

Unfinished feticide: a legal commentary

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Author's abstract

Jansen expresses concern as to the legal implications of both selective reduction of pregnancy and unsuccessful attempts at termination of pregnancy using mifepristone. This commentary examines the legality of both procedures and concludes that Jansen is over-optimistic in his belief that neither procedure is likely to fall foul of the criminal laws on induced abortion. By contrast his anxieties about civil liability arising from the subsequent live birth of a damaged infant are, it is suggested, unnecessarily pessimistic. Such an action is most unlikely to succeed if brought by the infant herself and any claim on the part of the mother will normally be dependent on proof of negligence. The commentary focusses on the law in England with relevant references to other common law jurisdictions.

Robert Jansen's interesting, if disturbing, paper addresses professional anxiety about possible legal implications of unfinished, unsuccessful feticide. Is there a significant risk that a medical practitioner who unsuccessfully attempts selective reduction of pregnancy will be held liable to the parents or to a damaged neonate? When mifepristone, the 'abortion pill', fails to achieve its lethal purpose and some months later a damaged baby is born may a wrongful birth or a wrongful life action ensue? Attempts at selective reduction and the use of mifepristone share a capacity to generate litigation where the procedures fail to destroy the fetus and produce a living, damaged infant. To the lawyer though the distinctions between the legal implications of the two procedures are such that each procedure must be considered separately.

Is selective reduction a crime?

Jansen considers it unlikely that the criminal law would be invoked to prevent selective feticide 'given society's acceptance of induced abortion'. He is perhaps somewhat over-optimistic in his diagnosis. Two questions must be addressed. Is selective reduction a contravention of the legal rules prohibiting destruction of the fetus? If it is, is it a procedure which

falls within the permissible grounds for the termination of a pregnancy? The lack of clarity in the legal rules surrounding selective reduction arises in part from the fact that those rules were formulated when the possibility of destroying selected fetuses, allowing siblings to survive to term, was undreamed of. Thus laws in the English-speaking world are directed at prohibiting inducing miscarriage or terminating pregnancy. Indeed the common law has often avoided conferring direct rights on fetuses, preferring such rights to be contingent on live birth and declaring that until birth the fetus has no legal personality (1). The key issue in England is whether a procedure directed only at selected fetuses is an act done '... with intent to procure a miscarriage' contrary to section 58 of the Offences against the Person Act 1861. If as is the case, there is no expulsion of the fetus can there be said to be a 'miscarriage'? Over-technical interpretation of the words of a statute should be avoided, particularly a statute enacted in 1861 when knowledge of the process of fertilisation and implantation was rudimentary. The evil at which the 1861 Act was directed was the killing of the fetus. As John Keown (2) and David Price (3) have argued, any act designed to prevent the continuing development of the fetus and its live birth falls foul of the 1861 Act. And in Australia (4) such an interpretation of section 62 of the Crimes Act 1928, similarly worded to section 58, has found judicial support.

Another argument seeking to place selective reduction beyond the boundaries of the criminal law regulating induced abortion is that the destruction of selected fetuses does not terminate the pregnancy. Where, as in England, the primary legislation prohibits inducing miscarriage, the question of whether the pregnancy as such is terminated is irrelevant. Indeed in England the use of the term 'inducing miscarriage' in the 1861 Act, which prohibits abortion, but the term 'terminating pregnancy' in the 1967 Abortion Act, which sets out grounds for lawful termination of pregnancy, creates a Catch 22 for selective reduction. If the 1861 Act prohibits destruction of the fetus, and the 1967 Act sets out grounds for the lawful termination of pregnancy, it has been cogently argued that incomplete termination is beyond the scope of the 1967 Act thus selective reduction can never be other than a criminal act (3).

Key words

Feticide; abortion.

However, to suggest that the 1861 Act must be construed in the light of its general purpose, and the 1967 Act be interpreted literally, is somewhat unreasonable. And I would consider that while selective reduction is caught by the criminal law the procedure falls within the 1967 Act if the grounds therein can be satisfied.

Where selective reduction is designed to destroy a handicapped fetus then in England at least the legality of that operation seems relatively unproblematic. A substantial risk that the child will be seriously handicapped is a lawful ground for abortion under section 1(1)(b) of the 1967 Act. If a multiple pregnancy threatens the physical or mental health of the mother, selective reduction must be justifiable under section 1(1)(a) of that same Act. The grey area lies where, as will usually be the case, the procedure is carried out to enable the other fetuses to survive. The Abortion Act of course permits termination where the continuance of the pregnancy jeopardises the health of 'existing children' of the family. On current legal principles the fetus does not qualify as an existing child endowed with legal personality and rights of its own. And attempting to argue that fetuses A and B are existing children whose health, even life, must be preserved by destroying C and D causes some philosophical and semantic difficulty. If A and B are children so are C and D and the common law has always asserted that it is unlawful to kill one person to save the life of another (5), save in self-defence.

The overwhelming probability is that selective reduction of pregnancy in England constitutes criminal abortion and can be lawful only on grounds specified in the Abortion Act and in accordance with the procedures required by that Act. The reality is that the criminal law regulating abortion was never designed to cope with the ethical problems inherent in selective reduction. Jansen may in the event be right that the criminal process will not be invoked. This is not because selective reduction is lawful but because prosecutors will shy away from the minefield of legal problems posed by the procedures, and legislators are unwilling to confront the moral problems thrown up thereby.

Will unsuccessful feticide result in tort liability?

If Jansen is over-optimistic about criminal liability, he is probably too pessimistic about the spectre of tort liability. Should a damaged neonate survive, true his parents may seek compensation for the cost to them of raising a handicapped infant, for his wrongful birth, and the infant may seek damages for wrongful disability or wrongful life. But either potential claimant will have to establish that the failure in the procedure and the damage to the fetus was negligent. In England, and many other English-speaking jurisdictions the test of negligence is very 'doctor friendly'. Did he fail to comply with a responsible body of medical opinion (6)? Only the negligently unsuccessful feticide will attract tort liability. Jansen speaks of the attempted feticide as

an assault on the fetus. That is very unlikely to be the case, if the procedure is lawful under the relevant jurisdiction's abortion laws, and is consented to by the mother. Otherwise every attempt at abortion could be prohibited by injunction as a threatened assault. In England the position is crystal clear. The Congenital Disabilities (Civil Liability) Act 1976 grants a child the right to sue in tort for pre-birth injuries only where it is injured as a result of a tort against the mother. There can be no question of an assault on the mother in such a case.

Liability is engaged then only if the practitioner is negligent. Should he be found negligent then he will be liable to the parents for their loss. A gynaecologist who negligently and unsuccessfully attempted an abortion of a young woman disabled by polio was held liable for the cost to her of raising the ensuing child as long ago as 1979. The court dismissed argument that as a matter of policy actions based on failed abortion should not be allowed (7). Where the procedure damages the child causing disabilities which would not otherwise have been present, the doctor will also be liable to the child for his wrongful disability. However, where the essence of the claim is *not* that the procedure disabled the child, but that it destroyed the wrong child, thus allowing the disabled fetus to survive, legal liability is more problematic. The disabled baby claims compensation for his wrongful life; he asserts that but for the doctor's negligence he would never have been born. In England the Court of Appeal (8) has ruled that claims for wrongful life are not actionable. And the preponderance of jurisdictions adopt a similar stance holding that it is not possible to place a monetary value on the difference between impaired existence and non-existence. Only in a limited number of jurisdictions (9), notably in a few States in the USA, is a doctor at risk of a wrongful life suit.

The 'abortion pill': safe for the doctor?

Mifepristone, the 'abortion pill', if used in compliance with abortion laws is unlikely to raise any question of criminal liability. Jansen asks though what legal consequences follow if the drug is taken, the fetus is not expelled and the mother refuses a surgical abortion to complete the procedure. Once again liability to mother or child can follow only if negligence is proved. The essence of an allegation of negligence is likely to be a failure by the doctor to obtain the mother's 'informed consent' to the administration of mifepristone. She may contend that (a) the risk of damage to the fetus was never fully disclosed *and* (b) the failure rate of the drug and the consequent need for surgical abortion was not adequately explained. In England the practitioner, in answer to such allegation, need only show that he gave that degree of information which a responsible practitioner would judge necessary (10). In Canada (11) and certain States of the USA he must meet the higher 'prudent patient' standard (12).

Administration of mifepristone without adequate counselling of the risk inherent in the drug and

consequent need for surgical abortion is likely to engage legal liability. In England any undertaking by the patient to agree to surgical abortion is as such unenforceable. But such an undertaking is unnecessary if proper consent has initially been obtained from the mother. However, should negligence at the initial stage be proved, could the mother's subsequent refusal of surgical abortion be regarded as contributory negligence thus reducing the award of damages against the doctor? In England it may well be that such a refusal would not constitute contributory negligence. If the possible need for later surgical abortion was not made clear from the outset, a court might be unwilling in effect to penalise a patient who has been misled. And in any case, as the alleged negligence by the mother did not contribute to the relevant disability but only allowed the birth of the infant, any contributory negligence on her part will not go to reduce the child's claim (13).

Conclusions

Gynaecologists are right to be concerned about the legal implications of selective reduction and the 'abortion pill'. Nevertheless the lack of clarity in the law may save them from much actual litigation. Attempting to 'bend' rules never designed to deal with either procedure benefits no one, but what legislature

will have the courage to confront the ethical and legal problems of modern abortion techniques directly?

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References

- (1) See *Paton v BPAS* [1979] QB 276; *C v S* [1987] 1 All ER 1230.
- (2) Keown J. Selective reduction of multiple pregnancy. *New law journal* 1987; 137: 1165.
- (3) Price D P T. Selective reduction and feticide: the parameters of abortion. *Criminal law review* 1988: 199.
- (4) See *R v Trim* [1943] VLR 109 at 112.
- (5) *R v Dudley and Stephens* (1884) 14 QBD 273.
- (6) *Bolam v Friern HMC* [1957] 1 WLR 634.
- (7) *Scuriaga v Powell* (1979) *Solicitors' journal* 1979; 123: 406.
- (8) *McKay v Essex AHA* [1982] 2 All ER 771.
- (9) Giesen D. *International medical malpractice law*. London: Kluwer, 1988: 478–481.
- (10) *Sidaway v Royal Bethlem Hospital* [1985] AC 871.
- (11) *Reibl v Hughes* (1980) 114 DLR (3d) 1.
- (12) See reference (9): 478–481 and also para 575 *et seq*.
- (13) Brazier M. *Medicine, patients and the law*. Harmondsworth: Penguin, 1987: 167–168.