Chapter 8 Summary: Prenatal testing and abortion for fetal anomaly

Prenatal genetic diagnosis, while still a relatively new practice, is tracked through public health programs globally. Despite the many technological advances in testing for genetic anomalies, there is inconsistency in surveillance reports.[1] While some maintain that the purpose of prenatal testing is to evaluate preventative measures, statistics show that the information collected about congenital conditions is leading to an increase in selective abortion.[2]

Prenatal testing began in the late 1970s with the use of amniocentesis to identify fetuses with Down syndrome or spina bifida. In addition to identifying chromosomal anomalies, prenatal screening can detect non-heritable conditions. The capacity to diagnose prenatally is now vastly disproportionate to the capacity to treat the illnesses or disabilities. Rather than preventing or treating a condition, the tests are often used to prevent the birth of individuals with certain undesired characteristics through termination of pregnancy. For example, the abortion rate for Down syndrome is 48.1 per cent across 16 European countries and is 98 per cent in Denmark.[3]

Now that prenatal screening is standard practice, women are often unaware they can refuse testing, and those who do are often seen as failing to "ensure the birth of a healthy child."[4] Additionally, those who carry a disabled fetus to term often are not provided with support or encouragement. As one author states, "disability rights advocates are right to think of genetic counselling as a search and destroy mission because testing will likely ultimately lead to greater intolerance of disabilities and less money for research or treatment."[5] Finally, although some women experience adverse psychological outcomes after terminating for fetal anomaly, many are not informed of this risk.[6]

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1 Lowry RB. Congenital anomalies surveillance in Canada. Canadian Journal of Public Health 2008; 99(6): pp. 483-5.

2 Ibid., p. 483.

3 Khoshnood B, Greenlees R, Loane M, Dolk H and EUROCAT Working Group. Paper 2: EUROCAT public health indicators for congenital anomalies in Europe. Birth Defects Research Part A (Clinical and Molecular Teratology) 2011; 91(Suppl 1): pp. S16-22. Nordvig L, Secher NJ, Andersen S. Psykologiske aspekter, brugerholdninger og - forventninger I forbindelse med ultralydskanning I graviditeten. Medicinsk Teknologivurdering 2006; 6(13): p. 12.

4 Seavilleklein V. Challenging the rhetoric of choice in prenatal screening. Ph.D dissertation. Halifax, NS: Dalhousie University, 2008.

5 Dixon DP. Informed consent or institutionalized eugenics? How the medical profession encourages abortion of fetuses with down syndrome. Issues in Law & Medicine 2008; 24(1). p. 21.

6 Korenromp MJ, Page-Christiaens GC, van den Bout J, Mulder EJ, Hunfeld JA, Potters CM, Erwich JJ, van Binsbergen CJ, Brons JT, Beekhuis JR, Omtzigt AW, Visser GH. A prospective study on parental

In conclusion, further advances regarding the use of prenatal testing, women`s understanding of their rights, and available support for disabled infants are necessary.

coping 4 months after termination of pregnancy for fetal anomalies. Prenatal Diagnosis 2007; 27(8): pp. 709-716.