Selective abortion

Doctors who perform abortions for social reasons are social technicians

EDITOR,—Richard L Berkowitz's editorial on multifetal pregnancy reduction describes a phenomenon that has been in evidence since abortion began but that has received little attention.¹ Referring to reduction abortion procedures that are performed for social reasons, Berkowitz uncovers something at the heart of the debate on abortion.

Social abortions have nothing to do with the prevention, healing, or palliation of diseases. They have little in common with medicine or surgery except in so far as medical or surgical techniques are used as a means to some socially desirable goal. The requirement of evidenced based medicine that the procedure is therapeutic and not harmful is ignored.²

"Psychological stress" may be what Berkowitz cites as a reason for performing an abortion, but the practitioner is obliged to prove that abortion will be psychologically therapeutic to the woman in the long term, not merely a temporary relief of stress. Despite the enormous numbers of abortions carried out in the world each year, abortion is the most underresearched intervention. Most abortions in Britain are carried out under the clause in the Abortion Act relating to mental health,³ yet almost all abortions are performed by gynaecologists who have little or no training in psychiatry. The Canadian Psychiatric Association stated in 1981, "Justification of a decision to terminate a pregnancy under pseudo-psychiatric rubrics is to be deplored."⁴

The original principle in medicine—healing—has been replaced here by that of manipulation. The profession should recognise this because the implications are enormous, economically as well as ethically. Such a commitment to making people temporarily happier without evidence of long term therapeutic benefit is not what medicine is for. Doctors who continue to carry out and recommend abortions for social reasons are not exercising professional judgment. They are social technicians and should be regarded as such.

It is right that these issues be discussed just now. This year marks the 50th anniversary of the Nuremberg tribunals. Little attention has been paid to this, presumably because of embarrassment at how the profession has lost sight of the ideals that were evoked at that time. The BMA council's own statement of principles included "The duty of curing, the greatest crime being co-operation in the destruction of life by murder, suicide and abortion."⁵

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- 2 Rosenberg W, Donald A. Evidence based medicine: an approach to clinical problem solving. *BMJ* 1995;310:1122-6.
- 3 National Office for Statistics. *Abortion statistics 1994*. London: HMSO, 1996.
- 4 Ney P, Wickert AR. Mental health and abortion: review and analysis. *Psychiatr J Univ Ottawa* 1989;14:506-16.
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Issues of reproduction must be faced more responsibly

EDITOR,—Recent articles on the ethics of reproduction highlight once more the tendency of modern medicine to create moral minefields.¹⁻³ Professor Phillip Bennett's remarkably candid statements¹ make it clear (as if we did not know it) that it is human life we are dealing with when we discuss the human fetus. If we choose to ignore this basic fact and continue to abort fetuses at will then arguing about selective reduction—be it three fetuses to one, two to one, or eight to two—is pure hypocrisy. Richard L Berkowitz's "lifeboat analogy"² is not ethically equivalent: selective abortion is a manmade situation, whereas the lifeboat scenario is usually the result of a natural catastrophe.

The story about the woman expecting octuplets raises another ethical problem.³ If our solution to childlessness (I speak as a childless married man) is some sort of "ovary boost" that is to lead to subsequent selective fetal destruction then we are committing two moral wrongs, whose sum can never be a moral right. If the aftermath of our "therapeutic" actions is too terrible to consider then we should think twice before we embark on this kind of venture. Unless we decide to face up to the issues of reproduction more responsibly, both at the personal and at the professional level, we shall continue to be plagued by ethical pseudodilemmas that cost human lives and create serious problems of conscience to professionals and patients alike.

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- 1 Duncan N. Light the blue touchpaper and stand well clear. *BMJ* 1996;313:432. (17 August.)
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Dead fetuses might have to be registered as stillbirths

EDITOR,—I wish to point out an aspect of the selective termination of fetuses in a multiple pregnancy that is not mentioned in Richard L Berkowitz's editorial.¹ As Berkowitz states, this procedure is usually performed in the second trimester with the intention that pregnancy should continue to the delivery of one or more healthy surviving infants (in the case that "caused a furor in the international press" the procedure was done at 16 weeks). If this objective is achieved the dead fetus will inevitably be expelled with its surviving sibling(s) after the 24th week of pregnancy. By legal definition this constitutes a stillbirth and should therefore be registered as such.

On one occasion in the past I was ordered by the registrar of births and deaths to register as a stillbirth a fetus papyraceus, delivered at term with a healthy twin, that weighed only 42 g and had been shown by diagnostic ultrasonography to have died, albeit spontaneously, at 16 weeks.² (An appeal against this ruling to the Office of Population Censuses and Surveys was rejected, with a warning that any failure to comply with the law in this regard was an offence.) The parents were understandably distressed to learn

that the barely recognisable scrap of humanity was officially a stillborn child requiring notification and funeral arrangements. Reasonably, they believed this to be painfully inappropriate—a belief that would certainly have been magnified had the "stillbirth" been a consequence of selective termination.

Another cause for concern is that upholding the legal requirements in such circumstances could seriously distort the stillbirth statistics of hospitals undertaking selective termination.

Such anomalies are surely unacceptable, and I believe that the law governing the registration of stillbirths should be altered. The desired result could readily be achieved by adopting the World Health Organisation's recommendation that registration of stillbirths be confined to fetuses weighing not less than 500 g.³

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- 1 Berkowitz RL. From twin to singleton. *BMJ* 1996;313:373-4. (17 August.)
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Psychological sequelae in people whose twin died at or before birth are unknown

EDITOR,—Many people will agree with Richard L Berkowitz that where abortion is available on demand, as in the United States, it is illogical to deny a woman the right to reduce two fetuses to

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Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

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