Unfinished feticide: the ethical problems

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Author’s abstract

Dr Jansen’s paper raises three main issues. The one with which he himself is most concerned is the question of which methods of abortion are ethically right, and whether methods which risk the birth of a damaged baby are wrong. But there are two others: first, how the (originally unintended) birth of a live but damaged child alters the moral situation, and secondly, whether the overcoming of sterility by inducing a multiple pregnancy in which some of the fetuses have to be killed in order for any of them to survive is at all morally acceptable.

One of the most interesting things about Dr Jansen’s paper is that the three cases he discusses all raise different ethical issues. Indeed, the first case, that where the attempt to induce a late abortion leads to the birth of a live child, but one certainly premature and possibly damaged, raises two issues: what it is now best to do for the child, and whether methods of abortion that run this risk should be avoided.

Essentially, the first issue is the problem that arises when any very premature and/or damaged birth occurs: should everything possible be done to help the child to live, or should the decision depend on an assessment of whether the child is at all likely to have a worthwhile life? (There is also the question whether, if the second view is taken, the law should be changed to permit infanticide under some circumstances.) The crucial point, indeed, is precisely the irrelevance of the fact that the situation has arisen because of an attempted abortion. If the abortion was being carried out for the sake of the child, the whole situation still needs to be reconsidered now that it is actually born. If it was for the sake of the mother, either this was on utilitarian grounds, as being overall for the best, or it was because she was held to have a right to an abortion. On the first view, again, the child’s birth requires a reconsideration of the situation, in which the mother’s rejection of the child (if she still does reject it) is only one factor among many affecting the question of whether the child’s life will be worthwhile. On the second view, the situation is even clearer: a woman may have a right to an abortion, but she certainly has no right to decide whether her child, once born, should live or die. Hence, the crucial ethical question concerns the obligations of the medical staff to the infant, and it is the same question that arises with any very premature birth.

The other question concerns methods of abortion: should this situation be avoided by the use of methods which kill the fetus before it is expelled? The problem here is that there is one ethical view – put forward by Judith Jarvis Thomson (1) – that a mother has a right to expel a fetus from her body, but no right to kill it, if it is possible to detach it alive. It has also been recently argued in this journal by Lilford and Johnson (2) that of the two methods of abortion which do kill the fetus in the womb, intra-amniotic hypertonic saline infusion is ‘outdated’, and surgery is, other things being equal, ‘morally worse’ than a drug-induced abortion both because of the greater emotional distress it causes and because of the ‘symbolic significance of manual fetal destruction’. Furthermore, the likely future trend seems to be towards increased use of prostaglandins and mifepristone, partly for these reasons.

An appropriately cautious conclusion might be that the whole issue of which methods of abortion are ethically preferable (given that a choice is available) needs rather more consideration, and that one factor to be considered, with regard to late abortions, is the risk of the abortion being incomplete and a live but damaged child being born as a result. But the points made above indicate that this is only one consideration among many, and it may well not be conclusive. Finally, we should note that all these considerations apply to Dr Jansen’s second case, where ‘a change of heart takes place after abortifacient drugs are taken, and the abortion does not proceed’, the disadvantage of a drug such as mifepristone being precisely that there is ‘an interval of time between administration of the abortifacient and occurrence of the abortion’, during which the woman may change her mind, with the consequent risk of an abnormal child.

Dr Jansen’s third case is the abortion of one or more of several fetuses in a multiple pregnancy. This may be done for one of two reasons. The first is that it may happen that one twin is seriously abnormal and the
other normal, so that it is thought desirable either to remove the abnormal twin by hysterotomy or to kill it in the womb, with the result that it is born dead. The ethical problems here are first, the general problem of whether it is right to perform eugenic abortions, and secondly, the fact that there is a risk, as Dr Jansen points out, of inadvertently damaging the normal twin. As he rightly points out, from the point of view of the safety of the normal twin, it would be better to change the law to permit infanticide of the abnormal neonate.

For anyone who believes that abortion of an abnormal fetus is right or justifiable, there is a serious problem here. Neither to advocate infanticide, nor to do nothing and allow an abnormal child to be born, nor to put a healthy child at risk is a very attractive option. Perhaps the issue is again one of methods, of which method of aborting the abnormal twin is least likely to harm the healthy one.

The second reason for selective feticide is the reduction of the number of fetuses in a high multiple pregnancy: the justification for this is that without selective feticide all four or more fetuses will probably die, whereas two or three have a reasonable chance of survival. If this is really the case, it is hard to see why the procedure is not ethically right, except for those who would see the deliberate taking of innocent life as always forbidden, whatever the consequences. But there is a serious ethical question as to whether the situation should arise in the first place, since many of these multiple pregnancies are induced by various types of medical treatment to overcome sterility. It may indeed be true that the most efficient way of guaranteeing that a previously sterile couple have children is to induce a multiple pregnancy and then kill some of the fetuses; but it may also be true that this particular method is so morally objectionable that other methods, even if less efficient, should be preferred.

I conclude that Dr Jansen’s paper raises, either explicitly or by implication, three very important moral issues. The first is the fact that a birth, under whatever circumstances, creates a new moral situation, and always requires a moral reconsideration. The second – the one with which he himself is most concerned – is that the ethical question of which method of abortion to use needs much more consideration, and one very important element in this is the risk of an incomplete abortion resulting in a damaged baby. The third is the question whether inducing multiple pregnancies, with the consequence of selective feticide becoming necessary, is ever in fact either needed or desirable. It is to be hoped that all three will be further discussed.

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References
