Society's interest in protection for the fetus

Editorial

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Kenneth M. Flegel, MD, MSc

Dr. Flegel is a practising internist at the Royal Victoria Hospital, Montreal, Que., and is an Associate Editor of *CMAJ*.

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The primacy of the person is a central tenet of Western civilization. In medicine this person-centred ethic is enshrined in the principle of individual autonomy, by which we understand that each person is free to make decisions and choices based on the values to which he or she is committed. At the societal level this primacy is acknowledged in the recognition of human rights.

Human rights constitute the touchstone of a mature and democratic society. Whereas human rights only make sense in the context of society (they would be unnecessary for a solitary person), protection of these rights is typically provided at the level of the individual person because rights are most often usurped from individuals or from the small groups to which they belong. The recognition of the rights of the most vulnerable members of a particular society is a measure of the degree to which that society has evolved.

The value we place on the life of each person has implications for our attitude about our arrival in the world and our departure from it. The latter is the subject of vigorous debate and interest at present, viz. the issues of assisted suicide and euthanasia. The range of discussion about dying is great, covering issues from personal values and choices to social attitudes and norms. When it comes to our arrival, the discussion is dominated by the abortion debate: the autonomy of the mother (freedom of reproductive choice) versus the beneficence owed to the fetus as a dependent moral being (the right to life). In this debate the absence of a component that addresses the interests of society may be explained by the fact that, until birth, the fetus is not considered an autonomous person and therefore cannot benefit from human rights. In contrast, a dying person, no matter how diminished, is still considered a person who potentially can benefit and therefore has these rights.[1] Full legal protection for the latter and none for the former is, nevertheless, disproportionate because the dying person has little life in prospect, whereas the fetus — particularly a third-trimester fetus — has full potential life.

Abortion in Canada is not subject to more than voluntary surveillance. Although the number of abortions performed in hospitals appears to be stable, we cannot know with any certainty that this is true for all abortions because those done in freestanding clinics are not routinely reported; some provinces do not report at all.[2] If hospital statistics are an accurate guide, the trend appears to be toward performing more early abortions, that is, before 13 weeks gestational age (Table 1). The rate of late abortions (after 20 weeks) has not, however, shown any decline. Virtually all of these late abortions are being done for women under age 40.[2] We do not have any information in this country about abortions after the gestational age of viability — 24 weeks — so-called very late abortions. Experience elsewhere suggests that some must be being done in Canada. In 1994 in the United Kingdom, 81 abortions were performed after 24 weeks for a rate of 1.2 per 10 000 live births.[3] For the same year in the Netherlands, the equivalent rate was 6.5 per 10 000 live births.[3] A reasonable guess based on our population is that at least 40 very late abortions are performed in Canada each year.

Does society have an interest in protecting the individual fetus? I believe that the following hypothetical case illustrates that it does. A young couple is eagerly anticipating the birth of their first child in 2 months' time. A clever biochemist, Dr. B, has developed a pill that causes only fetal death. Dr. B happens to have a grudge against this particular couple. At a social gathering, she slips the pill into

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the mother's sparkling water. The fetus dies in a few hours. The mother is unaware of the death and has a normal labour and delivery at term, suffering no ill-effects . . . except that her fetus is stillborn. Suspicion of evil-doing leads to an investigation. Though a brilliant scientist, Dr. B is less gifted as a criminal; it is determined that she had motive, means and opportunity. A search of her home uncovers the pill-making apparatus and a memorandum of evil intent. In present Canadian law, however, Dr. B could not be charged with any crime against the fetus, as she has not violated the rights of another *person* (although the mother could pursue Dr. B for her own suffering at the loss of her firstborn).

The foregoing hypothetical case of feticide is the counterpoint to pregnancy termination with the sole purpose of birth control. At the moment the only determinant of whether termination is considered birth control or feticide is the woman's intention. If there is to be an absence of legal protection for the fetus, an absence that is necessary to ensure the right to freedom of choice for the woman, the context is created in which the "noncrime" described above can take place.

As we seem to have moved in Canada to the position that a fetus becomes a person only after live birth, it does not make sense to speak in terms of providing the fetus with rights. But that position is a far cry from saying that the fetus therefore merits no protection. Where should this protection come from? We cannot rely on the current law, as recent cases in Canada illustrate. For example, legal attempts failed to find a woman culpable of harm against her fetus even though substance abuse had been proved.[4] In another case, a mother claimed to be unaware that she was pregnant when she attempted suicide and inadvertently shot her unborn fetus. Although a charge of attempted murder of the fetus was quashed,[5] she eventually pleaded guilty to a lesser charge of failing to provide the necessaries of life because she did not inform her physician about the possibility of the pellet lodged in the brain of her safely delivered child.[6]

Abortions in Great Britain and the Netherlands are subject to legal regulation. These countries are, nevertheless, among the few in Europe where very late abortions are practised. Our colleagues appear to have been cautious; the abortions they perform are nearly all done for conditions that would lead to death in utero or shortly after birth or that would necessitate life support after birth and would be accompanied by severe limitations on quality of life (in the Netherlands, the conditions under which very late abortion is practised are similar to those for euthanasia[7]). In both countries, governments have relied on the restraining influence of surveillance, the law and the good judgement of parents and physicians, without much resort to the courts.[3,8] In Canada, we have no assurance that very late abortions are subject to the same constraints.

It is time that we acted to provide the elements of protection that a truly civilized society would make available to one of its future members who is unable to demand this protection, for a society that does not protect its source of life and its potential for the future is failing to act in its own best interest.

Given the divergent views of Canadians on abortion, it is unlikely that by focusing solely on abortion we will find a resolution to the problems posed by it. The absence of adequate surveillance or any kind of control is, nevertheless, about as extreme a position as that of forbidding abortion under any conditions whatsoever. What is needed is an expression of our collective interest in our own origins as fetuses. Acting on that interest requires acknowledgement that it is a human and complex problem about which our views are in evolution. The approach we adopt will have to be at once human and sophisticated, capable of being adapted to our developing understanding. Whatever measures we choose, an expression of the kind of protection we want to provide for a viable fetus would be a good place to start.

Table 1: Number of hospital abortions in Canada and proportion of early and late abortions

Timing of abortion	1975	1980	1985	1990	1995
Early (< 13 wk), %	81.3	86.1	88.9	87.7	87.7
Late (> 20 wk), %	0.2	0.2	0.2	0.3	0.4
Total no. of abortions	49 033	65 243	60 518	71 092	70 549

Source: Statistics Canada.[2]

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Correspondence to: *Dr. Kenneth M. Flegel, Department of Medicine, Royal Victoria Hospital, 687 Pine Ave. W, Montreal QC H3A 1A1*