...WE MUST CONCENTRATE ON FINDING AND DEVELOPING PRACTICAL, REALISTIC ALTERNATIVES TO ABORTION

John Wyatt identifies a decisive shift in public attitudes to the unborn child

The new ethics of abortion

It is striking how the age-old debate about abortion seems to have changed irreversibly just in the last few years. The stereotyped confrontation between the 'right to life' of the fetus and the 'right to choose' of the mother has become much more complex. Some commentators are now talking about the 'new ethics of abortion'. So what are the factors which have changed the debate so profoundly?

Factors changing the debate

Firstly, there is much greater public awareness of the development of the unborn child, particularly because of the almost universal use of antenatal ultrasound screening. Advances in fetal physiology have also received widespread publicity. We now know that the fetus responds to stimulation from the first trimester, develops complex stress responses to the insertion of a needle from before 20 weeks, learns to distinguish sounds, tastes and vibrations, orientates itself in space and actively interacts with its intrauterine environment.

Secondly, continuing advances in neonatal intensive care mean that survival of extremely preterm infants at 23 and 24 weeks is now almost a matter of routine. Many parents, families and professionals are exposed to the remarkable sight of tiny infants attached to all the paraphernalia of life support machinery. Charities and individuals donate many thousands of pounds to buy intensive care equipment for their local baby unit. Behind the widespread interest and support lies more than mere sentimentality. There are deep-rooted intuitions that the protection, support and nurturing of vulnerable human beings, offering a chance of life to those who cannot fight for themselves, is an essential duty of a civilised society.

Thirdly, at the same time, there has been remarkable growth in antenatal screening for fetal malformations and genetic abnormalities, and an increasing 'medicalisation' of pregnancy. The new consumerist rhetoric of 'providing choices for pregnant women' has become widespread amongst health professionals. As the number of genetic tests increase, the problems of providing suitable counselling and information is likely to become more intractable. It seems inevitable that more and more couples will face decisions about terminating affected pregnancies.

The painful reality of trying to cope with a bewildering range of choices is changing the experience of pregnancy for many women. One study found that 79% of pregnant women were made anxious by the screening tests, and there is interesting evidence that the anxiety about fetal malformation often persists even when a test has given a reassuring result. Some have argued that antenatal testing encourages women to view their babies as commodities that may be rejected if found to be substandard. The effect of fetal screening is that many mothers hold back from relating to their unborn babies until tests have revealed that the baby is healthy. The pregnancy is tentative - some women don't tell anyone they are pregnant until the test results come back, sometimes 20 weeks or more into the pregnancy.

The growth of antenatal screening has 'medicalised' pregnancy by raising the expectation that medical expertise is capable of providing a baby free from impairment or illness, and that it would be 'selfish' or even 'antisocial' for parents not to avail themselves of this service. So technology has had the effect of encouraging a mother to distance herself from the child she carries. In some ways it seems to me that fetal screening offers a false hope, a technological mirage. It seems to offer the anxious parents the possibility of the security and confidence that their baby will be 'all right'. But the unpalatable truth is that no technology can guarantee a perfect child or a healthy outcome.

Fourthly, another major development is the

RCOG says 'abortion is a healthcare need'

New guidelines to doctors issued by the Royal College of Obstetricians and Gynaecologists say that abortion is a 'basic health care need', the cost of which should always be met by the taxpayer. They say that doctors should respect a woman's right to choose, that abortions should be carried out as soon as possible, and that no woman should have to wait more than three weeks. The guidelines which have been funded and approved by the Department of Health were produced in conjunction with the British Pregnancy Advisory Service (BPAS), the nation's largest abortion 'provider' and 'reviewed' before their final draft by a host of other pro-choice groups. They are available on the College website. (www.rcog.org.uk)

IN MANY CASES ABORTION REPRESENTS AN ATTEMPT TO PROVIDE A QUICK TECHNOLOGICAL FIX... BUT MEDICINE ALONE CANNOT SOLVE THE AGE-OLD HUMAN DILEMMAS OF THE UNWANTED OR DISABLED CHILD

growth of the disability rights movement. One eloquent voice is that of Tom Shakespeare, an academic sociologist who happens to have achondroplasia. He argues that 'disabled people are not consulted on matters which affect us: professionals, un-representative charities and governments all make decisions about disability, without considering that the best experts on life as a disabled person are disabled people themselves. Politicians, scientists and doctors alike must realise that disabled people do have a particular interest in prenatal testing and should therefore be systematically involved in the public debate'. Many disabled people regard antenatal testing for fetal abnormalities as a form of social discrimination against people like them. They argue that it is disingenuous for scientists and clinicians to claim that the development of antenatal genetic testing is neutral and value-free. The option of abortion for a range of genetic disorders places a negative value on people with the condition, and implies that it is socially desirable to prevent the birth of certain fetuses.

The obvious counter-argument is that abortion of a fetus with Downs syndrome, for example, does not necessarily imply disrespect for people with Downs syndrome, provided we accept that the fetus is not yet a person. It is argued that the decision to abort is intended to prevent a disabled person coming into existence - it has no wider social implications. But this is surely disingenuous. There is widespread condemnation of the use of abortion in India to allow parents to choose a male fetus for social reasons. This practice is seen as supporting social discrimination against women. In the same way social approval of abortion of fetuses with Downs syndrome can be seen as *'chromosomalism'*, enshrining social discrimination against certain forms of DNA! In the words of one disabled person, 'To the extent that prenatal interventions implement social prejudices against people with disabilities, they do not expand our reproductive choices. They constrict them.'

In the new debate about abortion the social dimension is increasingly coming to the fore. The truth is that in many cases abortion represents an attempt to provide a quick technological fix - a medical, technical solution to what is a complex social phenomenon. But medicine alone cannot solve the age-old human dilemmas of the unwanted or disabled child. And women and health professionals contemplating abortion cannot regard this decision as a purely private, medical one. The social context in which abortion takes place and its implications for society as a whole cannot be ignored.

A Christian response

So how can Christian doctors and health professionals make a practical contribution to the debate about the new ethics of abortion? Whilst we must seek to protect the vulnerable fetus from abuse, we must never forget the human pain that lies at the heart of these complex issues. The truth is that many women (and their partners) in our society are carrying painful and secret memories of past abortions. Instead of criticism and judgement, our duty is to empathise, to enter into the experience of pain, despair and perplexity.

Firstly, we must continually learn from the example of Christ. The Incarnation and the Cross are both supreme examples of empathy in action. Jesus did not condemn from the outside. He experienced humanity from the inside. He entered into human pain and perplexity, in order to transform it with forgiveness and hope. So whenever we engage in the abortion debate we should do so with sensitivity, with gentleness and with compassion.

Secondly, as health care professionals, we must not limit our involvement to the biological and medical aspects of pregnancy. Elaine Storkey in her meditation on the experience of Mary, the mother of Jesus, expresses sensitively the intuitive sense of wonder and the emotional demands of pregnancy from the mother's perspective.

'Pregnancy is itself a symbol of deep hospitality. It is the giving of one's body to the life of another. It is a sharing of all that we have, our cell structure, our blood stream, our food, our oxygen. It is saying "welcome" with every breath, and every heartbeat…the growing fetus is made to know that here is love, here are warm lodgings, here is a place of safety. This is one of the reasons why the decision for abortion is such a painful and heavy one. Of course there are those who have been taught by our culture to present themselves to the clinic with barely a second thought, accepting the sterile terminology of the hospital for what they are about to do: "a termination of pregnancy". Yet for many other women who have had an abortion there has been anxiety and grief and a sense of loss. In spite of all the reasons which directed them to take this step, some feel guilty of a deep betrayal of trust. They could not find within themselves the hospitality that was needed to sustain this life...'

The concept of pregnancy as hospitality has deep resonances with Christian thinking about community and neighbourliness to strangers. The challenge for us is how to communicate

New booklet criticised

A new Family Planning Association booklet titled 'Abortion – just so you know' has been criticised as making no reference to the physical and psychological dangers of abortion to women or of organisations which offer women choices other than abortion. In defending the publication, Anne Weyman, chief executive of the FPA, has said that the booklet addresses a real concern among teenagers for more information on a subject which they no longer saw as a taboo. *(BBC News Online,* 9 June & *SPUC media release,* 8 June)

these profound concepts in ways which are intelligible to modern secular people.

Thirdly we should identify with those who feel stigmatised and rejected by the practice of antenatal screening and termination. However admirable and compassionate may be our motives, when we contemplate abortion for a malformed fetus we are sending an implicit message of rejection. We are saying that we don't wish to accept this new other, to offer basic human hospitality. This, of course, is why disabled people represented by Tom Shakespeare and others, react to the practice of genetic screening and therapeutic abortion of affected fetuses. It strikes at the heart of a Christian understanding of community, and the responsibilities and duties we owe to one another. One of the unfortunate consequences of rapid advances in genetic knowledge may be the formation of a 'genetic underclass' – a growing group of individuals who are socially stigmatised in various ways by their DNA. The identification of a particular genetic sequence may mean that an individual is unable to obtain a job, purchase life or health insurance, obtain a mortgage or find a marriage partner. Since the days of the early church, the Christian community has seen a duty to provide practical protection and support for social outcasts of all sorts. Perhaps in future Christians will need to find new ways of supporting the outcasts created by genetic testing. The theologian Joseph Pieper once defined the essence of Christian love, 'Love is a way of saying to another person, "It's good that you exist; it's good that you are in this world".'

Fourthly, we must concentrate on finding and developing practical, realistic alternatives to abortion. The way of practical, supportive caring is never an easy alternative. It is costly in terms of time, emotional involvement and financial commitment. But it is an essential response if Christians who defend the rights of the unborn child are not to be guilty of hypocrisy. Unless we are in the forefront of providing practical care and support for those with problem pregnancies, helping parents struggling with the implications of bringing up a disabled or impaired child, and defending the rights of the disabled and stigmatised within our community, our supposed commitment to the sanctity of human life is deeply suspect.

There is no doubt that rapid advances in medical practice coupled with profound social changes have irreversibly altered the age-old ethical debates about abortion, disability and the sanctity of human life. Yet the new landscape offers remarkable opportunities for Christian insights and influence. The challenge for health professionals is to find ways of translating Christian caring into clinical practice in a way which is relevant and intelligible to modern secular people.

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Further reading

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Shakespeare T. Choices and Rights: eugenics, genetics and disability equality. *Disability and Society* 1998; 13:665-681

Storkey E. *Mary's Story, Mary's Song.* London: Fount, 1993

Wyatt J. *Matters of Life and Death.* London and Leicester: IVP/CMF, 1998

Changing policies leading to 6 million abortions in Britain since 1968

'I will not give to a woman a pessary to produce abortion.' *Hippocratic Oath*

'I will maintain the utmost respect for human life from the time of conception even against threat...' *The Declaration of Geneva (1948)*

'The spirit of the Hippocratic Oath can be affirmed by the profession. It enjoins… the duty of caring, the greatest crime being destruction in the co-operation of life by murder, suicide and abortion' *BMA Statement (1947)*

The child deserves 'legal protection before as well as after birth'. *The UN Declaration of the Rights of the Child (1959)*

'Therapeutic abortion' (may be performed in circumstances) 'where the vital interests of the mother conflict with those of the unborn child'. *Declaration of Oslo (1970)*

'I will maintain the utmost respect for human life *from its beginning*...' *The Declaration of Geneva (amended 1983)*

'Abortion is a basic health care need.' *RCOG(2000)*

KEY POINTS

The abortion debate is being made more complex by greater awareness of fetal development, advances in neonatal intensive care, the increase in antenatal screening and the growth of the disability rights movement. Christian doctors must continue to seek protection for the unborn; but we must also show empathy by entering into the experience of pain, despair and perplexity generated by the abortion issue. We can do this by modelling Christ's gentleness and compassion, promoting a positive view of pregnancy as hospitality, identifying with the disabled who have feel stigmatised by search and destroy technologies and supporting practical realistic alternatives to abortion. The new debate thereby offers real opportunities for Christian insights and influence.