Early Induction and Late Term Termination of Pregnancy

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Sometimes women who are pregnant are confronted late in pregnancy with the information that the child has a serious abnormality. This may even be described as a condition that is "incompatible with life". They are then likely to be encouraged to have an early induction" in order that they can get over the grief earlier and try again to have a healthy child. The phrase "incompatible with life" is a misnomer for as long as the child is still alive, even if that life may not survive long after birth.

The reality of such procedures, however, are that they are a termination of pregnancy and often enough the child could be born alive. Early induction is only permissible when the woman or the child is at risk because of the pregnancy and the early induction would give reduce grave risks to life for either the mother or the child. Early induction is then not the same as abortion because the aim is to preserve life. The aim should be to continue the pregnancy for as long as is safe for both. Even if the baby will die at or soon after birth, the mother can know that she has done her best for the child. Her grieving can also be helped by that knowledge and the opportunity to hold her child after birth.

The major problem in relation to abortion is a conflict between respect for the rights of the child before birth and the rights of women. That is to say, there is a debate to be had over whether the rights of the woman allow her to override the rights of the child in much the way that Judith Jarvis Thompson argues in her much discussed essay[1] on this topic in which she uses the analogy of the famous violinist being kept alive by a non-consensual sharing of another person's vital organ. The issue of that conflict between the rights of the child before birth and the rights of his or her mother not to be so encumbered are beyond the scope of this discussion of late term termination of pregnancy, because in this case the child can be born alive if there is a problem in continuing the pregnancy.

The matter of late term termination of pregnancy, therefore, is significantly different from abortion. Much more agreement may be achievable than is apparently achievable in regard to first trimester abortion.

Once a stage is reached at which the child is capable of being born alive then the removal of the child from the womb, which would otherwise constitute feticide (the legal term used in the UK late term), becomes separable from feticide or child destruction (the term used in Australia). The child is capable of an independent existence. Delivery and feticide become distinct events, distinct medical choices, even though they may be so contrived as to occur simultaneously. The

[1] Judith Jarvis Thompson "A Defense of Abortion" *Philosophy and Public Affairs Vol 1, No 1 Fall 1971* and reprinted in Peter Singer (Ed) *Applied Ethics* Oxford University Press: Oxford 1987 pp. 37-56

medical, personal, social and jurisprudential implications of this difference are both numerous and manifest. It is these differences that I have chosen to explore because the issue of late term abortion raises significant issues in relation to the possibility of recognising the dignity and rights of those who are not yet rational but are of the kind of being who has the capacity for rationality.

A concern with this is that the moment a positive law deprives a category of human beings of the protection which civil legislation ought to accord them, the state is denying the equality of all before the law. When the state does not place its power at the service of the rights of each citizen, and in particular the more vulnerable, the very foundations of a state based on law are undermined.

"Late term termination pregnancy" refers to termination of pregnancy at a stage when the child would normally be capable of being born alive. The gestational age and maturity at which the latter is so is obviously relative to advances in medical capability and the availability of the technology. Variously late term refers to that period of pregnancy which commences 20-24 weeks after the last menstrual period.

"Late term termination of pregnancy", in practice, also includes feticide as distinct from the "early induction of labour" which is usually used in the circumstances in which a pathological condition endangers the child or the mother during pregnancy and delivery is warranted in order to overcome the danger to the mother, the child or both. A major medical difference when the child is capable of being born alive is the fact that the pregnancy can be ended without ending the life of the child. Feticide is a distinct medical choice and may even be a distinct procedure before delivery (e.g. saline infusion into the uterus), during delivery (e.g. dismembering prior to extraction), or after partial breech delivery (suctioning of brain cavity during delivery - D&X).

The difference between feticide and infanticide is not the age or maturity of the child but whether the death is caused before or after complete birth. Whether there is medical effort directed to preserve the health and life of the child, or whether the procedure is done in such a way as to ensure that life does not continue, is a medical decision (albeit based upon whether the mother has decided that the child should live or die). There are obviously different attitudes within the profession about whether late term termination should properly be considered a medical option. The former US Surgeon General, Dr C. Everett Koop stated in an article in the *New York Times*[2] that with all that modern medicine has to offer, partial-birth abortions are not needed to save the life of the mother, and the procedure's impact on a woman's cervix can put future pregnancies at risk.

Medical and paramedical attitudes to late term termination of pregnancy are likely to be different, not only because the child may be capable of being born alive, but also because he or she will be larger; bone structures will have formed; and there is much discussion in the literature about foetal pain. Response to painful stimulus is evident and there has been much discussion about whether general anaesthesia in the woman would also anaesthetise the child.[3]

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[2] "Why Defend Partial-Birth Abortion? *New York Times* Thursday September 26th 1996

[3] See for instance a survey of specialist opinion "For Debate: Do fetuses feel pain? *British Medical Journal* 313: 7060 (28 Sept 1996) 795-798

The fact that there may be monitoring of foetal heart-beat and foetal movement, and recognition of signs of foetal distress will obviously affect the operating room personnel, particularly if the procedure is being aided by real-time ultrasonography.

In such circumstances there is more likely to be an operating room awareness of the existence of the child. The notion that this is just the removal of tissue is not likely to be sustainable.

There are significant psycho-social sequellae after second trimester termination of pregnancy.

A significant follow-up study of 84 women, in West Scotland, who had had second trimester terminations of pregnancy for foetal abnormality[4] concluded that within the context of continuing medical care, professionals have a responsibility to learn about this new kind of grief and to recognise (keeping the couples' reticence in mind) the signs that may signal a need for professional mental health intervention."[5] That there is such grief warrants exploration of whether there are matters that have been overlooked in the philosophical debate. I return to this matter in chapter five but simply wish to flag its relevance here..

An Oxford study of 71 women who had had termination of pregnancy for foetal abnormality[6] found that in the month after termination of pregnancy, many had high levels of psychiatric morbidity (41%) as determined by a standardised psychiatric interview, which is 4-5 times higher than in non-puerperal (10%) and post-partum women (9%) in the general population. 31% still felt guilty and angry 13 months later. Of the 71 women, about a third saw the baby after the termination, and of those who did not, just under a third had wished that they had. 14% arranged funerals for their babies.

The fact that women following late term termination of pregnancy may wish to see and hold the body of their child, the particular kind of grief, the possibility of a need for a funeral and burial, and the fact (discussed later) that the cause of death (post twenty-weeks) may be required to be certified by the doctor, are all indications that the medical circumstances for the women and presumably their spouses are distinct. There is much more required in the continuing medical management than would seem to be the case for first trimester termination of pregnancy.

There is something of a medical consensus amongst those who accept the practice, that the indications for late term terminations of pregnancy are narrower than for first trimester termination.

The Medical Board of the Australian State of Queensland reports that terminations are performed after 20 weeks for the following indications:

- risk to maternal life

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[4] Margaret C A Whit-van Mourik, JM Connor and MA Ferguson-Smith "The Psychosocial Sequellae of a Second Trimester Termination of Pregnancy for Fetal Abnormality over a Two Year Period" in *Psychosocial Aspects of Genetic Counselling* John Wiley and Sons: New York 1992, pp. 60-74

[5] Ibid. p. 73

[6] Susan Iles and Denis Gath "Psychiatric Outcome of Termination of Pregnancy for Foetal Abnormality" *Psychological Medicine*, 1993, 23, 407-413

- psychotic/suicidal maternal behaviour
- life-threatening illness
- lethal foetal abnormality
- gross foetal abnormality[7]

There is doubt over whether late term abortion is ever medically indicated as a treatment for psychotic/suicidal maternal behaviour. The procedure itself is a cause of psychiatric morbidity. The use of late term termination of pregnancy for risks to maternal life and for life-threatening illness would presumably be met if necessary by early delivery. Feticide at the same time is not a treatment for any condition of the mother. Further, in the various enquiries held into this matter, numerous gynaecologists have testified that medical conditions in the mother can always be managed without necessitating late term termination of pregnancy[8]. Given that risks to maternal life in late term pregnancy can be managed, and using early delivery if necessary, then there is no maternal *medical* indication for feticide in those circumstances.

Life threatening illness in the mother may raise the matter of whether she wants the child to survive her given that she is facing the possibility of her own imminent death, but feticide in such a case is obviously not a *medical* necessity, the indication, if there is one, is social. Without that necessity such a procedure would, as is discussed below, be unlawful in many jurisdictions. In the Australian State of Victoria, it would be the offence of child destruction punishable by up to twenty years imprisonment.

That leaves the matter of late term terminations of pregnancy for reasons to do with lethal or gross foetal abnormality. This is a new practice that has developed with the advances in ante-natal diagnosis. In the medical literature it is highly controversial. No consensus has emerged over what would be considered a serious enough indication[9]. Finally the social and cultural implications of feticide as a means of selecting what sort of people there should be has not yet been fully explored.

The medical differences described earlier between early and late term termination of pregnancy:

- the fact that feticide or child destruction is a distinct medical choice late term because the child can be delivered alive to an independent existence;
- because the foetus is more developed, responds to painful stimulus and has solid bone structures such that different procedures are required; and
- because there are continuing and very different matters of grieving and psychiatric morbidity involved in the termination of a pregnancy when the child is mature enough to be capable of being born alive and the mother is likely to have begun to relate to him or her such that afterwards she may want to see and hold the body of her dead child;

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[7] The Medical Board of Queensland *Terminations of Pregnancies in Excess of 20 weeks of Gestation: Project Information Paper* July 1997 p. 4

[8] See for instance the enclosed letter from Professor John Bonnar *et al* appendix 2.

[9] See for instance a debate carried out in the *Lancet* Vol 342, Aug 21 1993; Vol 342 October 9, 1993; Vol 342, November 6 1993.

all have profound personal significance for all those involved in late term termination of pregnancy, but particularly the mother, her spouse and any other children she may have.

By the time late term termination of pregnancy is contemplated, the pregnancy is likely to be known and discussed within the family. Other children, if any, are likely to be considering the coming of a new brother or sister. The profound significance of a decision to terminate late term cannot be overcome.

Infanticide, in our culture, is viewed with horror. When a mother kills a neonate, we regard it as such an horrific event, that we, our legislature and our Courts readily classify it as a result of a temporary mental state, not something that is likely to have been freely chosen. Medically there is no clear line between infanticide and feticide once the child is capable of being born alive.

The formation of personal morality is a social activity. We form our moral opinions around our own personal identity and self perception, but in community and in the reflection of the opinions of others. When precisely a new human life is recognised as having the status of an "other", a person to whom respect is due, is a matter of contention and there is a variety of views in the community about it. However, as we move further and further through the stages of development and maturity of a nascent human being then more and more people will have recognised that moral status. There is a kind of accrual.

In the first instance, a woman may be aware that there are those with whom she associates who take the view that the child has that status from the moment that the first cell is formed at fertilisation; then some others will give that recognition when the cluster of cells begins to gastrulate and the primitive streak forms; then later others will attach note to neural development and the capacity to feel and respond to painful stimuli; quickening when the woman can feel foetal movement is another significant stage, then there is the stage at which the capacity to be born alive is reached, then birth itself. At each stage the proportion of her family, friends and acquaintances who recognise that her child is owed respect as a member of the human family will have increased.

That accrual of respect for the worth and dignity of the child she carries will have a profound impact on the woman and her family, and on her doctor, as the pregnancy develops, whatever the individual view formed. The nature of moral thinking and its social context makes that so. Self perception is not entirely separable from the perception of others. How we view ourselves is often through the medium of our relationship to others.

Late term termination of pregnancy occurs at a stage at which that accrual of respect will be relatively advanced. In that respect alone, it is personally very different from early abortion. Further, the medical reality that, once the child is capable of being born alive, feticide or child destruction is a separate and distinct decision from whether or not delivery of the child is necessitated also has profound personal significance.

As we have seen the primary *medical* difference in late term termination of pregnancy is that because the child may be capable of surviving independently, then early delivery and feticide are separable medical events. Ending the life of the foetus (feticide) is a distinct medical choice in

such circumstances. The conflict between the rights of the mother to control of her own body and the right to life of the child she carries, which is central to the abortion debate, no longer exists with the same meaning once the pregnancy has reached late term. If necessary, the child can be delivered and survive.

Hence, unlike the general debate over termination of pregnancy, the specific debate over *late term* termination of pregnancy is a debate not about a woman's control of her own body. If necessary she can cease carrying the pregnancy by having the child delivered alive. The debate is over whether she and her doctor may decide whether in such circumstances the life of the child should be terminated during that procedure. This is, as the law has categorised it, a debate about *child destruction* (feticide in the UK legal debate).

Matters to do with overcoming grave dangers to the mother's life and health are distinct from the matter of whether feticide is also to be part of the management. The question of late term termination of pregnancy seems to turn upon whether feticide is ever legitimate.