

# Abortion and euthanasia



## NUMBERS AND RATES

Global and regional estimates of induced abortion, 1995, 2003 and 2008

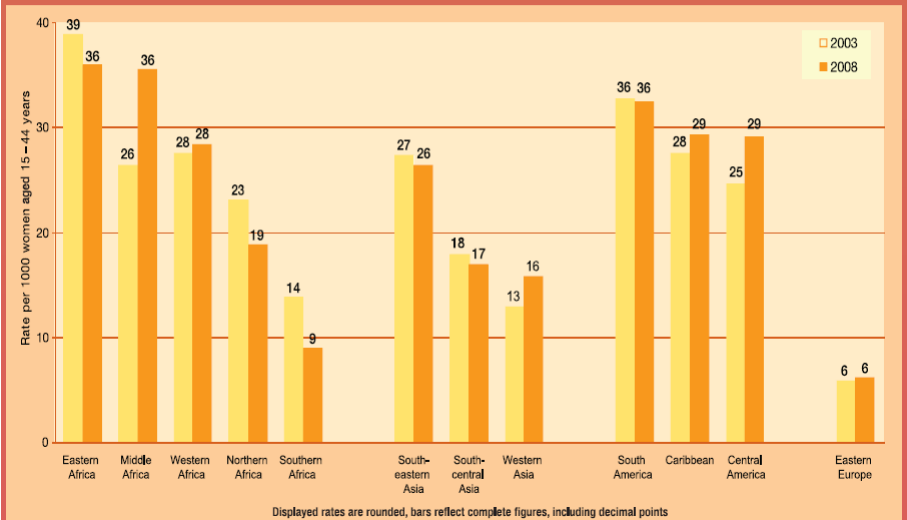
Region	No. of abortions (millions)			Abortion rate*		
	1995	2003	2008	1995	2003	2008
<b>World</b>	<b>45.6</b>	<b>41.6</b>	<b>43.8</b>	<b>35</b>	<b>29</b>	<b>28</b>
Developed countries	10.0	6.6	6.0	39	25	24
Excluding Eastern Europe	3.8	3.5	3.2	20	19	17
Developing countries	35.5	35.0	37.8	34	29	29
Excluding China	24.9	26.4	28.6	33	30	29
Africa	5.0	5.6	6.4	33	29	29
Asia	26.8	25.9	27.3	33	29	28
Europe	7.7	4.3	4.2	48	28	27
Latin America	4.2	4.1	4.4	37	31	32
Northern America	1.5	1.5	1.4	22	21	19
Oceania	0.1	0.1	0.1	21	18	17

\*Abortions per 1,000 women aged 15–44.

Source: Sedgh G et al., Induced abortion: incidence and trends worldwide from 1995 to 2008, *Lancet*, 2012, (forthcoming).



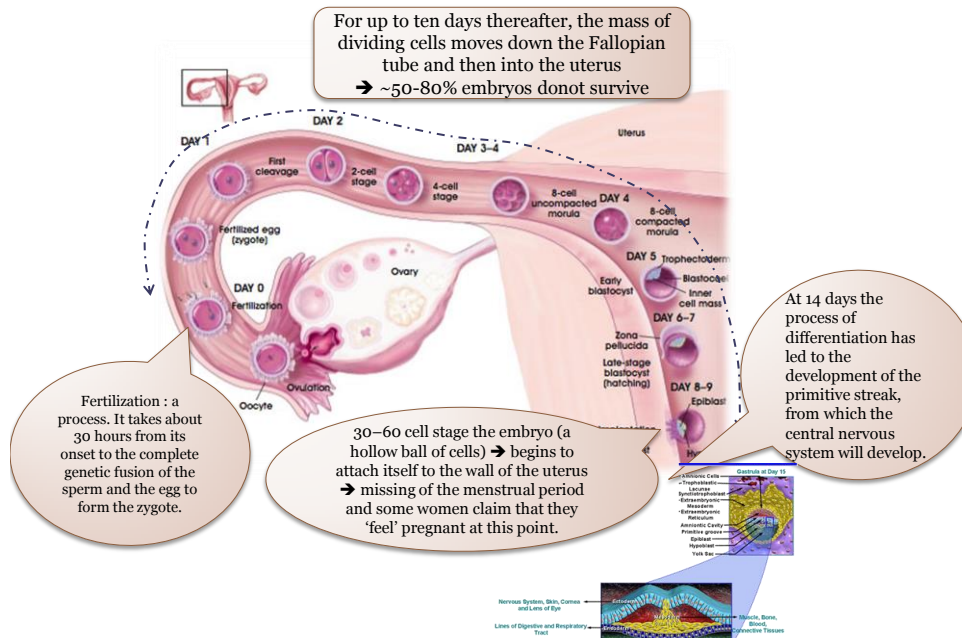
Number of unsafe abortions per 1000 women aged 15–44 years by subregion, 2003 and 2008

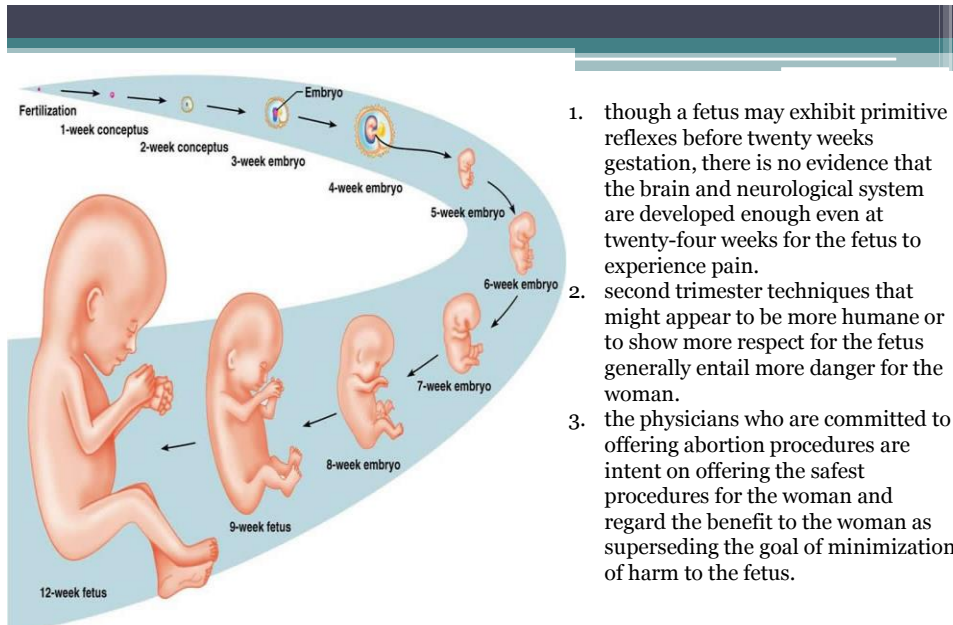


# Abortion

- **Definition:**
  - Spontaneous abortion = miscarriage = a spontaneous loss of a pregnancy before viability (at about twenty-four weeks of gestation).
  - Losses after twenty-four weeks of gestation in a pregnancy : *preterm deliveries*, or, in the case of the delivery of a fetus who has already died, *stillbirths*.
  - **induced abortion.**
- **4 things that should be considered:**
  1. whether medical knowledge clarifies the moral status of the fetus as a human being;
    - ❖ When does human life begin?
    - ❖ At what point should the 'moral seriousness' of human life require it to be protected by legislation?
  2. whether medical information on abortion confirms it to be safe for the woman;
  3. what the medical perspectives are on performing early versus late abortions, particularly in light of controversies regarding *partial birth abortion*;
  4. what the public health and international perspectives are on abortion.

## Warnock Committee (1985; Warnock, 1998)



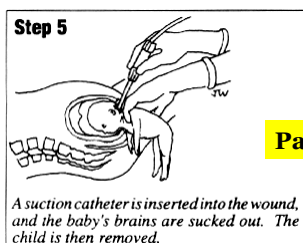
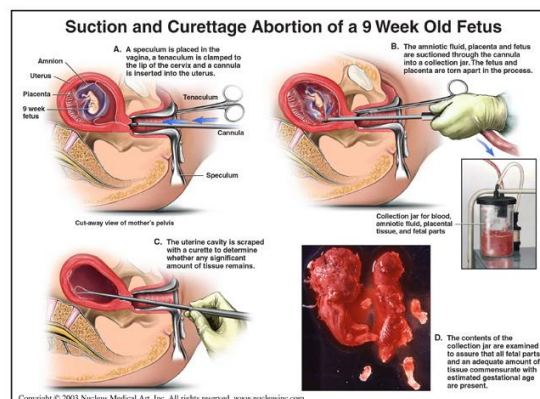


1. though a fetus may exhibit primitive reflexes before twenty weeks gestation, there is no evidence that the brain and neurological system are developed enough even at twenty-four weeks for the fetus to experience pain.
2. second trimester techniques that might appear to be more humane or to show more respect for the fetus generally entail more danger for the woman.
3. the physicians who are committed to offering abortion procedures are intent on offering the safest procedures for the woman and regard the benefit to the woman as superseding the goal of minimization of harm to the fetus.

biomedical investigation may provide regarding pregnancy, fetal development, and abortion, but it cannot provide a determination as to when human life begins.

## ABORTION PROCEDURES

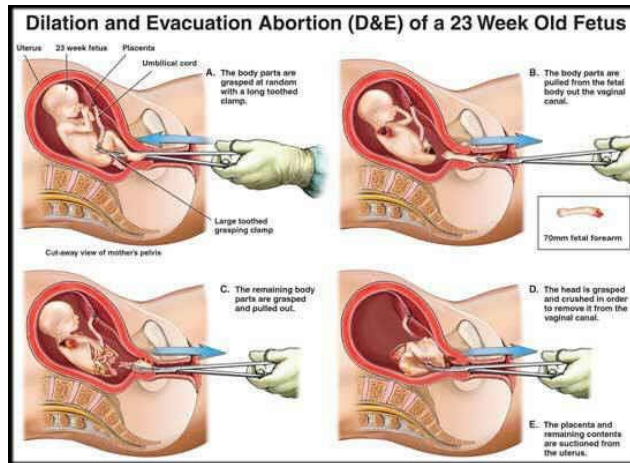
- between seven and twelve weeks' gestation
- suction curettage,
- Complications : rare



### Partial abortion

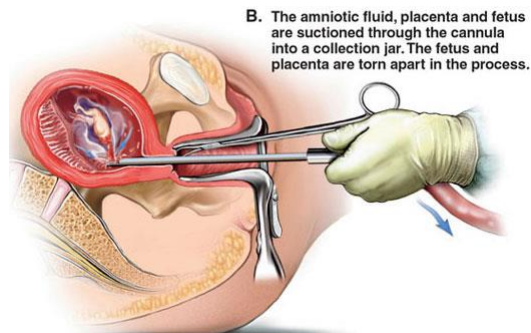
## ABORTION PROCEDURES

- At twelve to twenty weeks' gestation - dilation and evacuation (D&E),
  - the cervix is dilated gradually over a number of hours using sponge-like materials that expand as they absorb local cervical fluids
  - uses specially designed forceps in conjunction with vacuum aspiration to facilitate the removal of the uterine contents.



## ABORTION PROCEDURES

- In the second trimester is instillation abortion, in which a solution instilled into the amniotic cavity through the abdomen via amniocentesis results in the death of the fetus and termination of the pregnancy.
- More serious complications can occur during instillation procedures.





## ABORTION PROCEDURES

- A promising alternative to surgical abortion for early first-trimester terminations of pregnancy is chemical abortion.
- For example, the antiprogesterin drug RU-486 works by blocking progesterone production by the ovaries

## Euthanasia



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- *Euthanasia* (Greek words) : ‘a quiet and easy death’.
    - ➔ most people hope as they do not want their dying to be prolonged, painful or violent.
  - Voluntary euthanasia:
    - the deliberate ending of a person’s life, at their request, because they find their illness and/or disability intolerable.

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- Three main arguments for making voluntary euthanasia lawful:
    - **Autonomy**
      - The basic question is whether or not human beings have the right to decide themselves how they will end their lives.
    - **Necessity**
      - necessity is the most emotionally powerful.
      - Case histories:
        - A man had motor neuron disease, which causes progressive muscular paralysis but leaves sensation and mental function intact. His general practitioner told him that not only would he become increasingly disabled, but also his breathing would become more difficult as his lungs became waterlogged and that he would eventually choke to death. Faced with this the patient asked to have his life ended, which the doctor did, injecting him with a lethal combination of anesthetic drugs.
    - **Openness**

## Case:

- Dawson gave the King George V (UK) intravenously a lethal dose of morphine and cocaine and he died.
  - Dawson was able to return to London by the morning to his private practice (Ramsay, 1994).
- Dawson's main arguments in favour of euthanasia:
  - the patient was terminally ill
  - his dignity was assured
  - his suffering was relieved
  - the relatives were spared a long bedside vigil.

## THE CASE AGAINST EUTHANASIA

- Is there a downside to the exercise of autonomy?
  - men and women are not only individuals; they are part of society.
  - Thus a second important principle in the conduct of civilised human affairs is that individuals may only exercise their rights in so far as they do not infringe the rights of others.
- Are there effective ways of controlling the pain and distress of terminal illness apart from killing the person? Is voluntary euthanasia necessary?
- in 1992 :
  - Total number of deaths in The Netherlands in 1990: 12 900
  - Deaths not terminated or assisted by the doctor 9200
  - Termination of life at patient request 2300
  - Assisted suicide 400
  - Termination of life without patient request 1000
- 28% of all deaths in The Netherlands in 1990 involved the active participation of a doctor, → 7.7% of all deaths were actually procured by a doctor without the request of the patient



## PROLONGING DYING

- four main principles, which are widely accepted and underlie contemporary medical and healthcare practice:
  - **Beneficence:**
    - a doctor must always act in a person's best interest, that is in a way which confers benefit upon that person.
  - **Non-maleficence:**
    - a doctor must not harm a person. That can never be in a person's best interest.
  - **Autonomy:**
    - a doctor may not do anything to a person without their consent. Any person has an absolute right to refuse medical treatment.
  - **Justice:**
    - a doctor must act in such a way that resources are apportioned equitably within a society.

- five areas to consider in Euthanasia:
  - resuscitation
  - brain stem death
  - permanent vegetative state
  - intensive care, cancer treatment and heroic surgery
  - conjoined twins.

## RESUSCITATION

- Since 1960 the technique of external cardiac massage and expired air ventilation and electrical defibrillation has saved the lives of many people who would otherwise have died suddenly because their heart stopped beating from some reversible cause.
- This procedure cannot be proceed if:
  - the patient did not wish it
  - it would be useless
  - the costs were too great
  - the subsequent quality of life would be unacceptable.

## BRAIN STEM DEATH

- Death occurs when one of three organs cease to function – the brain stem, the heart and the lungs. If one of these stops working the other two cease to function rapidly thereafter and death occurs.
  - By passing a tube into the person's trachea and attaching it to a ventilator ('life-support machine') → inflate the lungs with oxygen and → hereby maintain the function of the heart, in the hope that recovery of the brain would occur and all three organs be able to function near normally again.
  - A key question then arose:
    - was it possible to distinguish between those people in whom such recovery would occur and those in whom it would not?
    - is it possible to identify those in whom the brain damage is fatal and the inevitable process of death has simply been interrupted?
      - When this happens the higher centers of the brain, which are the neurological basis of personhood, can neither receive nor transmit information

## PERMANENT VEGETATIVE STATE (PVS)

- In PVS :
  - the brain stem is intact so that the heart and lungs continue to function normally without artificial support.
  - People with PVS:
    - display sleep–wake patterns and respond reflexly to stimulation but show no evidence of cognitive function.
    - unable to swallow → have to be fed through a tube placed in the stomach via the nose and the oesophagus.
- Questions:
  - Is such a person alive?
  - Is feeding through a tube when the person is unable to take food and hydration normally through the mouth an artificial means of support?

## CONJOINED TWINS

- Problems:
  - To life as a conjoined twins → difficult
  - Separation by a surgical operation would cause the certain death of the other twin.

