus. If there is anything wrong with any of the chromosomes; if there is any misinformation, that will be replicated in every cell of the body."

Mary and her husband sat quietly on the couch.

"Now Mary, the 13th pair in every cell of your baby has one extra chromosome. And that's how we get the name Trisomy 13; 'tri-' means three and '-somy' from the word chromosome."

Mary's husband leaned forward. "Did this come from us?"

"No, this kind of thing occurs quite by chance. There is nothing that either of you have done that could either cause or prevent your baby from having Trisomy 13. Remember the blood tests that we did on both of you? They were normal; there is nothing wrong with your chromosomes. Either of you.

"Women who become pregnant at an older age, especially with their first pregnancy, seem to be at greater risk for this kind of thing. You're 32, right? But you already have a little girl."

Mary nodded. "Yes, Emily, she's three years old."

It was getting late in the day. The room had darkened. "I was wondering, Dr. Harrington, how long will my baby live?"

Dr. Harrington crossed his legs. "A fetus with Trisomy 13 will have severe mental retardation, physical disfigurement, and physiological dysfunctioning of organs and systems critical to life. We would expect the death of the baby to be imminent."

"But how long can my baby live?"

"Not very long. Not very long at all."

In the silent pause the room grew darker. Dr. Harrington slowly went on. "Mary, have you decided what you might do?" He glanced furtively at Mary's husband.

"I'm not going to do anything. I'm going to have the baby."

Mr. Hall is a physician's assistant in general internal medicine at the Pinehurst Medical Clinic in Pinehurst. None of us knew for sure how she felt or the reasons for her decision. Over the weeks, while we anticipated the birth of Mary's baby, her situation gave us much to discuss and even more to think about. At lunch the other day, we had an especially enlivened discussion about Mary's decision to not terminate the pregnancy.

"I'll tell ya; I just don't see how she can go on like this. It would drive me nuts."

"It is driving you nuts."

"Well what's she trying to prove anyway? I think she's selfish to drag her family and everyone else through this trip."

"Maybe she's a religious fanatic."

"Well, it's her personal decision to make. It's not ours. Not the government's. Not anyone else's business."

"But don't you think we—all of society —have a moral and social interest in women having abortions?"

"Yes, maybe so. But we should use reasoning, or even peer pressure, not laws, to regulate abortions."

"Well, Mary's in her third trimester now. The only way she could legally have an abortion now would be if her health's in danger."

"You could always find a doctor willing to say that. Gimme the salt there would ya?"

"Well, that's the way I think it should be."

"Think what should be?"

"No abortions after the first trimester, unless the mother's health's in danger. She should be able to make up her mind by then. Come on. Let's get real. We got to have some standards in life, for Chrissake."

"Well, maybe she could make up her mind but, ya know, I really think abortion should only be legal in the case of rape or incest—beyond the mother's health in danger, of course."

"You're on a slippery slope with that, ya know. Is a life less significant because the mother's health is in danger or because she was raped? Should the right of the fetus to live be dependent on the circumstances of conception? Is that justice? The life is no less significant because it was conceived as a result of rape; that's what I say."

"And people are just using abortion as another means of birth control. Even the pro-choice people will agree with that."

"If that's what you really believe, why aren't you passing out birth control pills—or educating about condom use?"

"Well abortion's murder and that's that."

"You know, murder is an awfully strong word. If you have a murder, then you must have a murderer. So who is the murderer? The physician? The mother? I suppose you'd recommend capital punishment for a woman who terminates her pregnancy. Ha! Now doesn't *that* make sense?"

"Well, by the end of the fourth week the heart starts to beat. You can see it later by sonography. By the seventh month the lungs are developed. By the end of the eighth week, the baby shows response to stimuli." "Listen, that's all true to varying extent with all animals. But we slaughter animals. Do you eat meat? So far, murder only refers to humans. Beating hearts, respiration, and reflexes do not make us uniquely human."

"Well then, just when are we uniquely human?"

"When we begin to think. That's what I say."

"Yah? Well, let's begin to think about getting out of here. Time to get back. Let's go."

Mary was first on the surgery schedule this morning. When they wheeled her into the operating room, she was talking with us, asking questions, attentive to all our preparatory activities.

When the anesthesiologist wanted to insert the catheter into her lumbar spine, she sat up for him, legs dangling over the side, three feet from the floor. And though hugely pregnant, she doubled over to facilitate his probing with the needle.

After we returned her to supine position, one nurse began the systematic prep of Mary's skin for surgery. She shaved Mary's taut belly, dabbing away the stubble with adhesive tape. Then, with a sponge on a flat wooden stick, she scrubbed her stomach with foamy orange iodine solution.

We all knew Dr. Richie and his pre-surgical word of prayer with each patient. He'd long since given us explicit instructions to not begin prepping the patient until he'd met with her for prayer. He always did this in the pre-op holding area, just before changing into his surgical scrubs. This morning we waited for Dr. Richie, but he could not be found.

"Oh, ya know, this praying stuff of his is a bunch of baloney," said one of the transport techs.

A couple of the nurses looked horrified.

"Oh come on," continued the muscular fellow, lounging against the counter. "It's a public relations ploy. See, the patient's family always waits with her in the pre-op holding area. He just puts on an act for them."

"Ya know, I read an article where they did a study that showed how patients who'd been prayed for had better recovery rates than those who had not been prayed for."

"It's not the prayer that heals a patient, it's their belief that it will."

"No but ya see, they had two groups of patients. One group was prayed for by clergy and laypeople outside of the hospital, and the other group was not prayed for. None of the patients knew who was being prayed for, neither did the attending physicians or nurses. And it actually turned out that the patients who were prayed for—even when they didn't know it—had better recovery rates. So how do you explain that?"

"I don't explain it because I think it's baloney."

Someone went looking for Dr. Richie and reported back that he was in the men's room and that we should go ahead with prepping Mary for surgery. We sensed that Dr. Richie wished to discreetly avoid the praying ritual with this patient.

Soon, Dr. Richie, his assistant, and the medical student approached. We knew he was a medical student because we had seen him earlier, on the wards, and he was wearing the blazer-cut, white jacket instead of the longer length, butcher-cut style. The three of them backed into the room, carrying their arms away from their bodies, at right angles, pointing up. Water ran off their elbows; they had just come from the scrub sinks around the corner.

So the three stood waiting for the scrub nurse to assist them. She was standing behind a table laden with long stainless steel tools and bowls and blue linens. She finally selected three blue towels and handed one to each of them.

The table and all that was part of the so-called sterile field was draped in faded blue linen. The blue was the color of the mountains which, though there were no windows in or near the operating room, were serenely reposing outside, all around us. It was a reassuring blue; it hushed the glaring overhead lights. The effect was an aura, to those of us standing back, in which blurry blue figures floated within the sterile field.

Holding their arms away from their bodies, the three dried their hands, starting with their fingers, then moving toward the elbow, never retracing their steps, one arm at a time, one side of the towel for each arm; all the while taking obvious care not to touch their unsterile green scrubs or anything else. Next, to each in turn, the scrub nurse proffered a blue paper gown, holding it full length in front of each, taking great care not to touch the inside of the gown. The surgeon carefully aimed his arms into each sleeve. The nurse held open a surgical glove, into which the right hand was thrust with a flourish. Then the surgeon used his gloved right hand to assist the nurse in gloving his left hand.

A circulating nurse came behind each in turn, pulling the gowns together and fastening them at the nape of the neck. The final act of the ritual was to tie the gown around the waist. The ties were affixed to the gown, and a thin cardboard marker was attached to the end of one of the ties. Dr. Richie picked the cardboard marker, held in place by light adhesive, off the front of his gown and handed it to the nurse waiting to receive it. She held it as he pirouetted to his right. Back at the starting place facing her, the gown was now belted. He tugged on the tie, and she on the cardboard, breaking the attachment. Then she pitched the cardboard piece into the big red trash barrel. Now, he took the left side tie, which was shorter and also affixed to the paper gown, and tied it to the longer tie held in his right hand.

We'd seen this glove and gowning dance countless times before and with many other surgeons, always the same. One time we overhead the student and Dr. Richie bantering at the scrub sinks. The student said that the scrubbing and gowning was like the ablutions, the symbolic garments, the priestly ritualisms of the clergy, in which he had also participated. "Oh yes," he had said with mock seriousness, "I understand you've

got to do all this stuff just right, or else it won't take."

Dr. Richie and the scrub nurse fully draped the patient in blue paper, leaving her abdomen exposed. They hung a vertical drape that separated Mary's upper body from her lower. The anesthetist, surrounded by his monitoring equipment and cart of medications, sat at her head. The spinal block effectively denervated Mary from the waist down. She was fully conscious and alert; she curiously watched everything we did. At one point she looked up over her right shoulder at one of the monitors and remarked flatly, "Isn't my systolic number a little low?"

Dr. Richie took his place on Mary's left side, the student on his left. The assistant surgeon stood on Mary's right, the scrub nurse to his right. The scrub nurse began by pulling the blue draped tables in snug around them, closing the sterile field. Using Mary's draped body as a working table, they assembled plastic tubes and cords, attaching them with clamps at the right place on the blue drape. The circulating nurses moved equipment into place, delivering various surgical paraphernalia to those ensconced within the sterile field.

Dr. Childs was stationed at the incubator across the room, ready to receive the infant. He had a stethoscope with a miniature chestpiece in his hand and a small plastic tube, attached to the wall, from which oxygen was to be delivered to the infant.

At Mary's last office visit, Dr. Richie had her sign the Do Not Resuscitate orders. Mary had been perched on the end of the examining table, and Dr. Richie sat with his back to her, face in her chart, pen poised ready to check the appropriate boxes. He had read with a galloping voice, "Okay now, do you want cardiac or pulmonary resuscitation, intubation, ventilation, tube feedings, IVs, antibiotics, or anything else for this baby?"

When there was no response, Dr. Richie wheeled around to face her. Mary's face was contorted and wet with tears. "I don't know," she choked, "I just don't know." That was the only time any of us had ever seen Mary break down.

Now, amid all the busy activity, the circulating nurse chose the precise moment to announce, "Okay, we're ready for the father." Seconds later, the door opened and a stiffly moving figure in a white paper suit, masked and hatted like the rest of us, was ushered in by an operating room attendant.

"All right now," continued the circulating nurse as the crackling figure edged toward her, "hold your hands together and don't touch anything blue." She sat him on a stool at Mary's left shoulder, behind the blue drape.

Without fanfare or even a word to make ready, Dr. Richie moved his hand in one quick, continuous stroke across Mary's lower abdomen. A panel of yellow, grapefruit-like flesh, Mary's flesh, flashed up behind his hand. The room was uncharacteristically quiet. In a stroking motion, using electrocautery, Dr. Richie cut through the next layer, exposing bright red, lean muscle tissue.

It was Mary who broke the silence when she remarked dispassionately, "I can smell my flesh burning." We all looked around to see who would say what next.

But Dr. Richie continued, deep in concentration, with no sign of having heard Mary's comment. He seemed to not perceive anything outside of his foot-square sterile field. The anesthesiologist mumbled something to Mary about the burning being done to stop any bleeding. Mary was easily appeased.

In a few moments we saw the shiny, swampy green placenta bulge into the clean-cut, red wound. Dr. Richie punctured the membrane and then, as always, things happened fast. The waters gushed from the wide wound; a gloved hand moved into the sterile field with a plastic suction tube; the blue drape was completely soaked in amniotic and bloody fluid.

Dr. Richie's arm slipped inside Mary's wound up to his left elbow, palpating and moving the baby into position. Mary's abdomen shifted uncannily under the blue drapes. Soon he brought forth a wet head with dark, coarse, matted hair. He grabbed a palm-sized suction bulb and began to aspirate fluid from the nostrils and mouth.

We all waited for the expected triumphal cry, but the grayish-blue head remained silent, facing the ceiling, suspended from Mary's wound, between birth and spontaneous life, as Dr. Richie worked and worked with the bulb.

After a long, quiet minute or so, unable to elicit the expected cry, he gently eased out a shoulder. The rest of the infant easily popped out and delivery was complete in seconds.

Mary's hair covering had not stayed in place; dark coils of damp hair framed her face. Again it was Mary who broke the silence, "Is it here yet?"

Dr. Richie answered with reserve, "Yes, Mary, it's a boy." The baby cradled between Mary's thighs, Dr. Richie and

his assistant coaxed the delivery of the placenta by gently tugging on the cord. Within the murky placenta, the thick, gnarled cord was a surprisingly brilliant blue; like finding sapphires in a muddy creek.

The infant was still silent, although his arms flailed. Dr. Richie and the assistant placed a clamp on the cord five inches from the infant's abdomen and another clamp several inches beyond that. The assistant cut the cord between the clamps. The placenta was inspected for abnormalities or missing segments, then it and the cord were scooped into a steel bowl on the bluedraped sterile table. By this time, the cord was already grey.

As soon as the baby was disconnected from Mary, Dr. Richie carried it to Dr. Childs, waiting at the incubator. Then he returned to Mary, to close her womb and abdomen with layers of sutures.

Dr. Childs busied himself with examining the baby. He continued the suctioning of the baby's nostrils and mouth while one of us waved the oxygen tube under the infant's nose. Dr. Childs addressed Mary across the room. "This baby is not breathing; but his heart is beating. I don't know, I just don't know. I don't think he's going to make it."

Mary spoke from behind the blue drape, "I want to hold him. Please just let me hold him."

Dr. Childs sighed and said, "Mary, you remember we said the baby would have physical deformities?" After a silence he went on, "Mary the baby's face is severely disfigured and..."

"That's okay, I want to hold him," interrupted Mary gently.

Dr. Childs solemnly wrapped the baby, covering his body except the head. Atop his head he fitted a blue knit cap, pulling it down over the baby's forehead and ears. In this way, the bundle looked like a typical newborn baby boy. Then Dr. Childs started his anguished walk to Mary across the room. "Mary," he said, "I can't let you hold the baby now because he still isn't breathing and we need to keep giving him oxygen and we need to keep him in the warmer."

Mary got a glimpse of her baby as Dr. Childs stood momentarily beside her. She looked curious and concerned but somewhat distant. Dr. Childs turned and quickly left the room, saying on his way that he was taking the baby upstairs, to the nursery. Dr. Richie and his assistant, still suturing, hadn't averted their eyes from their work and talked to each other only infrequently and in low tones.

Mary's husband had sat quietly on his stool throughout. His masked face emphasized his eyes which, though red and swollen, were dark with pain, a picture of mental suffering that we thought uncharacteristic and unexpected in so young a man. Without a word to Mary, he abruptly got up, shuffled across the room and out the door. His eyes never left the floor.

The surgeons finished their suturing. Dr. Richie peered around the drape and said soberly, "Mary, you did real good."

The three then ripped off their paper gowns and gloves, rolled them up and stuffed them into the trash barrel. "I'll be going to the Board meeting during lunch," said Dr. Richie.

"I think I need to go running," replied the student. They left the room and us with Mary.

Upstairs in the nursery, the baby had begun spontaneous breathing. He was crying—a low, pitiful bleating noise. Dr. Childs paced and sighed and shook his head and saying, "I don't know, I don't know, I just don't think he's going to make it."

The assistant surgeon, a silvery, distinguished-looking man, now dressed smartly in a suit, glanced at the infant. "I'll tell ya," he mumbled seriously, shaking his head, "I pray to God that he'll die. That would be the best thing for everyone."

Oxygen was delivered to the infant by the tube connected

to the wall and to what looked like a fish bowl, cut vertically in half and placed upside down, directly over the infant's head. The crying was muffled by the bowl, and the baby, now crying with much effort, his swollen sides heaving, kept catching his deformed mouth on the edge of the oxygen bowl.

The student peered at the baby inquisitively. He fingered the hands and the blue feet; all contained extra digits. The nurse in charge, a grey haired, steel-jawed woman noticed the student and went to stand by him, also watching. After a few moments, she spat out, "Cleft lips, cleft palate, omphalocele, no testes but the rectum is patent."

"Yes, but he's crying," said the student quietly, his eyes never leaving the baby.

At the same time, there were three migrant babies in the nursery. We called them migrant babies because their parents were migrant workers and stayed at the nearby camp. Two pink caps and one blue. All had dark eyes that glistened in the bright nursery lights, shiny black hair, and creamy tawny skin.

It was to this group that Mary's husband, still with the red beseeching eyes, came. He stood timidly in the doorway of the nursery, imploring a roomful of strangers. "Please let us hold the baby. Mary wants to hold the baby. Dr. Childs said we could. Please."

And this is why we all were wondering just how she'd react when finally the baby was brought to her. This would be the last time that Mary, still watching the nurses' station would ask, "Are they bringing him soon?" A nurse appeared from around the corner with the baby in her arms. She approached Mary's room cautiously.

Mary's eyes were riveted to her baby's face even though he had no eyes with which to return her gaze. She accepted the blue blanketed bundle, now quiet in his blue cap. She pulled her baby in to herself and raised him to her face. She kissed the baby's grotesque mouth and said, "I love you little baby boy of mine."