Accidental Eugenics at the Intersection of Abortion and Prenatal Testing

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Introduction

While abortion laws vary across the world, 56 countries currently permit the practice without restriction as to reason (Singh 10). This permission, combined with the increasing availability and use of prenatal testing, creates the potential for selective abortion in cases of disability. To prevent this eugenic practice, we need to prevent the termination of pregnancies where the foetus tests positive for disability, but are there grounds for permitting abortion in some cases while prohibiting it in others? The answer to this question is complex, and needs to be addressed from several perspectives.

First, I will examine one convincing argument in favour of abortion to determine whether there is a relevant difference between the moral status of abortion in general and the abortion of a disabled foetus in particular. Second, I will consider an important question related to policy: should the prohibition against selective abortion be absolute, or are there certain diagnoses of disability where we think that other considerations outweigh its moral impermissibility? One of the reasons given in favour of selective abortion appeals to the quality of life that disabled children will have; and there are, arguably, disabling conditions that have a severely negative effect on quality of life, which may give a pragmatic reason in favour of selective termination in certain cases. With this in mind, I will attempt to develop a set of criteria that we might appeal to in order to determine when this level of severity has been reached. Finally, I will briefly propose how such a policy could be put into practice in Canada or the United States given the legal decisions that led to the unrestricted permissibility of abortion, recognizing that such a policy must not place an undue burden on women who seek abortions for other reasons. There are two policy options available to prevent the eugenic practice of selective termination:

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either we place more restrictions on access to abortion and prohibit access when prenatal testing has already been performed, or we restrict prenatal testing to a later stage of pregnancy and allow termination in a limited number of carefully defined cases. While neither option is perfect, I believe that either would be preferable to the eugenic nature of selective termination.

**Background: Eugenics**

Whether we take the practice of selective termination to be a kind of eugenics will ultimately turn on how we define the term. Unfortunately, ‘eugenics’ turns out to be one of those terms that everyone seems to understand, but also one that they may have trouble defining. The most straightforward explanation takes eugenics to be the “study and practice of improving the human race by controlled selective breeding” (Hampton 553). This definition can be further refined to differentiate between eugenic practices that are positive and those that are negative: the former aiming to increase the ratio of desirable characteristics in a population, the latter seeking to prevent undesirable characteristics from entering the gene pool (Hampton 554). With respect to the latter, the goals of negative eugenics can be achieved either by preventing certain kinds of individuals from reproducing, thereby preventing those undesirable characteristics from being passed on to future generations; or by controlling the kinds of individuals who are born, and preventing those same characteristics from entering the gene pool in the first place. Under this simple definition, the selective termination of foetuses with disabilities would qualify as a form of negative eugenics.

But it is not enough just to define what eugenics is. If eugenic practices ought to be prevented, this must be because there is something morally wrong with them. So what exactly is it about eugenics that makes it wrong? Perhaps we can tease out some intuitions on about the subject by considering a specific negative eugenic practice. In the province of Alberta between 1928 and 1972, approximately 2,800 “mentally defective persons” were sterilized on the orders of the government appointed “Eugenics Board” in order to prevent them from having equally “defective” children (Caulfield and Robertson 60).¹ Two wrong-making features are immediately apparent: first, individuals were sterilized without their knowledge or consent; and second, those in power imposed the standard that determined whether or not individuals were sterilized. If these are the wrong-making features of negative eugenic practices, then it seems that we have a problem: neither of these features is present in the case of selective termination. First, we might say quite firmly that

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¹ I use the example of Alberta simply because I am the most familiar with it; organized eugenics programs also existed in Germany, Britain, and the United States (Paul, 6).
preventing an individual from coming into existence is not a violation of her autonomy because, being non-existent, she does not have any autonomy to violate. Second, unless parents are being forced to terminate these pregnancies against their will, the government is not abusing the power that they wield over their citizens. In this case there is no appointed “Eugenics Board” reviewing the results of prenatal testing and decreeing which pregnancies must be terminated; instead, prospective parents make the decision themselves.

Even though those in power do not explicitly require that certain pregnancies be terminated, however, there are indirect means of control that they might exercise. For instance, raising a child with a disability requires additional resources that might not be available to families, depending on their socio-economic status. If governments do not provide a means for these families to access the resources required to raise disabled children, then upon receiving a diagnosis of disability, parents may be more likely to choose termination. Not only are there indirect economic pressures, there are also social pressures that arise due to the relative rarity of disabling conditions. Prospective parents, for example, might choose to selectively terminate a pregnancy based on the fact that their disabled child would be unique among their peers and unable to participate in the same activities as other (“normal”) children of their age.² Does the fact that the ultimate choice belongs to the parents and not to the government make the practice of selective termination any less wrong?

This question demands a further distinction in our definition: retaining the distinction between positive and negative eugenics, we may also distinguish between strong and weak eugenics:

Strong eugenics could be defined as population-level improvement by control of reproduction via state intervention … Weak eugenics would be defined as promoting technologies of reproductive selection via non-coercive individual choices. (Hampton 555)

Given this, we can characterize the sterilization that occurred in Alberta as strong negative eugenics. It earns this label because of the way in which the government was involved: a government appointed “Eugenics Board” was responsible for carrying out sterilizations as per the guidelines laid out by the Sexual Sterilization Act (Caulfield and Robertson, 60). In contrast, selective termination is better

² Whether decisions based on “social pressure” can be justified is another topic for a different paper.
Caroline Lyster characterized as weak negative eugenics because it arises as a result of the choices made by individual parents (Hampton 555).

While we can make a distinction between strong and weak eugenics, this does not mean that we should treat one variety as less pernicious than the other. The two varieties share one final wrong-making feature: they reduce human beings, or potential human beings, to a single trait. This is the phenomenon of *synecdoche*: “not the literary device, in which the part stands in for the whole, but the characteristic response to a stigmatized trait, in which the part obscures or effaces the whole” (Asch and Wasserman 173). Synecdoche occurs when one focuses on a single feature that an individual possesses while ignoring all others as when, for example, a racist sees an individual simply as a “black woman” as opposed to “an educated, middle class, African American schoolteacher and mother of three who plays piano at church.” Synecdoche is wrong when the trait that an individual is reduced to does not justify treating them in a particular way: in the case of the “black woman,” the colour of her skin is not relevant in determining whether or not she should be president of the PTA, but an individual who reduced her entire person to her skin colour may attempt to justify her exclusion based solely on this fact.

To further illustrate the problem using the weak negative eugenic case, synecdoche occurs when parents make the decision to terminate a pregnancy after receiving a diagnosis of disability: they reduce their potential child to the single trait (the genetic abnormality that indicates disability), and use that information to determine whether they want to raise that child. Whether a child is disabled, however, has no bearing on whether that child is “worth raising”; its relevance, insofar as it has any, is on whether the expectations that the potential parents have for their pregnancy, their child, or parenthood will be met (Asch and Wasserman 174). But we might question whether termination can be justified simply on the basis of a pregnancy’s failure to fulfil those expectations. The problem of synecdoche is prevalent in the strong and positive versions of eugenics as well. In the case of sterilization, synecdoche amounts to basing the decision to prohibit certain individuals from reproducing on their genetic legacy rather than on their ability to be parents. And in the case of positive forms of eugenics, it is the opposite: individuals are encouraged to reproduce based only on some positive characteristic that they happen to possess, not on their desire to have families or be parents.

The most unique thing about “family eugenics,” or selective termination based on the results of prenatal tests, is that it is an emergent property of practices that are not explicitly intended to be eugenic; in other words, these are cases in which eugenics seems to happen by accident (Hampton 553). Abortion, whether one accepts with the arguments for its moral permissibility, is not intended for the
purpose of terminating only certain kinds of pregnancies. The non-eugenic aims of prenatal testing are, admittedly, a little less clear; but we could plausibly say that the original intention behind the introduction of the practice was to test for only the most severe or debilitating conditions, or to prepare potential parents for the birth of a child that they might not have been expecting. The eugenic problem fully emerges once a positive test for disability is combined with the lack of restrictions on abortion: under these conditions, potential parents may undergo prenatal testing with the intent of terminating the pregnancy if the test comes back positive for some less than desirable trait. Their intentions may not necessarily come from a (eugenic) desire to prevent certain kinds of children from being born, but the results speak for themselves: in the case of Down syndrome, for example, it is estimated that termination occurs in 85% to 90% of pregnancies in which the condition is diagnosed (Bauer 250).

The governments of both Canada and the United States have previously discontinued programs that could have been described as strong negative eugenics. Since it has been established that weak negative eugenics ought not be treated as any less pernicious than the strong varieties, then it follows that governments ought also step in to prevent these eugenic results from occurring. How can this be done? As a first step we might want to attempt to differentiate between the moral permissibility of selective abortion and the moral permissibility of abortion in general. If we can make such a distinction then we can begin to make a case for permitting termination in certain cases while prohibiting it in others.

Abortion

While the debate on the moral status of abortion is far from settled, there are many compelling arguments for its general permissibility. However, I feel that one important issue with respect to selective termination has often been overlooked: in these cases, we are considering pregnancies that were, at least initially, wanted. In order to tease out what I believe to be a morally relevant difference between wanted and unwanted pregnancies, I will focus my analysis on a very particular argument in favour of abortion: the so-called “Good Samaritan” argument, originally proposed by Judith Jarvis Thomson. This argument targets the claim that the impermissibility of abortion stems from the fact that the foetus has a right to life that outweighs a woman’s right to control her body, and does so through the use of a now (in)famous thought experiment:

You wake up in the morning and find yourself back to back in bed with an unconscious violinist… He has been found to have a fatal kidney ailment, and the Society of Music Lovers has canvassed all the available medical
records and found that you alone have the right blood type to help. They have therefore kidnapped you, and last night the violinist’s circulatory system was plugged into yours, so that your kidneys can be used to extract poisons from his blood as well as your own. The director of the hospital now tells you, “Look, we’re sorry the Society of Music Lovers did this to you—we would never have permitted it if we had known. But still, they did it, and the violinist now is plugged into you. To unplug you would be to kill him. But never mind, it’s only for nine months. By then he will have recovered from his ailment, and can be safely unplugged from you.” (Thomson 152-153)

This is obviously meant to be a situation analogous to pregnancy, and is meant to elicit a particular response to a specific question: are you obligated to remain plugged into the violinist? Many people would, intuitively, say that you are not, though they may have a difficult time explaining exactly why this is the case.

The point of this thought experiment is not that your right to control your body outweighs the violinist’s right to life, because that claim is implausible. As David Boonin points out in his analysis of Thomson’s argument,

[She] would surely agree that [the violinist’s] right to life would trump your right to control your body. If you met the violinist at one of his concerts and wanted to exercise your right to control your body by swinging your fists in a manner that would cause him to be pummelled to death, for example, she would plainly acknowledge that his right to life would outweigh your right to control your body. (136-137)

Thomson’s thought experiment is meant to question what exactly the violinist’s right to life entails. The intuitive sense in which it is permissible to unhook oneself from the violinist stems from the fact that while his life is threatened by his kidneys no longer being able to function, such that he needs to use yours to live, the mere fact that he needs your kidneys does not give him a right to use them (Boonin 155). On this account it would be very kind of you to allow him to use your kidneys for the next nine months, but in no way are you morally obligated to do so; and because no such obligation exists, it would be permissible to unhook oneself from the violinist. Thomson would call a person who remains hooked up in spite of a lack of obligation a Good Samaritan: they have gone out of their way and helped someone in need at some cost to themselves, when this action was not required of them (Boonin 158).

How does the case of the violinist apply to the question of pregnancy termination? Thomson’s argument, at its core, is that one’s right to life does not
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guarantee them the use of another person’s body, even if they need that body to sustain their own life (Boonin 156). So it is all well and good to say that the foetus has a right to life, but this alone is not enough to make abortion impermissible. In the case that a woman decides to carry a foetus to term, her doing so involves going above and beyond what is morally required of her. There are, of course, a number of objections to this line of argument. I do not have time to go over all of them in depth, so I will limit myself to the analysis of one that I believe to be the most relevant to differentiating between the moral permissibility of selective abortion and abortion in general: the responsibility objection.

The responsibility objection focuses on our intuition that individuals have a special kind of moral responsibility for the states of affairs that they bring about. It maintains that, “morally speaking, the [pregnant] woman is like someone whose voluntary actions foreseeably lead to an accident that causes an innocent bystander to be in need of her assistance,” the innocent bystander being the foetus, and the assistance in question being the use of the woman’s body (Boonin 167). Since the foetus would not have existed if the woman had not engaged in intercourse, by engaging in this voluntary act the woman assumes responsibility for the assistance that the foetus requires in order to survive. The objection seems plausible, but becomes less so when we distinguish between two different senses of responsibility: in one, we speak of responsibility for the innocent person’s existence, whereas the other involves responsibility for the innocent person’s neediness (Boonin 170). In the case of a woman who voluntarily engages in intercourse, she only seems to be responsible in the first sense:

It is the case that the woman did some voluntary action such that had she not done it the [foetus] would not now exist… But it is not the case that she did some voluntary action such that had she not done it the [foetus] would now exist and would not need her assistance in order to survive. (Boonin 170)

In other words, while the woman is responsible for the fact that the foetus now exists, she is not responsible for the fact that foetuses, in general, require assistance in order to survive. That factor is beyond her control, and so it would seem unreasonable to ask her to assume some kind of special moral responsibility for the foetus on account of it. If she was responsible in the second sense, then it might make sense to ask that she provide for the need that she created, but we can never really say that pregnant women have this kind of responsibility. That a foetus has needs is a biological, and not a moral, fact.

There is, potentially, one more sense of responsibility that we can distinguish from the other two by considering the case of a wanted pregnancy. A woman who becomes pregnant on purpose is responsible in the same way as a woman who
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becomes pregnant by accident: she is responsible for the existence of the foetus but not for its neediness. However, in this particular case we might also want to say that the nature of her relationship to the foetus means that she is responsible for meeting the needs that it has. We could say that by engaging in voluntary intercourse for the purpose of conceiving a child, she has assumed a special kind of responsibility for the foetus by becoming its guardian. I believe that this third sense of responsibility points toward an often-overlooked distinction between two different kinds of pregnancies: those that are wanted and those that are not. This distinction is not usually considered in the context of abortion due to the fact that women who become pregnant on purpose do not seek to have these pregnancies terminated, except in the cases we are discussing. We should always keep in mind that when we discuss selective abortion we are talking about the termination of pregnancies that were, at least initially, wanted. Given the purposeful nature of conception in these cases, I propose that the women (and the men) involved have role-specific moral obligations toward the foetuses that they carry, giving us a way to distinguish the moral permissibility of abortion in general from that of selective abortion in particular, and allowing us to conclude that the former practice is permissible while the latter is not.

If you recall, the Good Samaritan argument in favour of the permissibility of abortion is based on the premise that the violinist’s need for your kidneys did not establish a right for him to use them. Given the distinction between wanted and unwanted pregnancies, however, the scenario in the case of selection abortion looks significantly different:

You are a member of the Society of Music Lovers. Each month you read the classified section of your newsletter in depth, because often musicians find themselves ill and require the use of another individual’s organs for survival. One month you find, to your great delight, an advertisement: a famous violinist has fallen ill and requires the use of someone else’s kidneys for nine months. This is something that you have always wanted to do, so you run to the hospital and ask the nurses to hook you up.

Arguably the violinist in this case does have a right to use your kidneys, not because of his need but rather because of your offer: you sought him out, assumed responsibility for his well-being, and in doing so you have entered a situation in which you are no longer merely acting as a Good Samaritan but are instead acting as a guardian. Therefore, should you get bored after three months of being in this situation it would not seem permissible to pull the plug: the role you have assumed brings with it obligations, of which you were aware, that you are now bound to fulfil. Consequently, it is plausible to assert that the termination of (previously) wanted...
pregnancies is impermissible based on the role-specific obligations associated with guardianship. These are situations in which women conceived on purpose, not by accident, and therefore situations in which they assumed certain obligations that make selective termination wrong.

While it seems easy to accept the impermissibility of terminating a pregnancy for superficial reasons like boredom or a strong distaste for stretch marks, the specific case we want to consider is that in which a prenatal test determines that the foetus has, or is likely to have, a disability. Say you find yourself in a case like the one above, only this time after four months of being attached to the violinist you discover that he has a defect: he will survive, and he will still have the ability to be a musician, but something has happened to one of his arms and from now on he will only be able to play the triangle. Does knowing this fact change your role? It seems as though it should not: you are a member of the Society for Music Lovers after all, and individuals who play the triangle are not less of musicians than individuals who play the violin. To say that such a fact is relevant would imply that the role-specific obligations associated with guardianship are dependent on whether or not the individual being “guarded” lives up to certain expectations, and that a single fact is enough to determine whether or not those expectations will be met. First, to base the obligations associated with guardianship on the “guarded” individual living up to expectations has implausible implications: we want to say that parents are the guardians of their children even if their children do not turn out to be perfect. Second, individuals who would abdicate their role as guardian based on a single fact about the “guarded” individual are guilty of synecdoche and are thereby committing a eugenic act (Asch and Wasserman 174).

The distinction that I have described here in terms of guardianship is similar to what Adrienne Asch called the “any-particular” distinction. According to Asch:

…most abortions reflect a decision not to bring any [foetus] to term at this time; selective abortions involve a decision not to bring this particular [foetus] to term because of its traits. (Paren and Asch 15)

This distinction, however, has been criticized as inadequate due to the fact that the decision to terminate any foetus can often be recast as a decision to terminate a particular kind of foetus, rendering the distinction effectively useless. For example, consider the case of parents who already have three children and choose to end a pregnancy that would have produced a fourth child. One could argue that in this case the decision to terminate was based on the trait of being a fourth-born child (Asch and Paren 15). If the impermissibility of certain cases of termination derives from their being based on a particular trait, then the list of permissible reasons for
abortion might actually be quite short. The guardianship distinction, I would argue, avoids this problem because it bases the impermissibility of selective abortion on the question of whether or not the pregnancy was initially wanted. In the example of the fourth-born child, the relevant question is whether the child was conceived on purpose: if it was not, then the mother never assumed the role of guardian toward the fourth-born foetus and termination is permissible.

Quality of life concerns

It seems as though we can draw a line between cases of permissible and impermissible abortion, but we ought to ask ourselves whether there are other reasons in favour of allowing selective termination to occur. If you recall, in the thought experiment previously proposed, the “defect” does not seem that serious: the (former) violinist is still able to be a musician. This case is therefore not strictly analogous to all cases of selective abortion, and arguably it would be better to frame the problem in the following way:

You are a member of the Society of Music Lovers. Each month you read the classified section of your newsletter in depth, because often musicians find themselves ill and require the use of another individual’s organs for survival. One month you find, to your great delight, an advertisement: a famous violinist has fallen ill and requires the use of someone else’s kidneys for nine months. This is something that you have always wanted to do, so you run to the hospital and ask that the nurses hook you up. However, after four months of being attached to the violinist you discover that he has a defect: he will survive, but his hearing has been damaged and he has lost the ability to be a musician.

In this case it is not merely a matter of accepting that the musician will play the triangle rather than the violin, it is rather a case of the musician no longer being able to participate in something that perhaps made his life worth living.

While the reasons given by parents who choose to terminate a pregnancy based on the results of a prenatal test are complex, they do so, at least in part, because they hold a belief that the child in question would not have a life worth living. There are no studies that say this definitively, in large part because the sensitive nature of pregnancy termination means that “exit interviews” are not performed. This conclusion follows from the difference in termination statistics between “average” clinics and clinics that follow up a diagnosis of disability by introducing potential parents to families raising disabled children. In the latter scenario, only 60% of pregnancies are terminated, compared with 85-90% of pregnancies when this
information is not provided to parents. This suggests that when parents know that individuals with disabilities have lives worth living, they are less likely to terminate a pregnancy in which a disabling condition has been diagnosed (Parens and Asch, 41).

The obvious problem with this judgment is that able-bodied individuals are passing judgment on forms of life that they have not themselves experienced, and they are doing so using their own set of (able-bodied) assumptions and values. They argue that they would not find a life like that worth living, and so the individuals living those lives must feel the same way. However, as many authors have pointed out, this does not appear to be the case: “...when asked about the quality of their own lives, disabled people report a quality only slightly lower than that reported by nondisabled people, and much higher than that projected by nondisabled people” (Amundson 103). This has led to the “forms of variation” argument, which holds that disabilities are not intrinsically undesirable or handicapping, but that they are only perceived as such due to external factors; disabilities, on the whole, are relatively neutral forms of human variation (Steinbock 109). While most proponents of this argument subscribe to a purely social model of disability, I believe that it applies even in cases where there is an undeniably medical component, and as such I take this argument to be saying something more general: while being disabled might involve a medical problem or lack of ability, lacking that ability or having that medical problem does not in itself make life not worth living. In other words, the lives of individuals with disabilities can be better or worse depending on a number of factors independent of their physical impairment. This point of view acknowledges that disabilities are not necessarily neutral, but neither are they necessarily undesirable. If disabilities are forms of variation that are not inherently undesirable, then the decision to terminate a pregnancy based on the results of a prenatal test cannot be justified by appealing to the quality of life that a child with a particular disability might have. Selective abortion, in such a case, would be weak negative eugenics.

Disabilities, however, like people, come in various shapes and sizes: some cases are mild, some are severe, and in some the lack of ability can be compensated for. While in principle the line drawn by the guardianship distinction would treat all cases of selective termination as impermissible, we may nonetheless have pragmatic reasons for wanting to allow it to occur under certain circumstances. Here are four potential cases in which selective termination may be considered:

(1) The child will survive, but she will lack a typically normal function; for example, she might be blind or deaf.
(2) The child will survive, but she will not function in the way that children typically do; for example, she may have Down syndrome or fragile X.
(3) The child will survive and will possess normal function for some time, but will succumb to disease later in life; for example, she may have Huntington’s disease or be at risk for breast cancer.

(4) The child will only survive for a short time after birth, and during this time she will suffer a great deal; for example, she may have Tay-Sachs.

In all four of these cases, a woman would have assumed the role of guardian by voluntarily choosing to become pregnant; so according to that distinction it would in principle not be permissible in any of the cases for her to abdicate that role. However, many people believe that in the fourth case it would be permissible to terminate the pregnancy: this is a case where we seem justified in judging the quality of life that the child would have as not worth living.

In order to distinguish between those conditions that actually affect quality of life and those that are forms of variation we need a set of criteria. One potential set of criteria considers the effectiveness of treatments for the condition in question, the impact of the condition on the child or family, the age of onset, and the likelihood that someone who tests positive for the condition will actually develop it (Wertz 261). According to this method of determination, we might say that a condition actually affects quality of life in a negative way when:

(a) there exists no effective treatment,
(b) it has a large impact on the child and the family,
(c) its onset is early, and
(d) the likelihood of actually developing the condition is high.

However, while the application of these criteria allow us to make a determination about low quality of life in scenarios like (4), they would also allow us to make the same determination in scenarios like (2) or (3).³ Consider the case of Down syndrome: it is an early onset condition with no effective treatment, has an impact on both children and their families, and is present from the moment of birth.⁴ Does this mean that it contributes to a low quality of life? Arguably it does not, because when individuals with Down syndrome are asked about their lives they certainly see

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³ Making this determination in scenario (3) seems especially pernicious, as it reduces an individual’s life to a condition that they will only have at the end of it.

⁴ As for the likelihood of a foetus actually developing the condition after a positive test, the most widely used tests for Down syndrome indicate that a foetus is at risk for the condition, though amniocentesis that can confirm the diagnosis. However, even though the diagnosis is certain the severity cannot be known until after the child is born.
them as worth living, and it also seems as though they do not view their Down syndrome as problematic:

Jeremy Young suggested that having diabetes was a much more significant factor in his life. Rachel Kingston assured me that though she had once had Down syndrome, she no longer did, though the parents hadn’t realized this yet. Justin Marshall wrote that people with Down syndrome are normal and should be treated so, and Eloise Hartley said exactly the same thing. Ellen Wentworth was adamant that having Down syndrome meant nothing to her at all. My own daughter Maddie knows she has Down syndrome, but for her, all that means is that she occasionally needs a little more support than her sisters. (Gothard 339)

What these testimonies tell us is that Down syndrome does not completely meet criterion (b), as it does not appear to actually have a negative effect on the lives of individuals who are affected by it. This would lead me to conclude that termination after a diagnosis of Down syndrome is a form of weak negative eugenics that ought to be prevented.

While we could argue that termination in cases of Down syndrome is not permissible because criterion (b) does not appear to be met, there are still other ways in which we may refine the criteria to determine when disabling conditions actually affect quality of life in a negative way. I would like to suggest that a further solution might lie in specifying what it means to say that a condition can be treated. Intuitively this could mean something like a cure, but it may be more accurate to say that it means something like allowing an individual with that condition to function in a “normal” way, expanding the notion of treatment from strictly medical interventions to any number of alternatives. We should, however, further specify what we mean by “normal function,” because when we say that someone functions normally we might be speaking either about the mode or the level at which they function (Silvers 101). The mode of functioning is the way in which an action is accomplished. Consider the example of reading: the normal mode through which people accomplish this function is visually, by seeing the words. But there are other ways that people can read, Braille, for example, and these would count as abnormal modes of functioning. The level of functioning, on the other hand, is how well an individual performs a particular task. Even if an individual functions using an abnormal mode, she may still be able to perform the task as a normal level. To continue with the example of reading, someone who is adept at reading Braille may “still read at normal speed and comprehension” (Silvers 101). A condition may lead an individual to function abnormally with respect to mode, level, or both; and given this, we should conceive of potential treatments as restoring the norm in either of
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these areas. What I would like to suggest is that the restoration of either normal mode or level of function is sufficient to say that a condition has been successfully treated. This suggestion also has consequences for saying when a particular condition requires treatment: if either normal mode or level of function on its own is sufficient, then as long as one of these is present an individual does not need to be treated for her condition (though treatment should obviously be given if it is available).

Allow me to explain using the example of Down syndrome. Down syndrome is typically thought of as an intellectual disability, meaning that while individuals with trisomy 21 function in the normal way they do not function at the normal level. Under the scheme that I am proposing, this would mean that Down syndrome, as an intellectual disability, is not a condition that requires treatment: the normal mode of functioning is sufficient. Now, there are many other medical complications associated with Down syndrome: for example, these individuals are “more likely than the rest of the population to experience cardiac, respiratory and gastrointestinal problems. They are also more prone to vision and hearing impairment or thyroid problems” (Gothard 111). These are all deviations in level or mode of functioning that can be treated with medical, surgical, or social intervention. Down syndrome, therefore, does not meet criterion (a). Since personal testimony has also shown that it does not meet criterion (b) either, we have multiple grounds for concluding that the life of an individual with Down syndrome is one that it worth living, and that termination in these cases is not permissible on pragmatic grounds.

Given all of this, we can refine the previously given criteria and say that a condition is severe enough for selective abortion to be permissible when:

(a) treatments are not effective at restoring either a normal mode or level of function,
(b) it has a large impact on the child (that is not contradicted by personal testimony) and the family,
(c) its onset is early, and
(d) the likelihood of actually developing the condition is high.

However, even with those additions there are still two issues that need to be briefly addressed.

The first concerns criterion (d), and the question here is simple: what counts as a “high” likelihood of developing a condition? And, further, how is that likelihood determined? The latter is primarily an empirical question, and so I will not concern myself with it here except to say that some tests indicate with certainty that a foetus
will develop a particular condition, and other indicate only a chance that the condition may develop. As medicine advances the tests will change, and there may come a day when we can know, with closer to one hundred percent certainty, what kinds of conditions our children will develop. As for the former question, there is no simple answer, partly because the purpose of this criterion is to account for the uncertainty that comes with prenatal diagnosis: as previously mentioned, certain tests will indicate that a foetus will, without a doubt, develop a particular condition, while others may only indicate a one in ten chance. This probability, in turn, affects the way that we evaluate the remaining criteria: if a condition has treatments that are only partially effective, has a moderate to severe impact on the child and the family, and presents during mid-childhood, we might initially conclude that it is severe enough to warrant termination. However, if we add to our evaluation that the positive test only indicates a one in fifty chance of the child developing this condition our evaluation is likely to change, and it no longer seems like a situation in which selective abortion should be permitted. Perhaps we could arbitrarily say that the likelihood is “high enough” when there is a greater than a one in four (or one in ten) chance of actually developing the condition. Some might initially argue that this sets the bar too low, and that too many conditions for which prenatal tests exist will meet the criterion. This is true, but remember that there are other criteria as well, and far fewer conditions will meet those as well.

The second issue concerns how we weigh the impact of the condition on the child against the impact of the condition on the family. In the case of Down syndrome, the actual impact of the condition on the affected children seems minimal, but arguably the impact on families is extensive: children with a condition like this might require medical interventions, and they will also require additional resources both at home and at school. Should the inability of parents to provide these resources on their own weigh in favour of allowing selective abortion? I would argue that it does not, because the parents’ inability to provide these resources merely implicates the assistance of society. If societal resources do not come to their aid, then what was initially an accidentally eugenic practice becomes more explicitly so: by failing, or refusing, to provide the resources that families might need to raise disabled children, those in power make an implicit statement about the kinds of children that they want to see born, and exert an influence on whether or not potential parents choose termination over having a disabled child. We should therefore also make some adjustments to criteria (b)*: instead of saying that a condition is severe enough for selective abortion to be permissible when it has a large impact on the child and the family, we should specify that severity arises from large and irremediable impact. In other words, if the impact is one that can potentially be offset by the addition of resources it should not be weighed in the assessment.
Legal issues

Having gone through the moral and policy considerations, it is now necessary to consider the legal climate in which family eugenics is located in order to determine whether certain individuals could be denied access to abortion. The problem, as we shall see, is that any limits will have to be tailored to the particular country in which are to be imposed: abortion is legal for different reasons in different jurisdictions. To illustrate both the problem and two possible solutions, I will examine the different ways that abortion came to be legalized in Canada and the United States and the different forms that legislation to prevent family eugenics might take in each of them.

Until 1988, abortion was a criminal offense in Canada and access to therapeutic abortion was limited by section 251 of the *Criminal Code of Canada*, the relevant portion of which stated:

251. (4) Subsections (2) and (3) do not apply to
(a) a qualified medical practitioner, other than a member of a therapeutic abortion committee for any hospital, who in good faith uses in an accredited or approved hospital any means for the purpose of carrying out his intention to procure the miscarriage of a female person, or
(b) a female person who, being pregnant, permits a qualified medical practitioner to use in an accredited or approved hospital any means...for the purpose of carrying out her intention to procure her own miscarriage,
if, before the use of those means, the therapeutic abortion committee for that accredited or approved hospital, by a majority of the members of the committee and at a meeting of the committee at which the case of such female person has been reviewed,
(c) has by certificate in writing stated that in its opinion the continuation of pregnancy of such female person would or would be likely to endanger her life or health. (Richer Appendix A)

In order for a legal abortion to be granted the woman seeking it had to apply to do so, and her request had to be approved by a committee of no fewer than three qualified medical practitioners. Further, that committee could not include the physician who would have performed the abortion. The Supreme Court of Canada struck down this law in *R. v. Morgentaler*, on the basis that it violated section 7 of the *Canadian Charter of Rights and Freedom*, which guarantees the right to life, liberty, and security of the person. According to the Supreme Court decision,
Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman’s body and thus an infringement of security of the person. A second breach of the right to security of the person occurs independently as a result of the delay in obtaining therapeutic abortions caused by the mandatory procedures of s. 251 which results in a higher probability of complications and greater risk. The harm to the psychological integrity of women seeking abortions was also clearly established. (32-33)

The procedure outlined in the Criminal Code was found to be in violation of the principles of fundamental justice; further, the procedures and administrative structures were unfair and arbitrary, impaired rights more than necessary, and resulted in a disproportionate ratio of harms in comparison to benefits. While the result of the R. v. Morgentaler was legal and unlimited access to abortion it is important to note that the majority did not decide that women have an unrestricted right to access this service. The lesson we ought to take from Morgentaler is that any proposed legislation must be carefully considered in order to ensure that it does not violate the Charter in the same way that section 251 of the Criminal Code did. That is, as long as the procedures and administrative structures are not unfair or arbitrary, do not impair rights more than necessary, and do not result in a disproportionate ratio of harms in comparison to benefits access to abortion can be restricted in a way that does not violate the Charter.

Rather than a blanket prohibition against abortion with a provision for therapeutic access, the ideal legislation to prevent family eugenics would prohibit termination only in a limited number of cases. It might state, for example, that abortion in general is legal, but that abortion after prenatal testing is not permitted except in those cases where the foetus tests positive for a serious disability, or in cases where the life of the mother is in danger. Such a proposal would not necessarily be based on the criminal nature of doing the prohibited act, but rather on the well-established principle that doctors ought only to offer to perform procedures that are medically indicated. How would this legislation measure up against the precedent of Morgentaler? First, it seems as though the procedures and administrative structures are neither unfair nor arbitrary: women who were planning to terminate the pregnancy anyway would not have sought out prenatal testing in the first place and so will not be affected by such legislation, and there is a relatively clear way to distinguish between cases of disability serious enough to warrant termination. As for impairing rights more than necessary, the legislation as proposed above does not demand that women seeking abortion take any extra steps unless they have had prenatal testing; only in that case are additional barriers imposed.
There may, however, be some argument about the ratio of harms to benefits: parents whose children test positive for a disability that is not serious enough to warrant termination might argue that they are being asked to bear a particularly large emotional and financial burden. First, with respect to finances, any policy to prevent family eugenics ought to go hand-in-hand with increased funding for medical and social programs designed to support children with disabilities and their families. It is true that there are additional expenses associated with raising these children, but those problems can be mitigated with proper financial support. Second, at least some of the emotional burden associated with raising a disabled child may be due to a feeling of loss that parents experience when they realize that their child is not the one that they expected:

Tied up with the anticipated arrival of a baby is the expectation that the child will bring joy and happiness to the parents. [...] Most parents, particularly during their first experience of parenthood, marvel at the perfection which is their new child, and there can be few who have not harboured secret dreams and expectations. … At first glance, the birth of a child with Down syndrome seems to dash each on of these aspirations. (Gothard 31)

What potential parents need to remember is that there are a multiplicity of different kinds of lives out there, and that they are all equally worth living. It is important to remember that disabled children can live “happy, rewarding, and productive lives” (Bauer 249). Further, while raising a child with a disability might offer unique challenges, that does not make it any more difficult than raising a “normal” child. After all, it is not the case that “normal” children raise themselves without parental effort or supervision; the challenges faced by the parents of these children are simply different. Further, that the challenges are different does not mean that they are necessarily easier in one case: it is quite possible for the parent of a hyperactive “normal” child to be faced with far more (and more difficult) challenges than the parent of a mellow child with Down syndrome. Given all of this, I would argue that the ratio of harms to benefits is not disproportionate, and that a policy prohibiting abortion after prenatal testing would not violate the Charter.

The American legal context is quite different. In Roe v. Wade the United States Supreme Court ruled that it was unconstitutional for states to ban abortion performed before viability, a ruling that was based on the right to privacy. According to the majority opinion:

This right of privacy, whether it be founded in the fourteenth amendment’s concept of personal liberty and restrictions upon state action, as we feel it is, or, as the district court determined, in the ninth amendment’s reservation of
rights to the people, is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy. (Vaughn 343)

The majority did recognize, however, that the right to abortion was not unqualified and set the following limits: in the first trimester the decision is left to the judgment of the woman and her physician, in the second trimester the state may regulate the abortion procedure in ways related to maternal health, and in the final trimester the state may prohibit abortion except when it is necessary to save the life of the mother. In 1992 the United States Supreme Court revisited the question in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, and reaffirmed the essential holding of *Roe v. Wade* while rejecting the trimester framework and establishing an “undue burden” test to assess the restrictions that states imposed on abortion (Vaughn 347). According to this test, “an undue burden exists … if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the [foetus] attains viability” (Vaughn 350). After viability the state could continue to restrict access to abortion with exceptions for cases where the mother’s life was at risk.

Given the way that *Casey* frames an undue burden, it is unlikely that the Canadian solution would be successful in the American legal context. If you recall, the Canadian policy proposal would simply have prohibited women from accessing abortion if prenatal testing had been done. Since most prenatal testing is performed before the foetus reaches viability, this prohibition would be in direct violation of *Casey*. We should remember, however, that the permissibility of abortion is only one side of the family eugenics coin: prenatal testing is the other. Therefore, rather than restrict the reasons why women might be able to request abortion before the foetus attains viability it might be possible to place restrictions on when certain prenatal tests are offered. Because there are cases of serious disability where selective termination would be permissible, these tests could be offered before the point of viability and women could therefore choose to legally proceed with abortion on the basis of those results. Tests for non-serious conditions could then be restricted to the final trimester of pregnancy where the state is already permitted to prohibit abortion except when it is required to save the mother’s life. The results of these tests would have an informative purpose and would help parents prepare for the birth of a disabled child.

Neither of the options proposed above are perfect, but what they do is set us on a path much different than the one on which we are currently travelling. Unrestricted access to abortion, combined with the ability to test for various serious and non-serious disabilities, has led society, with the best of intentions, toward the slow elimination of an entire class of people (Bauer 250). This eugenic process
might be labelled as “weak” (lacking coercive force), but that does not make it any less pernicious. The most destructive consequences to society are the values fostered by allowing such a process to continue. Practicing selective termination of foetuses that do not have serious disabilities promotes the idea that people who are not normal do not have lives worth living; that they are, in other words, suffering in some way (Bauer 249). It promotes the false idea that parenthood is something that can be controlled, and “any parent who has ever handed the car keys to a teenager knows the folly of that thought” (Bauer 250). It implies that the role related obligations surrounding guardianship can be abandoned when the role becomes difficult to fulfil: if it is the case that potential parents can give up their responsibility toward a foetus after a diagnosis of disability, how can we stop actual parents from abandoning children who do not live up to parental expectations? Also, if we allow parents to selectively terminate pregnancies when non-serious disabilities are diagnosed, we become unable to justify prohibiting selective termination for sex or cosmetic features.

I admit that these sound like reactionary, slippery slope fears, but they are real questions that need to be addressed. How we deal with the eugenic problem at the intersection of unrestricted access to abortion and prenatal testing will affect how we deal with other potentially eugenic scenarios such as pre-implantation genetic diagnosis by making explicit the kind of values we would like to promote in society; and depending on the decision we will either be a society that embraces difference or one that denies its value.
Works Cited


