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Prenatal Diagnosis and Selective Abortion

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The practice of prenatal diagnosis raises a number of serious ethical dilemmas. I shall focus here on one of these: the selective abortion of defective fetuses. Selective abortion is commonly recognized as the central ethical dilemma in prenatal diagnosis, and it receives new urgency in light of the recent decisions on abortion by the United States Supreme Court.

The questions being raised here are first, what justifications are of-
ferred for prenatal diagnosis and selective abortion; and second, what are the implications of the ethical reasoning embodied in these justifications? I shall argue that the current and projected widescale practice of prenatal diagnosis and selective abortion establishes precedents which both violate fundamental principles of justice and threaten the traditional life-preserving orientation of medicine.

I

It may be helpful first to set the entire discussion in the context of two important trends in our changing social ethos. Both these trends have achieved sharp articulation during the time of development of prenatal diagnosis, and both have influenced arguments made on behalf of prenatal diagnosis and selective abortion.

The first trend encompasses a general awareness of “women’s rights” and specifically, a movement toward autonomy of women in the reproductive sphere. This trend received significant articulation in the Supreme Court decision in Griswold v. Connecticut (1966), in which a marital right to privacy in reproductive matters was declared to be protected as a constitutional right and its culmination can be seen in the recent declaration by the Supreme Court that “this right of privacy ... is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.”

Current concern for the effects of rapid population growth and the scarcity of resources has contributed to a second trend which influences this discussion: a movement toward a “quality of life” ethic which, according to an editorial in California Medicine, places relative rather than absolute value on human life. This “quality of life” ethic may be seen generally in the trend toward accepting abortion and specifically in arguments that it is better not to be born than to be born unwanted.

Thus prenatal diagnosis has arisen in a general climate of concern for “population growth,” women’s rights, the consequences of illegal abortions, the number of “unwanted” children and the discriminatory aspects of current abortion laws. It is within this general framework and its specific articulation in the recent decisions by the Supreme Court that the practice of prenatal diagnosis and selective abortion must be assessed.

Preliminary Observations

Before considering the morality of selective abortion, some preliminary observations are in order. Prenatal diagnosis itself is an information-gathering procedure. Clearly, the information gathered can be used in a variety of ways, and not only as the basis for selective abortion. Indeed, practitioners stress the fact that most diagnoses reveal a normal fetus and hence serve to reassure anxious couples4 and on occasion to prevent a scheduled abortion.5 Moreover, a few disorders may be treated prenatally or postnatally on the basis of a prenatal diagnosis,6 and it is hoped that more treatments will be available in the future. Thus prenatal diagnosis is advocated not only to provide for selective abortions, but because it potentially brings these other benefits as well. Nonetheless, a cursory examination reveals the centrality of selective abortion in the practice of prenatal diagnosis, and hence justifies a focus on this one issue.

To begin with, the importance of the “reassurance” rationale can be tested by asking first, whether any woman could have an amniocentesis just to make sure that the fetus she carries is normal, and second, whether a woman could get amniocentesis if she had no intention of having an abortion in the event of abnormality. The answer to both these questions is “no.” First, not all women are considered eligible for amniocentesis, but only those in “high risk” or “moderate risk” groups. Second, even for those women in high risk groups, amniocentesis will not be performed unless abortion is at least an option,8 and some practitioners would even say that the woman must be committed to an abortion before diagnosis will be performed.10 The reason in both cases is simple: the risks associated with the diagnostic procedure are considered sufficiently great so as to preclude the diagnosis in the absence of genuine risk of defect and sufficient benefit—the benefit of reassurance alone does not outweigh the harms of the procedure.11 No matter how important the reassuring function may be in actual practice, it does not constitute sufficient justification for widescale prenatal diagnosis.

Similarly, the argument that prenatal diagnosis “saves lives” by preventing abortions also depends on the acceptance of selective abortion: the interest here is not in saving the lives of all fetuses by preventing all abortions, but only in saving the lives of normal fetuses by preventing them from being aborted. Thus the entire line of reasoning depends on acceptance of the abortion of defective fetuses.

As for treatment, there are currently only a few disorders for which treatments are available and “at the present time, the emphasis is placed on diagnosis of disorders in which there is no treatment.”12 Moreover, even where treatment is available, most practitioners still allow the couple the choice of abortion, and indeed suggest that this is what most parents would prefer.13 Hence the availability of treatment does not rule out abortion.

Developing Treatments

But even though treatment is not a major possibility now, surely prenatal diagnosis might be justified as a necessary means to gain basic information needed in order to stimulate the development of new treatments.14 Attractive though this argument might at first seem, however, there are several problems here.

First, if parents would indeed choose abortion over “any but the most trivial treatment,” it is not clear that the impetus to develop treatments will exist.
II

Selective abortion is not, of course, a new issue. While it has rarely been a central issue in the "abortion debate," it has received at least sporadic attention following rubella epidemics and the thalidomide scare. A "eugenic abortion" clause has appeared in almost every proposed model code for abortion reform, and a number of states have included such a clause in revised abortion statutes within the last few years. Thus, the issue itself is not new.

What is new in selective abortion following prenatal diagnosis is the certainty of the diagnosis. Previously, a decision for selectivity or "eugenic" abortion had to be based on statistical probability of "risk" figures, now, an "actual diagnosis" can be made. This prenatal diagnosis is hailed as a great advance for "taking the gamble out" of pregnancy and genetic counseling.

The advent of prenatal diagnosis therefore focuses the question of selective abortion in a new and dramatic way: for the first time, the problem of selective abortion arises not because of accident or mishap, but because of the deliberate intervention of medical technology. For the first time, selective abortion is not an occasional and regrettable act, but the planned outcome of deliberate programs of medical practice.

Nonetheless, most of the ethical issues raised by prenatal diagnosis and selective abortion are issues that have been implicit or explicit in the "abortion debate" over the past few years. Now this debate has raged so long and hard and covered so much territory that one is well advised to exercise caution when entering the fray. Moreover, the recent decisions by the Supreme Court suggest that the wisest course might be to assume that the legal resolution of the issue also resolves the moral dilemmas.

Arguments Examined

However, I suggest that previous debate and present legal framework notwithstanding, there may yet be a little room for clarification of the issues and moral decision-making with regard to selective abortion. Therefore, I shall examine the arguments offered as justification for selective abortion and place those arguments within a logical framework which will help to ascertain what is really at stake in this practice.

The matter is complicated at the outset by the fact that few practitioners present explicit arguments to justify selective abortion. Most advocates simply refer to the legality of abortion or its acceptance within a significant reference group—for example, "therapeutic abortion may be offered where it is legal," "most people would probably prefer abortion," "most obstetricians would regard abortion as acceptable," and so on. Indeed, some practitioners specifically exempt themselves from responsibility for making the ethical decision, on grounds that it is their job to lay the empirical foundations on which legal, ethical, and political decisions will be made by others.

Nonetheless, alongside specific disclaimers and vague references to decision-making groups there emerges from the discussion a constellation of claims for selective abortion.

First, selective abortion is justified on grounds that it procures benefits for individual families: it protects them from the financial and emotional strains associated with bearing and rearing a child with a genetic disease and it minimizes the risks involved in pregnancy. Special pleas are made on behalf of families with a previous history of devastating defect, who may be afraid to "take a chance" with another pregnancy unless they can have prenatal diagnosis.

In addition, there is considerable emphasis on the rights of women and couples and especially on freedom of choice and autonomy in the reproductive sphere. Amniocentesis is seen as a technique which "opens doors"—that is, which expands the options available to women and their spouses, thus enabling them to exercise freedom of choice. It is a cardinal rule in the practice of prenatal diagnosis that the "ultimate" decision for both diagnosis and abortion is to be made by the couple.

One practitioner has even suggested that parents have a right to healthy children.

First Rationale

Thus the first rationale given for selective abortion is that of the benefits accruing to individual women and their families. As this rationale begins to shade over into
questions of women’s rights and reproductive freedom, it takes on the character of the first social trend enumerated above, assimilating the trend and contributing to it.

Alongside this concern for the pregnant woman and her family, there emerges another concern: an interest in the impact of genetic disease on society as a whole, and in the public health aspects of prenatal diagnosis. Justification for diagnosis and abortion is therefore also derived from benefits to society gained through wide-scale screening programs.

In the first place, geneticists contend that screening programs could have a eugenic effect in eliminating deleterious genes from the gene pool. In the second place, practitioners argue that screening and abortion would significantly reduce financial burdens to the state, since fewer children would be born needing costly medical or institutional care. Elaborate cost-benefit economic analyses have been made for several disorders. Concern for protection of society at large is thus the second reason given as justification for selective abortion.

Just as arguments regarding benefits to women “shaded over” into arguments about women’s rights and procreative freedom, so here the arguments regarding benefits to society shade over into a larger concern, which may be encompassed by the phrase “quality of life.” Prenatal diagnosis and selective abortion are justified because they function to preserve a norm of genetic health which is a part of the “quality of life.”

The concern for a standard of genetic health may be seen to operate, first, in the assumption that prenatal diagnosis and selective abortion function as “preventive medicine.” This assumption has been made explicit on several occasions. Moreover, it is implicit in the use of phrases such as “reduce the incidence of disease,” “eliminate disease,” or “prevent the birth of” rather than “abort.” As “preventive medicine,” prenatal diagnosis and selective abortion combine to preserve the norm of genetic health which is a part of the quality of life.

Second, concern for the norm of genetic health and the quality of life have been raised explicitly by several advocates. Quality of life questions are most often linked to questions of quantity, and it is here that the concern for genetic normalcy becomes most apparent. Prenatal diagnosis is seen as a means of quality control in a quantity-limited system. On the level of the individual family, the quantity-quality link is seen clearly in statements to the effect that with increasing pressure to limit family size, parents will not want to risk any departure from the normal in their offspring. Indeed, under pressures of quantity, quality control becomes a right: if the size of our families must be limited, surely we are entitled to children who are healthy rather than defective.

Social Needs

The quality problem is seen not only on the individual level, however, but also as a response to societal needs. Thus one practitioner claims: “The world no longer needs all the individuals we are capable of bringing into it,” and argues for selective abortion on these grounds. Prenatal diagnosis becomes a tool to ensure that “both the quantity and quality of the human race are kept within reasonable limits.” Maintaining the norm of genetic health thus justifies prenatal diagnosis and selective abortion because maintenance of the norm is a necessary step in ensuring quality of life in a time of concern for population growth.

The concern here is well summarized by one practitioner reflecting on the work of several pioneers in the field:

Dr. Gerbie and his associates have helped us take still another step down the long road which we must follow if we are going to improve the quality of human existence while searching for better methods of controlling population density.

Finally, the norm of genetic health may also be seen in the argument that the fetus has a right to be “well-born.” The argument here is that there is a fundamental right to be born “with normal body and mind” and that if this right is not to be fulfilled, then it is better not to be born at all.

In sum, the importance of genetic health is taken as a given, which carries its own justification. It is only necessary to know that there is a choice between health and disease; the obvious choice on the part of all parties — family, society, and the individual concerned — will be for health.

These, then, are the justifications for selective abortion: benefits to the woman and family and to society as a whole, both in terms of specific and measurable emotional and economic factors and in terms of the maintenance or restoration of the norm of genetic health.

III

We can now ask how these justifications fit into the context of the “abortion debate,” what other assumptions are necessary to explain them, and what it means to follow out their implications logically.

Several of the justifications offered for selective abortion following prenatal diagnosis are similar to specific arguments used to establish other categories of “indications for abortion.”

The concern to protect the woman and family emotionally and financially is not a new concern in the abortion debate, nor is it unique to selective (or eugenic) abortion; rather, it is reminiscent of the “psychiatric” and “socio-economic” indications for abortion. Thus if these arguments are used to justify selective abortion, the justification becomes similar to that used for the psychiatric and socio-economic indications. And indeed, it appears to be the practice in some places to require a psychiatric examination and justify the abortion as “therapeutic” on these grounds.

However, some advocates reject the “psychiatric indications” argument: one practitioner calls it
"circuitous" and "ridiculous" to require psychiatric examination of the woman following diagnosis of defect in the fetus. They want the presence of defect alone to be sufficient justification for abortion. This argument, therefore, parallels the traditional arguments for a separate category of "eugenic" abortion which has validity independently of other criteria.

The assertion that there should be an independent category of abortion for "eugenic" indications, in which the very presence of defect justifies abortion, is a logical outcome of reasoning on the basis of a norm of genetic health. Thus a psychiatrist commenting on prenatal diagnosis notes that "for some people, abortion of a defective fetus is less unsavory than abortion of a presumably normal fetus," and he explains this fact on the basis that it is "in line with our medical orientation that makes the extirpation of disease a noble act."

If arguments for selective abortion appear at first glance to coincide with various arguments for "indications" for abortion, however, there is also evidence of affinities between arguments used for selective abortion and the so-called "abortion on demand" arguments. Here, the basic claim is that the woman's freedom is an overriding value which dictates the availability of abortion "without reason" (that is, without public or legislative consensus on the reason proffered). Women may thus choose to have a child or not, to have a defective child or not, as they please.

Clearly, then, it is necessary to examine the arguments for selective abortion both within the general context of "abortion on demand" and within the more specific context of special claims made in the case of defect. It will also be necessary to suggest ways in which the recent Supreme Court decision impinges on the various arguments and sets the context for any future action.

IV

I shall begin by examining very briefly the question of "abortion on demand." (Before doing so, however, a brief note is necessary regarding the relation of abortion on demand to the more specialized arguments for abortion in selected categories. The history of the abortion controversy makes it obvious that it is possible to argue for selected categories of justifiable abortion without also condoning abortion on demand. I would argue that it is also logically possible to condone abortion on demand without necessarily condoning eugenic abortion. Logically, one can argue that a woman has the right to determine whether or not she is prepared to accept a pregnancy, but that having made that determination the particular status of the fetus should be irrelevant.)

The abortion on demand argument gives primacy to the freedom of choice of the woman. However, it must also deal with the fact that freedom of choice of one human being does not usually extend to the point of killing another human being; that is, there is a presumption that a human being has a right to life and that my freedom does not normally extend to the point where it deprives another of his right to life. Thus if the fetus is considered to be a human being, the woman would not normally have the right to kill that human being. To counter this difficulty, advocates of abortion on demand usually take either of two positions: First, they argue that the fetus is not a human being—or not "fully" human—and hence has no right to life. Second, they argue that although the fetus is human and hence has a right to life, there is something in the unique relationship of the woman and fetus that destroys the "normal" prohibition against killing.

Most advocates have taken the first approach: they assert that the fetus is not (fully) human. Arguments of this sort range from those that assert that the fetus is a mere "tissue" or part of the woman's body to those that recognize the fetus as a "developing" or "potential" human being, but argue that full humanity is not present until a specified time.

Must Set Time

The difficulty with this view is that advocates must then determine a time at which the developing embryo/fetus/neonate is considered to be (fully) human—six weeks? three months? at viability? one year after birth? That is, they are caught in a fine-drawing problem: When does the individual acquire full human status? The designation of a time of attainment of full humanity always presupposes the choice of criteria according to which humanity is determined—brain function? lung capacity? personality? speech?

Now these criteria for determining that one has reached full humanity always have to do with functional capacity and personal development. Hence it is always possible to ask whether there would be others besides fetuses who would, logically speaking, be subject to the determination that they are not "fully human" and hence not protectable under the law.

For example, geneticist Joshua Lederberg argues that the moment of conception should not be considered "as the start of human life," rather, he suggests, "an operationally useful point of divergence of the developing organism would be at approximately the first year of life," on the basis of development of language and cognitive interaction with others. However, the establishment of this time point on these criteria would obviously allow for the destruction of the newborn child up to one year of age. Logically speaking, Lederberg's criteria would allow for infanticide. At this point, Lederberg draws back from accepting the logical conclusions of his standards and refuses to discuss infanticide, on grounds that our emotional involvement with infants is sufficient to establish "a pragmatically useful dividing line." He then implies that the "tastes" or emotional involvement of "the majority" determines one's status.

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as a human being to be given full protection under the law: “To discuss the fetus during prenatal life as if he were a human being is merely to reflect the emotional involvement of that observer, according to a set of tastes not now shared by the majority.” One must ask, then, whether persons or groups who do not meet the standard of emotional involvement would be considered less than fully human and not protectable — for example, the convicted criminal or any outcast group.15 Once again, Lederberg draws back from the logical conclusions of his own argument and suggests that the criterion of emotional involvement “should not be confused with any objective biological standard by which we can set up principles of social order.”

Lederberg’s search for an “objective biological standard” to get him out of the problems he encounters with his own criteria illustrates as well as anything the inherent difficulty in this basic line of approach: any biological point that is chosen will be chosen on the basis of other criteria, and these criteria are all too often the results of our very human weaknesses. (Do we choose “spontaneous lung function” as the determining criterion of humanness because we really think it is a decisive criterion, or rather because we would like to be able to destroy the fetus prior to viability?) Are we willing to accept the consequences of our choices — what about those who must exist with the help of an iron lung?

**Human Standards**

In short, there is no “objective biological standard,” but only very real human standards. To be sure, some choices make more sense than others: Fletcher has suggested, for example, that in order to be consistent with our increasing orientation toward brain activity in defining the end of human life, we should also define the beginning of human life in terms of brain activity.25 Certainly, consistency is a desirable trait in both logical thinking and human interaction; indeed, this suggestion makes considerable sense. However, since the presence of brain activity in the fetus has been measured as early as six weeks, considerably before amniocentesis can be performed, Fletcher’s criterion would preclude prenatal diagnosis and selective abortion.

In view of the difficulties of drawing a line on the developmental continuum, several advocates of abortion on demand have preferred to take the second route: they argue for abortion on the basis of the special relationship between the woman and the fetus which is deemed to nullify the prohibition against killing. The most intriguing exposition of this argument along this line is that of Judith Jarvis Thomson.26

Thomson proposes that we accept, for the sake of argument, the claim that the fetus is human.27 The question then is, under what circumstances may we justifiably kill a human being? Suppose, says Thomson, that you wake one morning strapped to a famous unconscious violinist who needs your kidneys to survive; “is it morally incumbent on you to accede to this situation? Does the right to life of the violinist require this heroic and self-sacrificing act on the part of another person? Thomson concludes that it does not: “nobody is morally required to make large sacrifices, of health, of all other interests and concerns, of all other duties and commitments, for nine years, or even for nine months, in order to keep another person alive.” In essence, Thomson’s argument rests upon the moral right of the woman to remove herself from the violinist — or from the fetus. While separating woman and fetus in fact secures the death of the fetus, Thomson is not arguing that a woman has a right to secure the death of the fetus, but only to remove herself. Presumably, if pre-natal adoption or an artificial womb were available, either of the options could be used to preserve the fetus while freeing the woman.

This argument is more than intriguing; it has a certain force in its logic. Nonetheless, I think it also admits of some difficulties. Thomson claims that the woman has a right to remove herself from the fetus; the fact that the fetus then dies is perhaps unfortunate, but not central to the moral issue. Perhaps a different scenario will help elucidate the issues.

If one grants, as Thomson does, that the fetus is human, then the issue is whether one human being may remove herself from another when that other is dependent upon her body functions for survival. Surely the closest parallel to pregnancy, then, is the case of siamese twins, in which separation would cause the death of one twin. The moral question then is: could an adult siamese twin choose to “remove” herself from her twin, knowing full well that the twin would die, but claiming that her freedom was the more important value? (The medical practice of involuntarily separating siamese twins at birth, with the resultant death of one, does not change the moral argument regarding the rights of adult siamese twins.) If anything, it could be argued that we should feel more sympathy toward the plight of the siamese twin than toward the pregnant woman — the twin’s predicament is both involuntary and lifelong. Yet I wonder if we would be willing to accept the twin’s argument; would we not be inclined to consider the “removal” of one adult twin with the resultant death of the other to be murder, or wrongful killing? It is not clear to me that we are ready to argue logically that one human being may “remove” himself from another when that removal causes the other’s death.

**Other Examples**

Indeed, to bring the scenario a little “closer to home” for most of us, let us suppose that a man is responsible for the continued care of his elderly and dependent father, who will die if no one is in attendance at his bedside. Surely this man is morally free to leave his father’s bedside if there is
someone else to sit and watch over his father. But what if there is no one else? Is he then morally free to walk off, leaving his father to die? Or, suppose a young child needs medication every few hours to survive; is not that child's mother morally (and perhaps legally) culpable if she "removes" herself from the child and it dies?

In short, Thomson's distinction between removing oneself from another and securing the death of another becomes problematic when we consider a variety of cases. In cases where our nurturing function could be served by others, we are perhaps willing to argue that we have a right to remove ourselves provided that we have secured someone else to carry on the nurturing. But in cases where there is no one else to carry on that function — e.g., in pregnancy today, and in the case of siamese twins — I suggest that a view that really respects the full humanity of the other will not so readily allow us to argue that we may "remove ourselves," causing thereby the death of the other. (Hence, I suspect that Thomson has not really taken the human status of the fetus seriously, that she has not really overcome her own pre-disposition "that the fetus is not a person from the moment of conception.")

To accept Thomson's argument means to accept what it logically entails: the right of any human being to remove himself from one who is dependent on him, even if that removal results in the other's death — the elderly father, the child in need of medication, and the adult siamese twin. Once again, argument allows for the destruction of other human beings if we are not willing to accept these consequences, then we must reject the premises.

Thus far, I have dealt with the general question of abortion under the rubric "abortion on demand," locating two basic ways of approaching this issue and suggesting that there are problems in the extension of logic in either of these approaches. It has not been my intention to resolve the issue of whether or not the fetus is entitled to protection of its life, but only to illustrate the difficulties encountered in the position that denies protection to the fetus.

However, the question of selective abortion introduces a new element to the discussion. As Daniel Callahan suggests, with selective abortion we are dealing not with the problem of an unwanted pregnancy, but with the problem of an unwanted child. A logical exercise will illustrate what is at stake: Suppose that an artificial womb were available. Then, if the purpose of abortion is to free the woman from an unwanted pregnancy, logically the fetus would be placed in the artificial womb. Would a defective fetus also be thus preserved, or would its genetic status somehow "make a difference" in how it is treated?

Since the purpose of selective abortion is not only to protect the woman but also to protect society and preserve the norm of genetic health, it seems logical to assume that simply moving the fetus from one location to another would not be sufficient to fulfill the purposes of selective abortion. To the extent that selective abortion is oriented toward maintenance of the norm of genetic health or the "quality of life," it requires the destruction of those who do not meet this norm.

Now this illustration of the artificial womb is, of course, a hypothetical situation at present. Nonetheless, there are indications in the current practice that demonstrate the centrality of destruction of defective fetuses in this practice.

Determining Sex

First, prenatal diagnosis is used to determine the sex of the fetus in cases at risk for sex-linked disorders such as hemophilia. In such cases, the male fetus which has been aborted has a 50 percent chance of being normal. Thus half of the fetuses which are aborted in sex-linked cases will in fact be normal; this destruction of normal fetuses is allowed in order to ensure destruction of defective fetuses.

Now in the case of sex-linked disorders, one does not know whether a particular fetus is defective or normal; hence the abortion is done on the supposition that the fetus might be defective. A more complicated case, therefore, would be that of a diagnosis of twins which revealed one normal twin and one defective twin. In such a case, in order to "get rid of" the defective fetus, it would be necessary to destroy the normal fetus as well. Would this destruction of normal fetuses be allowed? To date, prenatal diagnosis has missed the presence of twins, but practitioners agree that parents would be allowed the choice. Thus even a known normal fetus could be aborted in order to abort an abnormal fetus.

Finally, since there is always a possibility of error in diagnosis, we can ask whether advocates prefer a false positive which would result in the abortion of a normal fetus, or a false negative which would result in the birth of an affected child. Practitioners disagree here. One states flatly that the loss of the "normal pregnancy" would be an "undefendable catastrophe." Another, however, suggests that it is a "more critical" error if a negative diagnosis is given and the child is born defective than if a positive diagnosis results in abortion of a presumed defective fetus and the defect is not confirmed upon examination of the abortus.

It seems clear that the practice of prenatal diagnosis establishes a distinction between the normal and the defective fetus, and allows for differential treatment of the fetus on this basis. As one concerned practitioner put it: "We are faced with problems of assigning values to individuals with given genetic characteristics and designing programs directed against them."

Serious Problems

What are the implications of adopting this kind of reasoning — of treating fetuses differentially according to their genetic con-
stitution? I suggest that there are a number of serious problems in establishing this kind of precedent, and I shall deal briefly with several of these, illustrating where appropriate with difficulties encountered already in the practice of prenatal diagnosis.

The first problem is that of determining the categories of fetuses considered destructible. Where is the line to be drawn on the determination of what constitutes sufficient "quality of life" to enable the fetus to live?

This problem will be encountered in two forms. In the first form, it has to do with the severity of genetic defect. The normative use of prenatal diagnosis is for severe, untreatable disorders (e.g., Tay-Sachs, Down's syndrome). However, even present techniques will diagnose less severe disorders (e.g., XO), and with expanding technology such incidents may be anticipated more frequently. Will abortion be allowed for less severe genetic disorders, or for disorders where treatment is available?

Already this problem is being encountered in the practice of prenatal diagnosis, and advocates appear to be divided in their responses. While some would maintain that "if there is an effective intrauterine treatment, then, of course, it should be applied," probably most would agree that abortion in the case of a treatable disorder remains a parental decision based on the informed counsel of their physician.

Second, the determination of destructible fetuses may be extended from clear genetic categories to categories of social disability or usefulness. As Kao says, "Once the principle, 'Defectives should not be born,' is established, grounds other than cytological and biochemical may very well be sought." The beginning of this trend may already be seen in the treatment of fetuses with XYY chromosomes, where the "prognosis" for the child is problematic primarily because of the possibility of socially undesirable behavior. If XYY fetuses are to be aborted, then what about fetuses of women living in undesirable circumstances—for example, women on welfare? Will "quality of life" come to be determined more on the basis of social usefulness than clear genetic disorder? One practitioner has already argued for prenatal diagnosis on grounds that "the world no longer needs all the individuals we are capable of bringing into it—especially those who are unable to compete and an unhappy burden to others." Surely such criteria as "ability to compete" extend the range of destructible fetuses far beyond the severely genetically handicapped.

Indeed, I would stress the fact that all categories chosen depend on some social criteria—even those that are most closely tied to genetic anomaly. For example, most practitioners consider Down's syndrome to be a "clear-cut" case calling for abortion. Certainly the genetic component—a trisomy G—is clear enough; and this genetic component is related to certain clinical symptoms such as mental retardation. But to determine therefore that fetuses with trisomy G should be aborted is to make a social judgment about the place of retarded individuals in society. It is possible to judge disability or deviation from a norm medically, but to determine that this deviation constitutes a significant handicap is to make a social judgment.

Drawing a Line

The first point, then, is that it is extremely difficult to "draw a line" with regard to the categories of fetuses which will be considered destructible, since all determination of such categories includes a social component and will be subject to the vagaries of social opinion. The phrase "quality of life" defines a continuum from the severely disabled through the socially undesirable to the "optimal" child. Where on this continuum will the line be drawn?

The second "line drawing" problem has to do with the time continuum. As one practitioner comments, "Early abortion based on prenatal diagnosis can be viewed as the modern counterpart of infanticide based on congenital defect." This, then, is the second serious problem implicit in the reasoning behind prenatal diagnosis and selective abortion.

These first two problems have been line-drawing problems—problems of determining the categories of destructible fetuses, and the time of destruction. The third problem is of a somewhat different nature. It involves the locus of decision-making and the possible conflict between "women's rights" on the one hand and the "quality of life" on the other. I suggest that as increasing value is assigned to the "preventive" function of prenatal diagnosis and selective abortion, the concern to eliminate de-
fectives and preserve the “quality of life” may logically be extended to deprive women and families of decision-making power.

Quality of Life
To be sure, at present advocates assume that the concept of “quality of life” embraces both the familial and the social aspects of prenatal diagnosis, and that there will be a concurrence of benefits to individuals and to society. They assume that if women are given freedom of choice, they will choose to abort defective fetuses and hence their choices will serve the best interests of society as well.

However, it is obvious that the interests of individual families and of society at large will not always coincide—even in the decision to abort the defective fetus. For example, it has been calculated that if all male fetuses at risk for hemophilia were aborted and “replaced” by female children, the result would be a dramatic increase in the number of female carriers of hemophilia—a 50 percent increase in the gene frequency in each generation. Hence, decisions made to benefit individual families might have a dysgenic effect on society as a whole.

On the other hand, at times where it would be beneficial financially to society for a fetus to be aborted, the woman or family might prefer not to abort. Would the woman’s freedom of choice be restricted here on grounds of benefiting society or preserving the genetic health? One concerned practitioner has raised the problem by suggesting that the uncertainty could result in an accentuation of the conflict in our society between personal choice and governmental control, which could possibly come in the form of selected programs of compulsory screening and mandatory abortion for some conditions that are deemed socially intolerable. Indeed, compulsory abortion has already been proposed.

In a situation where the fetus has no inherent rights and genetic health becomes an overriding value, compulsory amniocentesis and abortion is a logical outcome, as one practitioner rightly anticipates: The decision to terminate the life of a fetus has traditionally been denied even to the couple at risk, but the more widespread legal acceptance of abortion, the growing awareness of the impending crisis inherent in the population explosion, and increased concern for the social cost of genetic disease lead me to think that attempts to legalize eugenic programs may not be so untimely or even so far in the future as many of us have expected. Individuals in a society which is willing to allow even normal fetuses to be aborted simply at the request of the parents are not likely to be very tolerant of a known abnormal fetus.

To be sure, several practitioners have expressed their alarm at rejection of compulsory programs at the same time as they raise the question. But the point is that the movement toward compulsory abortion of defective fetuses is a logical outcome of elevating the norm of genetic health to override any rights of the fetus.

Further, once a principle has been established that the genetically unequal may be treated unequally in accordance with their genetic potential, other forms of unequal treatment will be encompassed by this principle. One of the first areas to be affected by the application of this principle will be that of procreation: the suggestion has already been made that reproduction be regulated in accordance with genetic inheritance—that “quality control” have a built-in “quality control” component. A practitioner has even claimed that “most of the women screened should not have been pregnant in the first place. All women who would have genetically high-risk pregnancies should be offered sterilization or an effective method of contraception.” Thus the way is opened up for other kinds of restrictive programs as well.

Impact on Medicine
Finally, the acceptance of selective abortion and its principle of unequal treatment of unequals will have profound implications for the practice of medicine. On the one hand, if selective abortion is a woman’s right, then the physician is obligated to provide for it. As with “abortion on demand,” the role of the physician is thus radically changed: “For the first time doctors will be expected to do an operation simply because the patient asks that it be done.” The physician, then, becomes a technician performing according to the desires of others. There is evidence already that this dilemma is being encountered in the practice of prenatal diagno-

sis, and that many practitioners are reluctant to give up entirely their traditional decision-making function. Thus, for example, one suggests that amniocentesis should not be done in cases of LSD ingestion because the physician would be obligated to provide for an abortion if chromosome breaks are found; here, the physician retains his power of making a medical judgment. Another practitioner has suggested that the use of prenatal diagnosis simply to determine the sex of the fetus constitutes an “abuse” of prenatal diagnosis and that information on the sex of the fetus should be withheld “unless it is crucial for management of the case.”

Prenatal diagnosis, in this view, is not to be a tool for the “frivolous” uses of women; yet if abortion is a woman’s right, then it must be performed no matter how “cold-blooded and contrived” it seems to the physician.

On the other hand, if selective abortion is justified not as a woman’s right but as a means of maintaining the norm of genetic health and promoting “quality of life,” the physician is in danger of becoming a technician for society. Theologian Helmut Thielicke declares that the doctor becomes an “engineer, a technician doing manipulations for a productive society.” Thus Friedmann suggests that “it is not difficult to imagine the emergence of pressures to set standards for desirability in genetically determined human characteristics,” and we must ask whose standards they might be.
Thus in the long run, this practice threatens the basic orientation of medicine: as geneticist Jerome Lejeune puts it, to "capitulate in the face of our ignorance and propose to eliminate those we cannot help" is to reverse the entire course of medicine. Not only do the principles established here have serious implications for human rights in society, but they also challenge the foundations of medical practice.

VI

Now clearly, many of these same problems have arisen in the general debate on abortion, and are not unique to selective abortion. In a sense, one could say that selective abortion gives a prismatic view of the implications of abortion in general—of the problems of extension of logic, the threats to human rights and to medical practice. Both abortion in general and selective abortion in particular involve the assignment of relative rather than absolute value to human life on the basis of some social criteria; hence both establish precedents which violate fundamental principles of justice as we have understood those principles in Western society.

Nonetheless, if the basic logic of selective abortion does not differ from that of abortion in general, it is focused and reinforced here in a way which makes its implications more striking and perhaps more threatening. As Kass suggests, precisely because of the quality of the fetus is at stake in the decision for selective abortion, this decision undermines the fundamental moral equality of all human beings. Further, the practice of prenatal diagnosis adds something to this equation: the deliberate institution of medical programs designed to foster selective treatment of human life. Friedmann captures the truth well in his haunting statement that prenatal genetic diagnosis seems at first no different from most other new diagnostic methods. Now we see that we are faced with problems of assigning values to individuals and designing programs directed against them.

For all these reasons, I submit that the current practice of prenatal diagnosis and selective abortion threatens basic human rights and I urge practitioners to reconsider the implementation of widespread programs of diagnosis and abortion. Prenatal diagnosis is indeed a very exciting new technology with many potentially beneficial uses in providing "therapy" for the afflicted fetus and help to anxious parents. These justifiable uses should not be overshadowed by allowing it to become strictly an exercise in selective abortion.

Violate Equality

Even more than abortion on demand, it seems to me, selective abortion embodies principles of unequal treatment which violate the fundamental moral and legal equality of all human beings. In the long run, this violation of fundamental rights of equal treatment is a more serious threat to the quality of life of all of us than the birth of numerous children with defects will ever be. I am heartened by the seriousness with which this matter has been taken in general both by parents and by physicians; nonetheless, it is a dangerous move to aid parents by eliminating their children. We must beware of the implications of moving to a "quality of life" ethic in which persons are judged according to their social utility and hence "some are more equal than others."

But perhaps it will be objected that in view of the recent Supreme Court decisions on abortion, physicians really have no choice: Does not the woman now have a right to an abortion, and if so, does the medical practitioner have any choice but to offer prenatal diagnosis and selective abortion?

Admittedly, the Supreme Court's decisions are ambiguous. The Court declares that the "right of privacy" established in the Constitution is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy," At the same time, however, the Court also maintains that "the abortion decision is "inherently, and primarily, a medical decision," and at all points it appears to give the decision-making power to the physician: "The abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." Thus it is not clear that physicians must comply with the demands of the woman; there appears to be room for "medical judgment" in all cases, and especially in cases involving late abortion. Minimally, physicians can choose to make a true "medical judgment" regarding the woman's "life and health" in each case, and not simply to allow the very presence of defect to be considered sufficient justification for abortion without further consideration of the "full setting of the case."

Finally, it seems to me that all of us, physicians and lay persons alike, have a responsibility to women and families to provide the emotional and financial support needed to enable families to care for children born with defects; although I discourage widespread prenatal diagnosis and selective abortion because of the serious threats to basic freedoms involved in this practice, I do not think the matter is settled morally by rejecting abortion. The birth of a child with a defect can indeed be a shattering experience for a family; it is the responsibility of all of us to ensure that families are provided with adequate resources. Ironically, as I write this, federal funds for many supportive programs are being curtailed; this we must not allow to happen.

If indeed the strength of a people can be measured by their attitude toward the weak, the defenseless, and the outcast, then selective abortion points to the weaknesses in our society and in ourselves. It seems appropriate, therefore, to close with a word of warning offered by Ralph Potter:

When a fetus is aborted no one asks for whom the bell tolls. No bell is tolled. But do not feel indifferent and secure. The fetus symbolizes you and me and our tenuous hold upon a future here at the mercy of our fellow men.

(References available on request.)

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