ABORTION AND NEONATICIDE: ETHICS, PRACTICE AND POLICY IN FOUR NATIONS

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ABSTRACT

Abortion, particularly late-term abortion, and neonaticide, selective non-treatment of newborns, are feasible management strategies for fetuses or newborns diagnosed with severe abnormalities. However, policy varies considerably among developed nations. This article examines abortion and neonatal policy in four nations: Israel, the US, the UK and Denmark. In Israel, late-term abortion is permitted while non-treatment of newborns is prohibited. In the US, on the other hand, late-term abortion is severely restricted, while treatment to newborns may be withdrawn. Policy in the UK and Denmark bridges some of these gaps with liberal abortion and neonatal policy.

Disparate policy within and between nations creates practical and ethical difficulties. Practice diverges from policy as many practitioners find it difficult to adhere to official policy. Ethically, it is difficult to entirely justify perinatal policy in these nations. In each nation, there are elements of ethically sound policy, while other aspects cannot be defended. Ethical policy hinges on two underlying normative issues: the question of fetal/newborn status and the morality of killing and letting die. While each issue has been the subject of extensive debate, there are firm ethical norms that should serve as the basis for coherent and consistent perinatal policy. These include 1) a grant of full moral and legal status to the newborn but only partial moral and legal status to the late-term fetus 2) a general prohibition against feticide unless to save the life of the mother or prevent the birth of a fetus facing certain death or severe pain and suffering and 3) a general endorsement of neonaticide subject to a parent’s assessment of the newborn’s interest broadly defined to consider physical harm as well as social, psychological and or financial harm to related third parties. Policies in each of the nations surveyed diverging from these norms should be the subject of public discourse and, where possible, legislative reform.
Abortion, particularly late-term abortion, and selective non-treatment of newborns (neonaticide), are feasible management strategies for fetuses or newborns diagnosed with severe abnormalities. These practices vary widely among countries, even among nations sharing similar political cultures. The same moderately malformed 25 week old fetus might be aborted in Israel, delivered but not necessarily resuscitated in Denmark, resuscitated but not always treated aggressively in the UK and treated aggressively in the US. Moreover, perinatal policy also varies within countries in that very different rules regulate abortion of fetuses and non-treatment of newborns. While infants in the US are considered little different from late-term fetuses, they are afforded less protection than their prenatal counterparts from decisions to terminate life support. Late-term abortion for many fetal anomalies remains prohibited, while selective non-treatment for newborns with similar afflictions commands increasing support. As inconsistent as this policy may seem, the situation is entirely reversed in Israel. There, infants and late-term fetuses are radically different from one another. This facilitates abortion on demand throughout the gestational period, while virtually prohibiting non-treatment of newborns. In England and Denmark a different paradigm of fetal and newborn status holds sway, further reconfiguring abortion and neonatal policy.

On the face of it, the reasons for disparate policy are not difficult to fathom. Each nation defines fetal and newborn status differently, each has different religious and cultural norms affecting views about sanctity of life, feticide and appropriate use of life sustaining treatment and each makes independent decisions about how best to allocate scarce medical resources. Nevertheless, it is perfectly reasonable to ask whether nations with similar underlying political cultures shouldn’t adopt similar policy on such an important issue. If true, we might consider that some national policies are wrong headed, not only because they are difficult to implement but because they violate basic underlying ethical norms.

These issues are rarely addressed in comparative studies of cross national health policy. International surveys of neonatal care or abortion policy do not ordinarily consider the normative validity of competing policy. At most, they offer a concise description and explanation of divergent policy. Most often this is, unsurprisingly, explained by underlying religious, historical and cultural factors. © Blackwell Publishers Ltd. 2002

1 B.W. Levin, International Perspectives on Treatment Choice in Neonatal Newborns, Social Science and Medicine 1990; 30: 901–912; B. Rolston and A.
disparate cross-cultural policy are often restricted to discussions of
divergent first and third world practices such as female
circumcision and infanticide. These issues generate enormous
debate. While some are content to approve of diverse practice in
the name of multicultural relativism, there are serious attempts by
some philosophers to condemn these practices because they are
antithetical to the conditions necessary for any form of human
morality. Interestingly, the preconditions of morality adopted by
these philosophers differ little from the norms of human rights
and dignity that typify liberal democracies. As a result, divergent
practice among developed nations is not normally the object of
ethical concern because they are thought to share the very norms
that serve as the springboard to criticize third world practice. But
neonatal and abortion policy show that this may not be the case.
Either these countries do not share the same norms, or the norms
are sufficiently elastic to permit wildly diverse policy, or some
policy is just plain wrong.

The following section compares divergent abortion and neo-
natal treatment policy in four nations: Israel, the US, the UK and
Denmark. Together they exemplify the common protocols for
late-term abortion and neonatal care. Immediately thereafter the
underlying ethical issues are raised. Any attempt to evaluate
disparate policy requires firm normative criteria. In the debate
over abortion and neonatal policy these hinge upon the moral
status of the fetus and newborn, and the distinction between
killing and letting die. Although democratic nations address
these issues differently, there are strong arguments that some
kinds of policy violate ethical standards. Most often, ethically
suspect policy is the most extreme: policy that either denies or
overly enhances the status of the late-term fetus, and policy that
draws too strong or too weak a distinction between killing and
letting die. There are grounds to think that some policies may be
incoherent, inconsistent or indefensible on normative and
practical grounds while others accord with defensible plausible
moral norms. Policies of the last sort offer practical solutions to
many of problems posed by abortion and neonatal care.


FETICIDE AND NEONATICIDE IN FOUR DEVELOPED NATIONS

Table 1 shows the range of policy for late-term abortion and selective non-treatment of newborns in four countries: Israel, the US, the UK and Denmark. These countries exemplify a different paradigm of treatment based on six common protocols for abortion and treatment of anomalous newborns. While other permutations are certainly possible, the policies described below represent the most common practices among developed nations.

Late-term Abortion Strategies

Although most developed countries permit early-term abortion at the mother’s discretion, regulations governing late-term abortion vary considerably. As the fetus matures, laws and practice in many countries afford it a growing degree of personhood that attenuates the mother’s rights to terminate her pregnancy. This leads to three types of policy that can be described as restricted, partially restricted, and unrestricted. Restricted policy limits, usually by law, late-term abortion except to save the life of the mother. This describes American policy where more than 40 states have banned post-viability abortion. Partially restricted policy lacks legal codification but confers a measure of

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personhood that normally restrains physicians from performing late-term abortions unless to save the life of the mother or prevent the birth of severely anomalous newborns. This characterizes late-term abortion policy in the UK and Denmark. Finally, unrestricted late-term abortion policy denies personhood to the fetus and allows the mother wide discretion to terminate her pregnancy at any gestational age. This is currently the case in Israel.

**Neonatal Management Strategies**

One may also describe three types of neonatal management strategies: a statistical or threshold protocol, an ‘initiate and reevaluate’ approach and a ‘treat until certainty’ approach. The statistical approach sets a threshold based on criteria of gestational age and maturity which must be met before a premature newborn is treated. This approach is endorsed by the Danish Council of Ethics and is based on the poor statistical outcome of treating a particular class of premature newborns. An ‘initiate and reevaluate’ or individualized approach begins care in all but the grimmest cases and reevaluates its efficacy as treatment continues. If ineffective, treatment is withdrawn. This protocol describes neonatal care in the UK and, contrary to stated ‘wait until certainty’ policy, also characterizes American treatment protocols. Finally, a ‘wait until certainty’ strategy resuscitates and treats newborns until death or discharge. This characterizes care in Israel.

Table 1 also reveals inconsistencies. Restrictive abortion policy is relatively conservative and leads one to expect similarly conservative neonatal policy. But this is not the case in the countries surveyed. American abortion policy is conservative but its neonatal policy moderately liberal and flexible. Israeli neonatal policy is conservative while its abortion policy is among the most liberal. Denmark’s neonatal policy is among the most liberal, offering broad criteria for withdrawing and withholding treatment, but its late-term abortion policy remains relatively


restricted. Only the UK is moderate on both counts. A closer look brings these internal contradictions into sharper relief as each nation seeks to set a policy that will adjudicate conflicts between fetal and neonatal rights and interests on the one hand, and maternal, familial and social rights and interests on the other.

Abortion and Neonatal Policy in Israel

The Israeli case serves as a clear example of dichotomous public policy. Prior to birth, the mother has complete *de facto* discretion over her pregnancy. The law, to be sure, presents a somewhat different picture. By law, abortion is illegal except for fetal birth defects, pregnancies in women older than 40 or younger than 18 years of age, pregnancies that endanger the mother’s physical and/or mental health or out-of-wedlock pregnancies (including rape and incest). While abortions require committee approval, the statute is interpreted so broadly that few applications are denied and the incidence of late-term abortion in Israel is one of the highest of developed countries.\(^8\) During the prenatal period, there is no countervailing weight attached to the interests of the fetus whatsoever. This inevitably creates some measure of distress as physicians are asked to perform very late-term abortions that legislators did not anticipate when they enacted the law in 1977 before the widespread use of ultrasound to detect deformities late in pregnancy.

While Jewish and Israeli law remain ambivalent about abortion and, in particular, prenatal personhood,\(^9\) there is no such uncertainty about the momentous significance of birth. Birth confers legal and moral personhood and fundamentally changes the status of the fetus. The transition to personhood is not gradual, as it might be with a disputed viability criterion, but sudden. After birth the rights of the child are overwhelming. As a person in the fullest sense the newborn enjoys an undisputed and state protected right to life.

Following birth, children’s rights are close to sacrosanct. Although Israeli law forbids patients the right to withdraw treatment, a recent patient rights act grants patients the right of informed consent and the right to refuse (withhold) treatment. But this right, however abridged in comparison to other developed countries, is further curtailed with regard to children.

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8 Gross, *op. cit.* note 3.
Parents require court approval to withhold treatment and courts have been extremely reluctant to provide anything less than full, aggressive treatment for children, including, for example, a child suffering from Tay-Sachs disease (although the very same child could have been aborted at any gestational age).\textsuperscript{10} Prevailing treatment protocols follow an aggressive management strategy and discourage selective non-treatment of newborns. There is no threshold below which babies are not treated, no wait and see attitude, no room to withdraw treatment and little room to withhold treatment at the sole request of the parent.\textsuperscript{11} There is apparently no consideration of cost, although as a result of universal prenatal care, the number of very low birth weight infants is less than half that of the US.\textsuperscript{12}

Abortion and Neonatal Policy in the United States

In the American case fetal, family, and children’s interests are constantly juxtaposed. As is well known, abortion is available virtually on demand during the first and, to a somewhat lesser extent, during the second trimester. However, at the beginning of the third trimester or age of viability (whichever comes first), the American fetus gains a measure of legal personhood, recognition and protection unprecedented among most developed countries.\textsuperscript{13} At this point fetal interests gain ascendancy and seriously compete with the health and well being of the mother and other family members. Nevertheless, the fetus does not have an absolute right to life. Both the mothers health and, in some states, fetal best interests attenuate the fetus’s right to life. On one hand, the fetus may be aborted in those rare instances when the mother’s life is threatened.\textsuperscript{14} On the other hand, a fetus may also be aborted if it is so grossly deformed or impaired that it is not

\textsuperscript{10} Shefer v The State of Israel (Israel Supreme Court), 1993, PD506/88.
\textsuperscript{11} Eidelman, \textit{op. cit.} note 7.
\textsuperscript{13} Roe v Wade (410 U.S. 113, 1973) recognizes the beginning of the third trimester as the benchmark for viability, i.e., the capability of a fetus to survive outside its mother’s womb with reasonable care, and legal protection of fetal interests. Later Court decisions such a Webster v. Reproductive Health Services (492 U.S. 490, 1989) have allowed for the possibility that developing technology may move the age of viability forward.
\textsuperscript{14} Threats to the mother’s health constitute reasons for late-term abortion in no more than 5–10% of cases in Israel and Denmark (see Gross, \textit{op. cit.} note 3).
judged to be in the fetus’s best interest to continue to live. But this is a minority opinion; quality of life judgments remain unendorsed by most states.

The status of the American neonate, however, has not enjoyed the same measure of consensus as his late-term fetal counterpart. If, in the mid-1970s, US courts reiterated the sanctity of newborn life, the medical community was moving increasingly toward subordinating neonatal interests to those of the parents and family, allowing parents considerable latitude to withdraw or withhold treatment. This lead to several prominent cases where routine, but life-saving surgery was withheld from babies suffering from Down’s syndrome. Initially the courts supported this trend and upheld a parent’s right to make treatment decisions that may lead to an infant’s death. However, it was not long before a coalition of pro-life and disability rights organizations lobbied to curtail a parent’s right to limit treatment to defective newborns. Emerging ‘Baby Doe’ regulations (1982) were draconian and made doctors, hospital and parents criminally liable for medical decisions that had hitherto been routine. In 1984 Congress relaxed these regulations and they now stipulate that treatment cannot be withheld unless the infant is irreversibly comatose, or treatment is futile and inhumane. Quality of life cannot be considered in treatment decisions.\(^{15}\)

In practice however, there is evidence that parents continue to retain a dominant voice in treatment decisions that are based on the interests of the child and family alike, interests that often include quality of life assessments.\(^{16}\) Family interests alter the decision-making calculus so that similar cases may be decided differently depending upon family circumstances. Appropriate financial and moral support may allow families to pursue


aggressive treatment for their newborn, while the same infant may go untreated if the family cannot cope financially or emotionally with a malformed infant. Policy is ambiguous and practice often *ad hoc*. Compare this with Israeli policy which, whatever its other faults, maintains a relatively clear set of guidelines throughout the neonatal period.

Abortion and Neonatal Policy in the UK and Denmark

In contrast to the US and Israel, policy in the UK and Denmark always weighs the interests of the mother/family over that of the fetus, a perspective that also characterizes policy in Canada, Australia and the Netherlands. Although the fetus’s interest remains subordinate to the mother’s, parent’s and/or family’s welfare, abortions in Denmark and the UK require institutional approval at some or all stages of a woman’s pregnancy. While authorities routinely approve first term abortions, they are reluctant to perform late-term abortions, a situation paralleling US policy.

However, if the statistics of late-term abortion in Denmark and the UK are similar to those in the US, the juxtaposition of maternal and fetal rights is not. By the third trimester the American fetus gains a firm measure of legal personhood and protection that it does not acquire in England and Denmark. In neither country is the fetus’s gestational age a statutory consideration affecting abortion. Both countries allow women to abort severely deformed fetuses regardless of gestational age although the level of required severity remains a source of contention and discretion. Other considerations such as economic hardship (in Denmark) or statistical risk to the mother’s health (in the UK) also apply equally throughout a pregnancy. However, abortion regulations are interpreted by a body independent of the mother and her physician. As a pregnancy progresses, the potential for conflicts of interest intensifies and policy makers sense that decisions about maternal and fetal interests are better left to a third party. In practice, moral considerations of fetal personhood together with


19 Ibid.
reservations about feticide prohibit late-term abortion unless the fetus is severely malformed or threatens the mother’s life.20

This outlook changes in the neonatal period as newborn rights recede in the face of a parent’s and/or society’s right to withdraw or withhold treatment to newborns. The Danish position is often regarded as extreme. In 1995 the Danish Council of Ethics recommended that premature infants should not be aggressively treated if they are younger than 24 or 25 weeks or physically immature. This frees resources to treat older infants most likely to survive and also reflects a preference to withhold treatment for an entire high risk class rather than begin treatment and then withdraw it later.21 But gestational age is not a hard and fast criterion. Considering factors such as a family’s emotional and/or financial well being, parents may choose to resuscitate a newborn who falls below the age threshold or, conversely, decline to resuscitate one who remains above it. Moreover, there is evidence that the Danes are slowly moving away from this modified threshold protocol to one approaching an ‘initiate and reevaluate’ position.22

In contrast to Danish policy, the English abjure a treatment threshold in favor of withdrawing care. British case law echoes American jurisprudence. Early rulings in both nations allowed parents to refuse routine treatment to Downs babies. Unlike American lawmakers, British parliamentarians did not address the issue by statute but allowed the courts to set policy instead. Although later court rulings took a dim view of withholding routine treatment from Downs babies, the practice was never regulated as strictly as in the US. Reviewing British court rulings Mason and McCall Smith note with some dismay that the courts ‘demonstrated that there is no such thing as an absolute obligation to preserve the life of a physically abnormal baby’.23 In light of these court rulings, the British interpretation of selective non-treatment, in contrast to the avowed American position, makes room for quality of life decisions as well as considerations of family and societal interests.24 Israeli policy is more extreme and is guided only by sanctity of life.

21 Danish Council of Ethics, op. cit. note 6, p. 36.
22 Norup, op. cit. note 17.
23 Mason and McCall Smith, op. cit. note 15, p. 155; see also Blank, op. cit. note 17, p. 225.
Dilemmas of Disparate Policy

The diverse policies just described create a number of practical and ethical difficulties. Within nations policy makers often tend to formulate late-term abortion and neonatal treatment policy in isolation, when, in fact, the two are closely linked. The result is discordant and inconsistent policy that can discomfit health care providers. In Israel, for example, aggressive neonatal treatment protocols coupled with liberal abortion policies prevent physicians from counseling a wait and see approach for potentially malformed newborns. As a result, physicians will perform late-term abortions when they might prefer to avoid active feticide and reserve the option of withholding treatment after the baby is born. In the US, on the other hand, caregivers may withhold treatment for severely handicapped newborns but often in a way that does not satisfy the letter of the law. Here, inconsistencies push practice away from stated policy. While American child abuse statutes are relatively strict, actual practice often countenances non-treatment for reasons other than a newborn’s strict welfare. Practitioners are often wedged between the dictates of explicit policy and extenuating circumstances in the field. In Denmark practitioners may be also caught between policy and public opinion. While Danish abortion policy enjoys a consensus, policy recommending non-treatment of certain classes of neonates is falling into disfavor with the public and some physicians. 25 This creates added pressure to change policy and reexamine underlying norms.

The difficulties created by divergent policy lead one to ask whether one policy might be better than another. Doing so should encourage us to search for ethical principles to evaluate abortion and neonatal policy. While it might be impossible and perhaps even presumptuous to suggest that ethics can bridge diverse national cultures, even those that share liberal and democratic values, it would be a mistake to think that ethics has nothing to say. But instead of a singular set of moral norms to govern such a complex issue, it might be better to aim toward a range of permissible policies to bring some consistency to the question of abortion and selective non-treatment of newborns.

FROM FETUSES TO NEWBORNS: A SLIPPERY ASCENT

Underlying disparate policy are two troublesome issues: the nature of fetal and newborn status, and the morality of killing fetuses and letting newborns die. Each is shrouded in ambiguity, doubt and dissent.

Moral status, as I will shortly argue, is important because it affords a criterion to help adjudicate the conflicting interests of the mother/parents/family and fetus/newborn. While one may permit early-term abortion, for example, because the moral status of the embryo is vastly inferior to the mother’s, late-term abortion becomes increasingly difficult because the developed fetus gains a large measure of moral recognition that may allow her interests to override her mother’s. The question of status is not limited to fetuses. Although newborns are, for the most part, full fledged persons, there is room to weigh the combined interests of the mother, family and society against the neonate’s. A newborn’s interests, particularly a severely impaired newborn, are not always paramount.

Moreover, abortion, feticide, selective non-treatment and termination of life support are all actions which either directly or indirectly facilitate death. Whether permissible or not depends upon their affinity to homicide and murder, and upon the distinction, if any, between killing and letting die. Resolving these questions – fetal/newborn status, non-treatment and feticide – in a way that will not necessarily lead to a single, ethically correct answer but to a balanced range of options will facilitate consistent and morally acceptable policy and practice.

Fetal and Newborn Status

Personhood is generally the first criterion of claim rights and is both a legal and moral concept. Legal personhood uses statute or judicial fiat to confer recognition to certain members of society thereby protecting and guaranteeing a wide range of rights. Moral personhood is distinct from its legal counterpart suggesting that some criteria independent of the law and its machinery afford a measure of respect for one’s life and interest. Israel and the US exemplify the extreme positions: Israel offers no legal or moral status to the fetus, while the US offers both. Neither position can be cogently defended and both create policy that is difficult to implement.

With the exception of Israel, there is a large measure of consensus that the late-term fetus enjoys some measure of moral
personhood. Moral personhood confers a measure of moral claim rights, most often the understanding that the late-term fetus has an interest and moral right to live that can only be overridden if the fetus poses a severe threat to the mother’s health or is faced with a life full of severe pain and suffering. Moral personhood is conferred relatively late in a pregnancy as the developing fetus achieves a measure of viability, sentience and human cognitive developmental capacity thereby affording limited rights and protection.26 Emphasizing the recognizable features of human cognition reinforces the distinction between humans and animals while, at the same time, preserves the personhood of reversibly comatose patients.

Alternative positions remain problematic. The Catholic Church, for example, confers personhood at conception. Save Ireland this is not the basis for policy in any Western nation where early-term fetal interests are rarely recognized, or remain subordinate to maternal self-determination. At the other extreme, minority opinions conferring personhood with self-awareness attained in early childhood27 have prompted sustained philosophical debate. However, these viewpoints have never been seriously considered by policy makers or legislators for reasons that are both moral and practical. To push the criteria for moral personhood beyond birth ignores emerging features of human cognitive capacity and the emotional bonding that usually accompanies a child’s birth.28 Practically, the slippery slope is ever present. Denying moral personhood at birth not only makes it difficult to define a similarly unambiguous alternative but creates an uncertain, unstable and unpredictable social climate wherein the newborn is afforded only limited legal standing and protection that may impinge on the rights and perhaps lives, of others as well.

Although most nations grant some measure of personhood to the late-term fetus, the Israeli position denies moral and legal personhood.


28 See Warren, op. cit. note 26, p. 215–218. While cognitive capacity is an intrinsic criteria for personhood, the emerging bond between the newborn and those around her offer relational criteria of personhood that strengthen the newborn’s status vis a vis the late-term fetus.
personhood until birth and endorses unrestricted late-term abortion. However, all is not well with Israeli policy. Born of ambivalent Jewish law as it pertains to fetal status, the preeminence of the newborn child (particularly a Jewish child), and some altogether contingent political factors that accompanied the passage of the law in 1977, current policy unsettles many precisely because it ignores the imperative to grant some measure of moral personhood to the late-term fetus and to restrict late-term abortion. But while moral consensus for change is growing legislative initiative remains frustrated by political impediments.

Finally, one must consider an American policy that grants the fetus both moral and legal personhood. Legal personhood is rarely applied to fetuses and the US position is at best ambiguous. Reading the US Supreme Court’s discussion of personhood in the context of abortion one is struck by the inadequacy of the language needed to define legal personhood. While the justices first assert ‘that the word ‘person’ as used in the Fourteenth Amendment, does not include the unborn,’ they conclude that ‘the unborn have never been recognized as a person in the whole sense.’ This suggests that they may be persons in some sense, a sentiment contributing to the Court’s eagerness to affirm a viability standard. With viability comes a measure of legal protection for the fetus unmatched by that extended to children after they are born and entrusted to the care of their parents.

But I suspect that the legal toehold is not entirely justified. Instead, the US Supreme Court decision represents a rather awkward compromise between pro-life advocates who confer moral personhood at conception and those pro-choice supporters who opt for a later date. As a compromise, viability was chosen as the applicable criteria but it was invested with

29 Following the fall of the Rabin government by a vote of non-confidence in late 1977, a caretaker or transitional government took charge until new elections could be held. Because a transitional government cannot be brought down by a vote of no-confidence, the religious hinge parties were unable to threaten the government. This allowed a bipartisan group of secular parliamentarians to pass Israel’s liberal abortion law. The original draft of the law confined legal abortion to the first 12 weeks of pregnancy but this reference was dropped when the bill was presented for ratification. When questioned by the religious parties, the bill’s sponsors replied that the deletion was a typographical error. True or not, it was never corrected.

30 One recent suggestion proposes a 50–50 rule. Any late-term fetus with an illness that carries at least a 50% chance of 50% impairment may be aborted. See note 32 for additional suggestions.

31 Roe v Wade 410 U.S. 113 (1973), emphasis added.
special status and affords little room for quality of life judgments in the third trimester.

The Court’s position is unconvincing. Not only are the legal grounds questionable (by the Court’s own admission) but one finds unacceptable religious overtones as well. Quality of life judgments are permissible when there is reasonable cause to conclude that a fetus will be so severely impaired that it no longer has an interest to continue to live due to illnesses resulting in certain death or severe impairment. This outlook guides practice in the UK for example, prompting researchers to search for criteria to determine which illnesses are sufficiently severe to warrant late-term abortion. The criteria necessary to justify late-term abortion are a legitimate subject for public discourse and there are no grounds to deny quality of life judgments unless religious considerations of sanctity of life have, somehow, snuck in. This might help explain US policy, but does nothing to justify it.

Questions of status have less impact on newborn care. Although there is very little disagreement over the moral and legal personhood a newborn enjoys, the strength of newborn interests relative to the interests of others remains contentious. In the US and Israel, for example, newborn interests are granted overriding weight to an extent that prohibits quality of life judgments and prevents parents from considering the best interests of their family as they weigh treatment options for an impaired newborn. But this view creates a special class of patient in the newborn that is unwarranted. Consistent with the principle of self-determination, patients’ rights in most countries allow a competent patient or his surrogate to discontinue treatment for a number of reasons that include quality of life and consideration of third party interests. There are no grounds for restricting this right when exercised by parents of severely handicapped newborns.

In general, the status of the late-term fetus and newborn infant converge. To a great extent a late-term fetus is similar to a

32 See Chervenak et al, op. cit. note 20. The U.S. Office of Technology Assessment defines severe handicaps as severe mental retardation (IQ<70), severe cerebral palsy, blindness and severe hearing defects while moderate handicaps are narrowly defined as an IQ between 70 and 80. However, it is doubtful whether they intended that these serve as criteria for late-term abortion. (Office of Technology Assessment. 1987. Neonatal Intensive Care for Low Birth Weight Infants: Costs and Effectiveness. Health Technology Case Study 38. OTAHC-58. Washington DC. US Congress, Office of Technology Assessment.

newborn and both should be treated equally. This should lead to a certain symmetry with regard to abortion and neonatal policy: abortion and selective non-treatment of impaired newborns are both permissible for reasons associated with diminished quality of life and in deference to the compelling interests of affected third parties who will be adversely affected by the birth of a handicapped child. National policy to the contrary – the reluctance to withhold treatment from a Downs’ baby in Israel coupled with a willingness to abort the very same late-term fetus (and much the opposite policy in the US and Britain in the early 1980’s) – is deficient in light of the close proximity between fetal and newborn status. Nevertheless, the symmetry is not perfect. Feticide, on the face of it, is not the same as letting die. Although the fetus and newborn may enjoy similar status, one might be permitted to withhold or withdraw treatment from a newborn but never be allowed to kill a late-term fetus. What effects does this dichotomy have on the consistency we are seeking in abortion and neonatal policy?

**Feticide: Killing and Not Letting Die**

Unlike an impaired newborn who dies of an underlying disease when treatment is terminated, a similarly affected fetus must be deliberately killed, usually by fatal injection. However, if there is rough symmetry between the status of the late-term fetus and neonate, and if infanticide by lethal injection is proscribed, then we must have serious reservations about feticide. The question remains whether these doubts are sufficient to preclude late-term abortion entirely or whether there are grounds for more moderate policy. Here again, it is in instructive to look at the extremes. US policy, largely proscribing late-term abortion, and Israeli policy, largely permitting it, are, ultimately, difficult to defend. The status of the late-term fetus and newborn is sufficiently different to allow some instances of feticide but sufficiently similar to prohibit unrestricted abortion. Moreover, killing is not the same as letting die. It is considerably more serious thereby making it perfectly reasonable that the state step in to restrict feticide under certain circumstances.

Were newborn and fetal status entirely identical there would be no question about prohibiting feticide. However, they are not. In spite of their close affinity, one cannot ignore the momentous impact of birth. With birth, the physically independent newborn becomes the undisputed master of his body and gains a right of
‘self-ownership of the body’. The self-ownership of the body affords an unambiguous moment to either grant or significantly enhance the newborn’s legal status. Birth and the accompanying emotional bonds it nurtures further strengthen our sense of a newborn’s moral personhood. As a result the newborn’s social status – a combination of its moral, legal and emotional standing – is strengthened to an extent that the newborn patient enjoys a right to beneficent treatment, quality of life and self-determination mediated through his parents that cannot be abridged. The fetus does not enjoy this full range of recognition.

Nevertheless, one must remain wary of feticide. First, the late-term fetus by virtue of its advanced development maintains an interest to live assuming it is not so severely impaired to be denied a reasonable quality of life. Second, feticide is killing: it is not letting die. As a result there are good grounds for strict state regulation. In light of these considerations a justifiable policy of feticide lies midway between the Israeli and American extremes. On one hand, it regulates feticide, usually by committee and strict statute while, on the other hand, it permits late-term abortion to either protect the mother’s life or the fetus’s best interest.

While one may reason through to a cogent policy of feticide, one may, nonetheless, overcome the aversion to killing late-term fetuses by choosing to forego fatal injection and care for any live abortus as a premature newborn, care which may include selective non-treatment. This pushes all the ethical questions into the neonatal arena. Here too, the ethics that will guide policy are complex. Children are not simply small, incompetent adults. On one hand, they are sometimes thought to enjoy a special status, diligently protected by the state as they are in Israel and the US. On the other hand, the Danish Council of Ethics has endorsed a policy of global non-treatment, one that attenuates neonatal rights in a way rarely countenanced for adult patients. As before, the extremes offer fertile terrain for ethical debate, as the best answers emerge somewhere in the middle ground.

34 Mason and McCall Smith, op. cit. note 15, p. 148.
35 The idea of social status answers Mason and McCall Smith’s concern that the unique status of the newborn is undercut by a definition of personhood based on intellect (Ibid.). While the intellectual or cognitive definition establishes firm grounds for moral personhood, the idea of social status offers a richer understanding of personhood that differentiates the newborn from the late-term fetus.
Neonaticide: Withholding and Withdrawing Treatment from Newborns

Active euthanasia – killing anomalous newborns by fatal injection – has never been a serious policy option and remains proscribed even in the Netherlands where there is widespread support for euthanizing competent adults. Rachels’ well publicized argument that killing in the form of a quick death by lethal injection is more humane than a protracted death by starvation and dehydration prompted considerable debate but is best turned on its head. Although one may agree that killing is little different from letting die, one need not necessarily agree that killing is as acceptable as letting die.³⁶ In fact, conservative policy makers seem to favor this position; if the distinction between killing and letting die is vague and indeterminate, and one is morally prohibited from killing, then one is equally prohibited from allowing impaired newborns to die.

But any position that collapses killing and letting die is going to be problematic. Rachels’ argument ignores the intuitive idea that killing is accompanied by causality, deliberately originating ‘a fatal sequence of events rather than allowing one to run its course’.³⁷ The conservative position prohibits or severely restricts a neonate’s right to withhold or withdraw treatment and ignores the fact that while killing is wrong, there might be good reasons to forego treatment and allow a disease to run its course. If policy consistently denies parents the right to forego treatment in any case, as in Israel, then a newborn’s best interests are grossly neglected. It cannot be the case that any life is worth living or that a fatal disease cannot be allowed to run its course or that a newborn can be condemned to a life of severe pain and suffering. Israeli policy is singular in this regard, other Western nations long having accepted standards that, at a minimum, allow parents to forego treatment in these extreme cases. This turns our attention to the ethics of two distinct policy options: global non-treatment and selective non-treatment of impaired newborns.

Global Non-Treatment of Newborns

Although a contentious ethical issue, the option of foregoing treatment is limited to a relatively small class of newborns whose

treatment falls between the extremes of clearly beneficial and clearly futile care. A treatment is beneficial when it will most likely lead to a significant improvement in the newborn’s condition. A treatment is futile if the likelihood of benefit is ‘extremely small’ (<1%) or ‘the quality of the outcome of the intervention is extremely poor’.

Between futility and beneficence lies a grey area of various degrees of suspected impairment. Given the high probabilities of handicap and the not inconsiderable costs associated with caring for these infants, there are grounds for withholding treatment from an entire class of premature newborns subject to parental approval. The Danish Council of Ethics terms this a ‘modified threshold approach’ and it applies to infants in the 24–25-week-old range. Decision-making calculus is dictated by utilitarian rules of social choice that leave only limited room for individual discretion. An entire class of newborns will not be treated under the assumption that a significant number, though not necessarily a majority, will either die or survive with severe handicaps.

A threshold approach assumes that it is both morally permissible to weigh cost factors and to allow patients to die by withholding life saving treatment. Cost factors assume that premature newborns are essentially no different from similar classes of severely ill individuals who require expensive treatment. Just as one may reasonably deny expensive treatment to classes of patients suffering from particular diseases, one may similarly choose not to fund treatment for very premature infants. A threshold approach, which is no different than any other rationing technique, assumes that newborns are qualitatively no different from other classes of patients.

Nevertheless, one may try to point to significant differences between neonatal treatment and treatment for other classes of severe and expensive-to-treat diseases. First, failure to treat neonates will cause the death of all those in the affected class, including healthy infants. If the rights of the healthy overwhelm those of the ill then all should be treated. Second, one may argue that resuscitation at birth is a basic life-saving procedure that in and of itself is not expensive. Failure to provide basic resuscitation infringes on the right to basic health care that many developed countries grant their citizens and further


39 Danish Council of Ethics, op. cit. note 6, p. 28.
violates the basic professional duty of beneficence. Resuscitation is logically distinct from continued treatment; performing the former does not necessarily commit one to the latter.

It is not always easy to answer these objections. In fact, if practice is any guide it appears that most health care systems accept objections such as these and look askance at anything resembling a threshold approach to neonatal care. However, it is important to understand how these objections might be blunted. First, the failure to resuscitate newborns is no different from providing any other life-saving care. Second, neonatal care is expensive and legitimately subject to rationing criteria and third, neonates have no special privileges vis à vis other patients.

Failure to provide life saving treatment to an entire class of patients, be they very premature neonates or patients requiring transplants, is justified on economic grounds if treatment is very expensive and the outcome uncertain. It is of no moral significance that non-treatment will inevitably lead to the death of an entire class of patients while treatment may significantly improve the quality of life for some. This argument assumes, of course, that resuscitation of newborns is not an inexpensive procedure but is inherently linked to extensive intensive care. And, in fact, neonatologists often complain how their hands had been tied by decisions made in the delivery room, particularly in peripheral hospitals with no neonatal ICU. Once resuscitation is initiated there is often little choice but to continue treatment. This belies the contention that resuscitation and subsequent care are discrete events. Instead they mark a continuous chain of events that can only be broken when an infant’s conditions changes and a new decision must be made to continue care.

Nevertheless one may accept this argument, accede to the high costs of neonatal care and still argue it remains worthwhile to pursue resuscitation and intensive care treatment. Simple economic logic may dictate that a neonate’s very young age makes the cost per quality adjusted life year (QALY) significantly less than other expensive treatments like organ transplants. While the economics remain contentious, the overall cost of neonatal care is increased by aggressively treating extremely preterm newborns. This is a result of partial success. When transplants fail, the patient inevitably dies, but when neonatal


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treatment fails a patient may survive with severe handicaps and heavy long term costs.41

There is much to recommend a threshold policy and, as I have argued at greater length elsewhere, the policy endorsed by the Danish Council of Ethics answers to the demands of justice, utility and autonomy.42 If one accepts the claim that modern medicine is quickly reaching the point where some care must be rationed, then there is good reason to include intensive care for very low birth-weight infants in the category of rationed treatment. Any serious objection to this argument hinges on the claim that neonates, however impaired, deserve special recognition. Indeed, this claim suffuses even more limited policies of selective non-treatment.

Selective Non-Treatment of Newborns

Because many are as yet unprepared to ration neonatal (or any other) treatment, policy and practice in most nations allows for selective non-treatment of newborns. But the criteria for non-treatment of neonates are substantially different from those governing non-treatment of adults. For adults – competent, once competent or never competent – the rights to withhold or withdraw treatment are both defensible forms of a patient’s right to refuse medical treatment.43 However, it is noteworthy that same US presidential commission’s recommendations for neonatal care are far more restrained:

... Permanent handicaps justify a decision not to provide life-sustaining treatment only when they are so severe that continued existence would not be a net benefit to the infant ... [this decision excludes] considerations of the negative effects of an impaired child’s life on other persons, including parents, siblings and society. ...44

44 Ibid., pp. 218–9.
This position, consistent with American legislation governing neonatal care, clearly rules out any policy of global non-treatment. It cannot, however, be sustained.

The commission’s policy recommendations for care of newborns are relatively strict if compared to the rights that adult patients usually enjoy. As they weigh treatment options, parents may not consider quality of life nor third party interests, two factors that any patient may legitimately appraise. Unlike many of the well reasoned justifications that characterize the Commission’s report, its support for restricting neonatal rights is surprisingly thin. It is based on a) the small number of ‘ambiguous cases,’ i.e., those in which treatment is not clearly futile or beneficial, b) the inability of neonatology to predict which babies will survive together with the degree of impairment they may suffer, c) a clear desire to protect children against harm if and when it conflicts with parental interests, and d) an underlying belief that removing all but the most futile care is tantamount to killing and not simply a matter of letting die.45

References to the relatively small number of problematic cases and the inability to form firm prognoses are non-starters. The weight of ethical dilemmas does not depend on the number of cases. At best, ambiguous cases are those including the entire class of infants younger than 24 weeks and smaller than 750 grams. But this does nothing to temper the intractable nature of the dilemma and sets the stage for the detailed policy recommendations formulated by the Danish Council of Ethics. The inability to reach firm prognoses is at the crux of the dilemma but it cuts both ways and recalls the cogency of the social choice argument. In the absence of firm prognostic tools one may make a decision based on generalized outcomes. Although individual cases are uncertain, the outcome for the entire class is not.

Further justification for a restrictive policy – the desire to protect the child from any harm and a life without any ‘net benefit’ – is troublesome for two reasons. First, there is no mechanism to determine ‘net benefit’ and, second, harm is clearly multidimensional and cannot be narrowly defined as only death or severe suffering. In the opinion of the commission, ‘net benefit is absent only if the burdens imposed on the patient by the disability or its treatment would lead a competent decision-maker to choose to forego treatment.’46 But how can this standard be applied? Even competent decision-makers will

46 Ibid., p. 219.
disagree about what conditions they can tolerate. On one hand, handicapped newborns have never known a normal life with normal expectations, leading many to suggest that they can somehow bear more hardship. On the other, caring parents may legitimately ask why a newborn be should be subject to a life of any pain or suffering.

The fact remains that harm narrowly understood only as death or severe pain and suffering infringes on the rights we grant adult patients. A child, like an adult, may be harmed if he dies, or suffers, or is handicapped or is economically deprived. By the Commission’s reasoning, death and extreme suffering are incontestable harms while handicaps and economic deprivation impinge only on quality of life. But, it is not clear where right to life arguments end and quality of life arguments begin. Once one leaves the domain of certain death and considers harm to the patient, then all forms of harm merit consideration by the parent including harm to third parties be it the family or society at large.

There is no prima facie reason to prohibit parents from considering the interests of other family members, particularly other children in their care. If the competent decision-maker can weigh third party interests why can’t the parent of a handicapped newborn? This is particularly true if one considers a parent’s obligation to his or her other children. If the birth of a handicapped child brings social, economic or psychological hardship, it is legitimate, if not obligatory, for a parent to prevent that harm from befalling any child, or any future child, under his care.

In spite of the cogency of arguments that support either a threshold policy or one of selective non-treatment, they pale if aggressive treatment policy is ultimately driven by the belief that a decision to withdraw and/or withhold life support from premature newborns is tantamount to killing. Ordinarily, ethicists have little difficulty dismissing this particular argument. Any decision to forego life sustaining treatment is nothing more than to let a patient die. There is no fatal sequence of events precipitated by the physician and the patient does not die of any cause other than the underlying disease. Yet it appears that there is something more going on in pediatric care: letting die may, in fact, still be like killing when children’s lives are at stake.

Is Letting Die Still Killing?

Commenting on the Messenger case, one where a premature infant was removed from a respirator and his father later tried and acquitted for manslaughter, J.J. Paris observes:
Even though there is now universal agreement in the philosophical and legal literature that there is no moral or legal difference between withholding or withdrawing life-sustaining machinery, the circumstances of this case show that psychologically and politically the gulf can be enormous.\(^{47}\)

Why was there such an outcry against withdrawing life support from an anomalous newborn? If there are no compelling ethical arguments to restrict a policy of non-treatment what are we to make of the political and psychological resistance?

Political resistance comes from anti-abortion or other interest groups but is of dubious ethical merit. While there is widespread consensus that the moral status of late-term fetus is nearly commensurate with the newborn infant, the status question remains unresolved prior to viability. As a result, there are many Americans, on both the religious right and the secular left, who are willing to protect post-viable fetuses but lock horns over early-term abortion. The latter is far more contentious, raises issues that admit of no common ground and affects the lives and rights of millions of pregnant woman and fetuses. In such a supercharged atmosphere abortion groups vie to mobilize resources and public opinion. Very often their success depends on sensationalist, media driven cases: partial birth abortion, active euthanasia and selective non-treatment of impaired children. Although the real issue for pro-life and pro-choice groups is early-term abortion and reproductive rights, battles are fought and won on narrow lines. Partial birth abortion and egregious non-treatment of anomalous infants are issues that bear indirectly on the early-term abortion debate. Winners garner the public support, financial sponsorship and prestige vital to the continued success of their movement.

Psychological resistance comes from the strong emotional reactions associated with the vulnerability of small children. It was painfully evident when the Israeli Supreme Court refused a mother’s request to withhold ventilator support from a child dying of Tay-Sachs disease. It is one of the most comprehensive bioethical cases adjudicated in Israel to date but after a detailed analysis of voluminous secular and religious literature it appears that the judges were, in the final analysis, overwhelmed by the countenance of a young child peacefully asleep:


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Yael suffers neither pain or distress. *Like any other child,* Yael cries when she is hungry, uncomfortable or in need of routine care. Her light still burns and shines upon all who approach her bedside. Under these circumstances, sanctity of life is the sole, determinate factor in this case. . . .

While one may rationally accept the argument that to forego treatment is only to let one die, there is often the feeling that to let a child die is to kill her or at least as wrong as killing her. But the argument should be resisted. It lacks ethical foundation and only serves to exacerbate the dilemmas of late-term abortion and neonatal care.

**CONCLUSION: ETHICS, PRACTICE AND POLICY**

Ethics cannot, and should not, justify everything. In some cases ethical imperatives coincide with public policy and/or practice while in other places they diverge. Policy in no nation surveyed answers entirely to all of the ethical demands.

The question of a late-term fetus’s moral status, so intractable in the case of early-term abortion, is largely a matter of consensus among bioethicists and policy makers. Even in nations that do not stipulate a gestational age limit on abortion, there is a growing tendency among practitioners to resist any late-term abortion that is not intended to save the mother’s life or serve fetal/newborn best interest – narrowly defined as prevention of certain death or severe pain and suffering. Nevertheless, fetal status is not identical with newborn status. This leads to an interesting ethical paradox clearly impinging on policy and practice. On the one hand, the inferior status of the fetus allows consideration of feticide, an act of intentional killing that cannot be condoned when the patient possesses a full measure of legal and moral personhood. On the other hand, the very act of permissible killing creates an imperative for the state to be vigilant. As a result, the state’s interest to protect the fetus may be stronger than its interest to protect the newborn. This is not because the status of the fetus is in anyway superior, but because the act of killing must be closely regulated. Partially restrictive late-term abortion policy should be offset by more liberal neonatal policy; knowing that it is permissible to withdraw treatment from anomalous newborns tempers the need for feticide.

The treatment options for anomalous newborns nevertheless remain contentious. While one intuitively draws a distinction

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48 Shefer v The State of Israel, emphasis added.
between killing and letting die, this distinction is sometimes ignored in the case of children due to tangential political or psychological pressures. It is sensible to restore this distinction, the very same one that categorizes adult health care decisions. Letting die, whether the result of withholding or withdrawing treatment, is not killing. Either option to forego treatment may be taken at the behest of the surrogate decision-maker without any special regard for the age of the patient. Similarly, if infants are full-fledged patients whose interests are represented by surrogate decision-makers then their interests must be interpreted with the same discretion that pertains to any adult patient and may reflect social, familial and economic concerns.

Applying these guidelines to the policy of those nations surveyed pushes toward ethical consistency between abortion and neonatal policy in a way that will also tend to resolve the tension between policy and practice. Israeli policy is deficient on several counts: abortion is too liberal and neonatal treatment protocols too restrictive. This leaves families faced with the possibility of an anomalous infant very little room to maneuver and forces parents and physicians to abort fetuses whom they might prefer to deliver and reevaluate following birth. However, because cessation of life support is prohibited it is far easier to stay within the letter of the law and choose late-term abortion. Yet many health care professionals have severe doubts about the ethics of unrestricted late-term abortion while, at the same time, voice astonishment that they cannot discontinue life support to terminally ill pediatric patients. Some have responded to the first concern by asking the legislature to bind their hands by enacting strict guidelines governing late-term abortion and legislation protecting health care providers from wrongful life suits. Nevertheless, it is clear that without a less restrictive neonatal policy, undue hardship will be created for many parents as abortion remains the only viable alternative for dealing with potentially anomalous newborns. This leads to two unfortunate outcomes that might easily be avoided: relatively healthy fetuses are being aborted and relatively ill newborns are being maintained on expensive life support. While there are recent indications that withdrawal of treatment may become an option for adult patients, policy will continue to create ethical distress at the bedside until both abortion and neonatal treatment protocols are modified.

Official policy in the United States is also subject to street-level pressures that should bear on change. In the case of late-term abortion, the statutes of most states place an overwhelming emphasis on fetal interest, making it difficult to obtain an
abortion for severe anomalies in these jurisdictions. Nevertheless, late-term abortions continue to be performed for these reasons. No firm statistics are available but it must be the case that women either travel to the few states allowing late-term abortions for fetal anomaly or that physicians game the system, aborting anomalous fetuses under the rubric of fetal threats to maternal health.\textsuperscript{49} Moreover, published reports, as noted, indicate a willingness, if not responsibility, on the part of physicians to abort severely anomalous fetuses. The myopia of state policy on this issue is glaring. Similarly, policy articulated in the child abuse laws is increasingly divorced from practice as health care professionals are willing to acquiesce to parental wishes to discontinue life support out of consideration for the infant’s quality of life and/or the best interest of other family members. While selective non-treatment remains, for the time being, a less volatile issue than abortion in the US, the ethical imperatives side with practice not policy and therefore deserve careful consideration.

Clearly, it is not always the case that practice reflects ethics. In spite of some emerging pressure, neonatal practice in Israel still does not coincide with the ethical imperative to allow termination of life support as it does in most other countries. In the United States, the number of abortion providers continues to dwindle, indicating a reluctance on the part of physicians, for any number reasons, to practice abortion. In the UK, the disparity between abortion and neonatal management creates a different kind of dilemma.

We are therefore on the horns of a dilemma which is the inexorable result of the Abortion Act 1967 – given that we acknowledge a woman’s right to terminate her pregnancy because she feels unable to accept her defective fetus, by what reason should we insist that the roles are reversed and that the interests of the defective neonate outweigh those of the potential carer?\textsuperscript{50}

Mason and McCall Smith describe the kind of asymmetry posed by inconsistent policy. Ethically, the dilemma begins to dissolve as physicians in the UK develop guidelines that do not allow a

\textsuperscript{49} This remains a matter of conjecture. Late-term abortions in the US numbered 1170 in 1992. (Guttmacher Institute. 1997. \textit{The Limitations of US Statistics on Abortion}. Washington, DC. The Alan Guttmacher Institute.) It is not known how many were performed to protect the mother’s health but based on data from other nations the number is probably no more than 5–10% (Gross, \textit{op. cit.} note 3).

\textsuperscript{50} Mason and McCall Smith, \textit{op. cit.} note 15, p. 163.
woman complete discretion to terminate her late-term pregnancy while at the same time interpret neonatal interests so they do not ‘outweigh those of the potential caregiver.’ Policy should endorse a similar course, otherwise it is clearly possible that, like in Israel, undue pressure will be exerted on providers to abort late-term fetuses that parents and physicians alike would prefer to deliver.

Danish policy recommendations deserve special consideration. Threshold policies that deny scarce resources to high cost, high risk groups are not, in and of themselves, illegitimate nor do they violate any of the ethical conclusions reached above. A patient’s age, be it very young or very old, offers no privileged moral claim to scarce resources. Insofar as health policy is not blatantly discriminatory, Danes may certainly decide to accept the recommendations of the Council of Ethics to limit treatment of certain preterm infants and fund more cost efficient pediatric care. Careful consideration of Danish policy is likely to give policy makers pause as they evaluate the merits of their own policy. It draws our attention to the economic imperative of rationing, our excessive infatuation with what the Council has termed ‘techno-crazed fantasies of [medical] engineering’, as well as our exaggerated reverence for small children. Danish practitioners, too, especially those moving toward a policy of initiation and reevaluation, will take note of these arguments.

Given that many policies are deficient in some way, how might change best be undertaken? In many cases, it is gratuitous to call for legislative initiative. The ferocity of the abortion debate simply forbids any concerted effort to bring about change in at least some of the countries surveyed. In the US and Israel, for example, it simply will not happen. While many secular Israelis would like to restrict late-term abortions all are aware that the original abortion law was born of fortuitous circumstance and that any attempt to modify the law may simply bring its abrogation. Similarly, there is no call in the US to liberalize post-viability abortion regulations or repeal the child abuse statutes, leaving one wondering whether prudence demands that the status quo remain undisturbed.

Apathy, however, is dangerous for several reasons. First, practice cannot always modify policy. Regardless of the ethical imperative to do so, Israeli physicians, for example, will not discontinue life support without a court order. Second, if unofficial practice supersedes explicit policy there is no room for regulation. We don’t know what is really happening with third term abortion in the US or what guidelines govern decisions to forego neonatal care. Third, lack of symmetry between policy and

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practice may, at best, make it difficult to follow legal guidelines with any degree of precision. At worse, we may ultimately be encouraging caregivers and parents to break the law, yet, when they do, remain reluctant to punish them. Cases like Messenger and Linares – parents arrested but later released or acquitted, often following agonizing public trials, after they disconnected their children from respirators and allowed them to die – characterize this ambivalence.\textsuperscript{51} This cannot help but impinge upon the public’s perception of law and order.

But the effects of deviant practice are not entirely negative. Deviant practice should force reexamination of policy. While the chances of legislative change might be slim, there remain good reasons to place these issues on the public agenda. Recent descriptions of deliberative democracy point to the essential need to raise the level of dialogue with regard to public issues such as health care, abortion and bioethics.\textsuperscript{52} Even specific issues – guidelines for determining sufficient severity of pain and suffering to justify feticide, for example – can only benefit from dialogue between politicians, health care practitioners and the public. There is crucial need in all these nations to use and improve existing avenues of public discourse – community meetings, public hearings and referenda – to work through these issues before they are brought for legislative consideration. While this may not, ultimately, bring new legislation, it would certainly serve to raise the level of public appreciation of the complexity of the bioethical issues faced in modern society and so, in the very least, temper the social dissonance that occurs when practice deviates from policy.

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