

The disposal of the aborted fetus – new guidelines: ethical considerations in the debate in Sweden

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Authors' abstract

During the 70s and 80s ethical debate concerning the fetus became intensive. The great advances made in medical technology and research and improvements in prenatal diagnosis as well as in embryological research have led us to believe that the fetus is an individual with recognised claims to protection. In Sweden the aborted fetus has previously been considered merely as a risk-disposal problem, equivalent to dangerous and infected material and there have been no specific guidelines for the treatment of the fetus after abortion. In July 1990 treatment of aborted fetuses was changed with the general guidelines from the National Board of Health and Welfare. The present paper sets out the main contents of the guidelines and discusses the gradually changing views concerning the status of the human fetus in Sweden, as well as the public debate which has been a contributing factor to these changes.

Introduction

Questions concerning the beginning and end of life have always been an integral part of medical ethical debate. During the eighties the fetus became the central subject in a more intensive debate. The great advances made in medical technology and research and the improvements in prenatal diagnosis during the 70s and 80s form the basis for this intensification. Embryological research has led us to believe that the fetus is an individual with its own reactions, even though it is totally dependent on the mother (1).

But the current debate also clearly touches on several important philosophical problem areas such as the beginning of human life, the borderline between conscious and unconscious life and whether the principle of respect for persons can be applied to a fetus.

In the UN Convention on the Rights of the Child, it is said that: 'The child, by reason of his physical and mental immaturity, needs special safeguards

and care, including appropriate legal protection, before as well as after birth' (2).

The heightened concern for the status of the fetus also raises certain substantial and practical problems: how should we deal with the aborted fetus? How should our hospitals handle this issue?

The question is relatively unproblematic if the fetus is considered as a waste product generated by the normal activities within the health care system, analogous to an amputated limb. But if the fetus is considered as a developing human being, the issue takes on a different character. Then it is pertinent to ask about the ethical and other values underlying our treatment of such fetuses.

In Sweden the aborted fetus has, until quite recently, been considered merely as a risk-disposal problem, with the fetus equivalent to dangerous and infected material, and there were no specific guidelines for its treatment after abortion. With the general guidelines from the National Board of Health and Welfare, July 1990, treatment of aborted fetuses has been changed (3). The purpose of the present paper is to set out the main contents of the guidelines (SOSFS 1990:8) and to discuss the gradually changing views concerning the status of the human fetus, as well as the public debate which has been a contributing factor to these changes.

Background

Why have we had this process of change? The current Swedish law on abortion came into force on January 1st 1975. The essence of the law is that if the pregnant woman decides, after mature consideration, that she wants to abort her fetus, then she shall be allowed to do so before the end of the 18th week. If an abortion is deemed necessary after the 18th week of pregnancy, then permission from the National Board of Health and Welfare is required. An abortion may not be carried out if it is considered that the fetus is viable. Pursuant to current practice, no abortion is permitted after the 22nd week of pregnancy.

During the 60s and 70s, prior to the abortion legislation, ethical issues concerning vulnerable life, including the fetus, became the subject of intensive

Key words

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interest (4). New methods, ie ultrasound, amniocentesis and chorion villus biopsy, created ethical, psychological and legal dilemmas and at the same time emphasised the unique character of the fetus. In the 80s, with ever-increasing advances in fetal diagnostic technology and the possibilities of discovering ever more diseases and deformities in the fetus, current procedures for dealing with the fetus together with other risk-disposals from the hospital were increasingly experienced as ethically offensive.

A first step in the creation of a new approach was a change in legislation in 1982, with the intention that cremation of a stillbirth, deceased before the 28th week of pregnancy (no lower limit was indicated) could take place without a certificate of cremation, if a doctor's certificate was presented to the administrator of the crematorium.

Before the change of legislation in 1982 it was only possible to bury or cremate that which was defined as a dead child. From a legal point of view a clear definition is indispensable. According to the law a human being born after the 28th week of pregnancy is a child, even if stillborn. Any human being, who at birth shows signs of breathing, heart activity, or pulsations in the umbilical cord, is medically defined as a liveborn child, even if born before the 28th week of pregnancy. Fetuses showing no such signs at birth before the 28th week of pregnancy are defined as spontaneous abortions.

These distinctions reflect the medical-technical resources of neonatal care in Sweden at the time of the legislation. The 28th week coincided with the time when the fetus was supposed to be viable, where viability was understood as ability to survive outside the uterus given appropriate intensive care (5).

The 1982 legislation was important but incomplete for there were no concomitant changes in other regulations, needed to adjust practical routines. But the most important reason why the change was relatively ineffective was psychological. There was a silent and perhaps unconscious reluctance to acknowledge the change in approach. The situation was delicate and very few wanted to bring the underlying conflict into the open.

Furthermore, the change was not mandatory. The pertinent paragraph was worded so that it only became applicable when someone explicitly demanded the kind of treatment it permitted. But very few people at that time were aware of the options. Thus the new possibilities were very sparsely used.

The 1982 law did, however, overcome some of the worst effects of the pre-existing legal situation, which had sometimes had remarkable consequences. Thus: suppose that in a twin pregnancy one twin was born alive but died shortly after birth while the other twin died in the uterus. If this occurred before the end of the 28th week of pregnancy, the dead intrauterine twin would not have been defined as a human child and therefore could not be buried or cremated at the

crematorium. On the other hand irrespective of when it was born, the other liveborn twin would be entitled to cremation or interment.

If the parents in the case stated above wanted both twins to be buried, there would have been great difficulties. Even though they would probably have seen both the dead twins after the delivery, and would probably not have been able, psychologically or emotionally, to discern any morally relevant difference between them, nevertheless the earlier legislation made no exceptions, and would have prevented both being buried or cremated together.

However, the 1982 legislation did not greatly influence attitudes or behaviour in regard to the aborted fetus. Yet as several official reports published in Sweden dealt with the ethical and legal status of the fetus, a gradual change of view regarding the fetus became obvious. A decisive change was indicated in the additional terms of reference to the Committee of the Swedish Government official report on (artificial) insemination. In its third report of April 1987 the committee, which had by then adopted the name, The Committee of the Unborn Child, took into consideration questions on the protection of the unborn child (6).

The National Board of Health and Welfare is a governmental board under the Ministry of Health. In the general guidelines from the board, *Risk-disposal within the Health Care System* (7), aborted fetuses are mentioned in addition to 'tissue from human beings or animals and dead experimental animals' as 'biological materials', that are classified as risk-disposal.

The Committee of the Unborn Child implicitly rejected this view of the fetus. In the committee's final report, *The Pregnant Woman and the Fetus - Two Individuals* (8), it is clearly stated that 'the mother and the prospective child are two separate individuals, both of whom are deserving of protection . . . 'The developing human life has a great intrinsic value. It cannot be viewed purely as a part of the woman's body.'

From 1986 to 1988, the question of the treatment of the aborted fetus was thoroughly debated in the Swedish Parliament (9).

In the late 80s some hospitals tried to develop their own routines in order to give the aborted fetus a more respectful form of treatment. One of the first hospitals in Sweden to initiate the alternative treatment of the fetus was Örebro Medical Center Hospital, where routines were introduced in October 1986. This became a model for a number of hospitals in Sweden and the new routines constituted a framework for the multidisciplinary committee which was set up in the autumn of 1988 by the National Board of Health and Welfare to elaborate guidelines for taking care of fetuses after abortion.

To ascertain the current state of affairs the committee started its work with an inquiry among all of the 93 general hospitals in Sweden. At approxi-

mately 30 of them only early abortions (≤ 12 th week of pregnancy) were performed or, alternatively there were no abortions done at all.

At 16 of 63 hospitals performing late (13th to 22nd week) abortions, the routine of cremating all fetuses from induced as well as spontaneous abortions had been implemented. Some other hospitals reported that they would change over to new routines within a short time. A majority of the 63 hospitals also replied that in cases where the woman or the couple had expressed special wishes concerning the treatment of the aborted fetus, such wishes had been taken into account, for instance by having the medical social worker or the hospital chaplain help the couple to make the necessary contacts to arrange for interment.

Thus it appears that at 16 of the 63 hospitals where late legal abortions appear, special routines that were roughly similar had been initiated for the treatment of fetuses from late abortions. It was clear from the answers to the questionnaires from those hospitals where such routines had been initiated, that they worked well. Both patients and health care personnel clearly regarded this as an improvement compared to previous routines. Other hospitals signalled awareness of the need to improve their routines and also a need for national guidelines.

The recommendations of the working group have as a premise that a fetus which it is possible to recognise as being human should not be regarded as risk-disposal. If this view is accepted, there is no alternative to cremation within the current health care system. As the ashes must be taken care of, the anonymous interment or spreading at the cemetery without any ceremonies or formalities has been regarded as an acceptable and worthy act.

The National Board of Health and Welfare also stresses that all information to the woman or couple concerning the treatment of the fetus should be given on her or their conditions. This means that it is for the woman or couple to decide whether she or they want any information about, or to take part in, the actual after-care.

The guidelines from the National Board of Health and Welfare

The guidelines emphasise the importance of considering the individual woman's or the couple's situation and special needs. Frequently, in the case of spontaneous and also in some late legal abortions, it might be necessary to discuss the treatment of the aborted fetus with the woman or the couple. We assume that the later the abortion is, the greater the need for discussion. The woman or parental couple should therefore have the opportunity to express special wishes, either to replace or supplement the ordinary routines.

The head of the department of obstetrics and

gynaecology is responsible for informing the health care personnel involved about the routines in the treatment of aborted fetuses and also of the procedures to be used when informing the patients. It is presumed that each hospital will come to an agreement with the authorities of the crematorium concerning the routines for taking over, and for further treatment of, the fetus.

The guidelines of the National Board of Health and Welfare for handling stillbirth fetuses from late abortions (> 12 w) are as follows:

- 1) The fetus is sent from the department of obstetrics and gynaecology to the pathology department together with a doctor's certificate. If a pathological/anatomical investigation is required a note of admission shall be enclosed. This step should be noted in the woman's records. At the pathology department the fetus is allotted a sequence number, which is also noted in the doctor's certificate. This is filed at the pathology department.
- 2) The fetus is kept for some time (2–4 weeks) at the pathology department, so that the woman or couple may have time to express special wishes or requests concerning its treatment.
- 3) A doctor's certificate, with a code number, accompanies each fetus at the time of the transport to the crematorium. At this point it is no longer possible to identify the woman.
- 4) The fetus is cremated and the ashes are buried or spread anonymously in the cemetery. There should be a possibility of cremation and interment in a non-anonymous grave, if so desired by the woman or the couple. From an ethical point of view all abortion disposal should be treated in the same way, but as parts of the fetus usually cannot be identified at early abortions, the guidelines suggest no change in the treatment of early aborted fetuses (\leq week 12). But when parts of the fetus can nevertheless be identified, the same procedure as in late abortions should be used. In those cases where the woman or couple request a special treatment, that special treatment should be available. This implies the same kind of routines as at late abortions.

Discussion

The new Swedish rules concerning the treatment of the aborted fetus gave rise to an extensive debate during which many ethical issues came to the fore. The sensitive nature of the subject in question caused many to believe that the debate was both misguided and emotional. Not unexpectedly, the introduction of the new rules brought to light more fundamental ethical questions: How should the fetus, living or dead, be regarded? What kind of protection is the fetus afforded, in law or in the prevailing ethical consensus? At what point in its development should it be regarded as a person (10)? Much of the debate focused on the pregnant woman

and on women's reactions to the proposal, as well as how both health-care personnel and society at large felt about the problem.

The Catholic ethic as well as the Geneva Declaration states that we have full moral duties to protect the fetus from conception. The contrary point of view states that there are no such duties until before the 23rd week. Somewhere between those two beliefs is a 'grey-zone'. Swedish law permits free abortion up to the 18th week, but after the 12th week the woman is offered the opportunity of talking to a medical social worker. After the 18th week the decision for abortion is taken by the National Board of Health and Welfare. This means that the fetus is accorded an increasing value even when abortion is permitted.

In our opinion, the value of the fetus has many dimensions. In the first place it has an intrinsic value which is deeply rooted in life itself and which is not dependent on its degree of development or autonomy. But the fetus also has an instrumental value, above all to the woman whose experience of it is primarily dependent on its size and development.

Criticism of the new rules has been based on three points:

- 1) Many have argued that in practice the new rules take the side of the fetus and give it a moral value, without the changes having been preceded by an extensive moral-ethical discussion. Some gynaecologists believe that the new rules mean they will have difficulty in not regarding abortion as murder. Several women debaters and women's organisations asserted that the motion had been accepted without discussing the many problems, especially the ethical problems, which could arise. If the fetus was given the same value as a person it would mean a change of view regarding abortions.
- 2) Among the many critics were gynaecologists, who stressed that the new rules gave women requiring abortion an increased sense of guilt. They received heavy support from women's organisations. Both groups believed that women seeking abortion under the new rules would be more prone to self-reproach and increased psychological stress.
- 3) A third question that turned out to be controversial was founded partly on a misunderstanding. It was thought that taking care of the aborted fetus necessarily included a funeral before the ashes were buried in a memorial garden.

In conformity with what we have said above, it is our belief that the value of the fetus, even in the early stages of pregnancy, implies a duty for those involved to treat an aborted fetus with dignity. The new rules that are now in force in Sweden meet this requirement.

From the point of view of society the new rules thus entail an important decision in regard to a fundamental question of ethics which, as we see it, out-

weighs the possible discomfort that some women may experience. We have difficulty in understanding that the current criticism has support in reality and that the rules could decisively increase the feelings of guilt and psychological reactions which often go hand in hand with the carrying out of legal abortions. It is important to emphasise that the amended treatment applies only to late abortions which in Sweden are in the region of 250 to 300, out of a total of 38,000 legal abortions annually. Only those women who explicitly demand to know how the aborted fetus will be treated, will be given this information. Otherwise it is up to health care personnel to decide if information is to be given. Nevertheless we believe that it is in everyone's interest that there is access to information for those who require it, especially those women who have lost a longed-for child through a spontaneous abortion.

It is now an accepted fact that many of the personnel engaged in abortions have great difficulty in accepting the fetus as waste. Even the operation itself causes troubled minds, and this is aggravated by nonchalant treatment of the aborted fetus. There is no reason to doubt that the amended rules for the treatment of the fetus have been experienced as a great relief by health care personnel. Such points of view have weighed heavily in establishing the new rules.

The new rules mean that society has taken a stand in favour of dignified treatment of the aborted fetus, and we believe this to be both important and right. We have difficulty in believing that this will affect the rules pertaining to abortion as applied in Sweden today. That the new rules and guidelines will continue to be discussed and possibly questioned in the future will depend not only on the fact that improved treatment of the fetus has become reality but also on the progressive debate on the rights and protection-level of the fetus.

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