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Perfection: The Fatality of Down Syndrome

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Abstract

Down syndrome is a condition that carries with it a negative stigma and many negative assumptions. The advancement of the medical community has begun to allow expectant parents to anticipate whether their child will have Down syndrome. However, in recent years mothers are using the results of prenatal tests as a deciding factor to decide if they will continue the pregnancy. The negative stigma associated with Down syndrome has transformed into a discrimination against people with Down syndrome. There are many influencing factors that affect the decision-making process of expectant mothers. The decision to terminate one's pregnancy is not made in isolation; everyone is affected by their environment. The decision of mothers to selectively abort unborn children with Down syndrome will not be changed until the environment the mothers live in changes.

Keywords: Down syndrome, Abortion, Selective abortions, Prenatal testing

Perfection: The Fatality of Down Syndrome

Down syndrome is a chromosomal abnormality which results in birth defects. The medical community has recently begun developing screening for through various forms of prenatal testing. Although older mothers are at a higher risk for having a child with Down syndrome, they are not the only women who bear children with this specific birth defect. With the recent development and widespread availability of prenatal testing, women are presented with information and inappropriate pressures to make decisions about their future and the health of their unborn child. The combination of societal expectations for perfection and the progression of the medical community are negatively influencing the abortion rates of pregnancies professionally diagnosed to result in a baby with Down syndrome.

The decision to terminate a pregnancy relies heavily on the mother's reasoning and beliefs along with advice given by others. No decision, especially one to terminate a pregnancy, can be made in an isolated bubble, apart from influential factors. According to the National Right to Life (1994) agency, 93 percent of abortions are performed for the "convenience of the mother". Consequently, it can be said that majority of abortions are performed for reasons other than to preserve the mother's health. A reason in which an abortion would be performed for the health of the mother may be if the mother were diagnosed with uterine cancer that could be surgically removed. Social expectations and norms dictate many life decisions, is it not surprising that the societal norms also dictate which children are acceptable to live? When decisions of what is acceptable to wear and what it is acceptable to look like or even when it is acceptable to get married it is not much of a reach for norms to also be allowed to decide life worth of individuals.

Culture plays an impactful role in shaping personality, beliefs, and worldviews. Cultural norms and expectations are unique to the location and time in which they develop. What is acceptable and expected in another culture during the 1980s is not the same as what is socially and culturally acceptable and expected in America today. Within the United States of America, there are not unanimously agreed upon beliefs or standards. However, as a whole, the greater American culture influences individual beliefs and expectations throughout the country, regardless of region. Despite a lack of universal beliefs and morality, the United States does maintain common law put forth by the Supreme Court, along with medical standards that are put into place as national standards of health care. Before change can occur in an entire population, societal expectations and cultural norms reflected in the behavior of the society must see its flaws and begin the appropriate corrective process.

Background Information

In America today, abortion is becoming less and less taboo. What was previously a shameful act is now considered by many to be an empowering decision that promotes the all-or-nothing ideals of feminism. Regardless of the genuine intentions of the woman, an abortion is seen by feminists as an exercise of women's right to choose. Selective abortions go beyond the assertion of women's rights. Women are not simply encouraged by the "my body, my choice" philosophy. Increasingly, parents are persuaded by the societal fallacy that the only acceptable child is the one that looks like other children; any unborn child that does not fit the norm must be defective. A feminist disability critique argues that "this reproductive decision-making process may indeed be shaped by the under-recognized sense that some people 'just should not be born'. It is quite plausible that this is a decisional process colored by eugenic ideals" (Piepmeier, 2015, pp.17). This selective abortion increase

is not a movement unique to the United States. In an international study, Roizen and Patterson (2003) found that “the number of terminated pregnancies with Down’s syndrome has increased, and the prevalence of Down’s syndrome births has decreased from one in 700 to one in 1000” (pp.1282). The decrease in prevalence of Down syndrome is not to say that fewer children with Down syndrome are being conceived; they are simply not being born. Rejecting a pregnancy based solely on the presence of a characteristic or a group of characteristics is selective abortion at its core. Addressing the effect of the lack of fetal privacy in 1995, Jeffrey Botkin makes the statement that “For the past twenty years, a consistent 79 percent of the U.S public has believed that abortion should be available ‘if there would be a serious defect in the baby’” (pp.32). The general public is receiving more detailed information and expected to react in a way that is seen as appropriate by society. With the advances in medical technologies, expectant mothers have the option to learn if their unborn child may have Down syndrome. Selective abortions occur when a mother uses this knowledge then to decide to terminate the pregnancy.

Down syndrome is a chromosomal birth defect that affects the twenty-first chromosome pair. It is commonly referred to as trisomy-21 because the condition produces three chromosomes where normally there are only two on the twenty-first pair. Although the connection between the twenty-first pair of chromosomes and Down syndrome was established in 1959, a preliminary study has touched on the possibility that a potential mitochondrial disorder may be an influencing factor in the presence of the extra chromosome on the twenty-first pair (Roizen, N. J., & Patterson, D., 2003). Because medical technologies are continually advancing, the medical community and the general public know more about chromosomal abnormalities like Down syndrome and have information readily available to

them. Ignorance is not bliss, and knowledge can open doors that may otherwise be closed. The actions of the medical community have the power to decide if the condition of Down syndrome—along with the people who have the condition—is eradicated or is allowed to benefit individuals with Down syndrome to receive better care.

Although Down syndrome is a chromosomal abnormality that is primarily evident through physical characteristics, there are health problems associated with the condition as well. Just as any parents of a newborn should be vigilant, there are some conditions that children with Down syndrome are more prone to develop. Children with Down syndrome can be born with a heavier body, resulting in a mal-proportioned head-body weight, which can establish a pattern that can result in obesity later in life (Roizen, N. J., & Patterson, D., 2003). In addition to the routine APGAR (Appearance, Pulse, Grimace, Activity, Respiration) test that newborns are given, physicians will check for “congenital heart disease, hearing loss, and ophthalmological problems” (Roizen, N. J., & Patterson, D., 2003, pp.1283) in newborns with Down syndrome (Gavin, M. L., 2018). The extra testing newborns with Down syndrome receive is beneficial to the newborn because it allows both the parents and the physician to anticipate any future health problems that may develop or may be present at birth. Apart from physical and medical conditions, individuals with Down syndrome also have some level of mental and emotional deficits. A study conducted by Khoshnood et al. (2006), reported that “Down syndrome [is] the foremost known genetic cause of mental retardation” (pp. 2139). While these deficits may appear slowly, they become increasingly evident as the individual grows and develops while the development of their brain and mental capabilities is hindered by genetic obstacles. However, let it not be said that individuals with Down syndrome lack potential in life simply because of increased health vulnerabilities.

The first step for anyone to thrive is to overcome health complications and this is not specific to individuals with Down syndrome; it is applicable to any person with any health complication. Medical assistance may be needed to overcome physical health problems. Adjusting learning curves and creative teaching approaches may be necessary to overcome cognitive health delays. Rather than submitting to the quick-fix of abortion, the life of the person should be considered rather than just the facts of the condition the individual may have.

Science and medicine aim to answer questions and provide society with increasing knowledge about itself and its surroundings. The same is true of prenatal testing. Since the 1970s, the medical community has been successful in testing for chromosomal abnormalities such as Down syndrome (Roizen, N. J., & Patterson, D., 2003). Although Down syndrome is not the only abnormality that can be screened for using prenatal testing, such tests are generally accredited for that primary use. The availability of prenatal screening to all expectant mothers has become a safeguard for physicians and the medical community in general. In recent years, it has become legal precedent that parents have a right to know about the health status of their unborn child. The presence of abnormalities such as Down syndrome is included in this legal precedent (Bassett, K., Lee, P. M., Green, C. J., Mitchell, L., & Kazanjian, A., 2004). Physicians have come under backlash after failing to offer prenatal testing to expectant mothers. In a society that has grown acquainted with having all knowledge within reach and solutions to problems being found in courtrooms, it is not surprising that families are holding physicians responsible for failing to inform.

American society has grown to be fully consumed in the here and now. Virtually everyone has a cell phone equipped with the latest technologies and applications. Gone are

the days when a massive desktop computer was needed to access electronic email correspondences that may have been sent hours or days before. Even further gone are the days of snail mail when it was necessary to sit down, write a letter and wait for it to be picked up and delivered by the postman. Today, it is seen as peculiar and against-the-grain of expectation for a person not to own a cell phone that is always on his or her person. Modern American society is dominated by a “get in now, get it quick” mentality. The constant flow and availability of information by smart phone technology and internet accessibility has taken the mystery out of life and replaced it with the desire to know everything. Society’s desire to know has led to a search for answers to questions never asked before, such as detailed, yet ambiguous, health statuses of unborn children. Parents want to know everything about their child, even if that information could be wrong. Hindsight is always “twenty-twenty,” and parents who did not receive a detailed health report on their unborn child are regretting their choices. Rather than accepting the life they have in their hands; these parents are taking action against the medical community for failure to inform.

Wrongful birth lawsuits have begun to hold responsible a physician or medical community that did not provide information, e.g. screening, about the health of an unborn child. Parents have stood in courts to testify that had they known that their child would be born with Down syndrome, they would have aborted the pregnancy. The United States court system is setting the precedent that physicians must offer prenatal screening to every expectant mother or be at risk a wrongful birth lawsuit because they allowed for the child to be born and not allowing the parents decide the fate of their child. According to the law, parents have all the power, the unborn child has none, and the medical community is a tool to serve the parents. However, the law does not show the whole picture. The law focuses on the

decision to abort and the implications of that decision. While there are factors at play in the decision of abortion, those factors occur behind the scene and are irrelevant in the eyes of the law.

Where it all started: The Desire for Knowledge

To begin at the beginning is to start with the foundation of Planned Parenthood and its initial goal: birth control for all women. The original founder of Planned Parenthood, Margaret Sanger, did not believe that abortions classified as birth control; rather it was a “dangerous method of family planning” (Planned Parenthood, 2016, pp.1). However, this belief that Planned Parenthood was founded on began to shift, changing until it developed into the legally protected right that abortion is a “childbearing decision” and carries no “expression of moral unease” during the time that the Supreme Court ruled on *Roe v. Wade* in 1973 (Planned Parenthood, 2016). Planned Parenthood’s shift in ideals may be attributed to the change in leadership within the foundation. Shortly after the Supreme court’s decision on *Roe v. Wade*, Planned Parenthood saw a new president: Gloria Feldt (Planned Parenthood, 2016). David Tell critically analyzes Feldt’s opinion that “Only love can make a family” (Tell, D., 2003, pp.36). From Tells’s critical perspective, Feldt has been known to hold the belief that “it’s got to be the right kind of love too, involving the right kind of semen donation, deposited and filed with the right kind of prospectus by the right kind of co-parents proceeding from the right kind of teleological first principles” (Tell, D., 2003, pp.36). A vital piece of what Feldt does not understand is there is not a right kind of anything, there is only what is. The right kind of what Feldt is speaking of is a fantasy and has no place in reality because no one has it; it is an unreachable and unrealistic ideal. David Tell also has reason to believe that Feldt uses her book *Behind Every Choice is a Story* to allude to her stance that

“being born has its down sides—that abortion is what’s mercifully best for the millions of ‘fetuses’ who cannot hope to live lives so full and beautiful” (pp.36). This argument for abortion is not an isolated case of such belief. A group of thinkers known as anti-natalists fall into the same belief with similar supports. Although Feldt never makes this anti-natalistic claim outright, Tell believes it is through her tone that betrays her accepting reputation (pp.36). Feldt may be pulling from anti-natalist ideals.

Precedent of Roe v Wade. In 1973 the United States Supreme Court ruled in favor of Roe, concluding that abortion “on demand” is constitutionally legal based on the right to privacy established in the Fourteenth Amendment. Supreme Court justices voted with a seven to two majority. The right to privacy established in the Fourteenth Amendment is exclusive to the expectant mother. There is no consideration of the potential for the unborn child to be extended the same right. The medical and the psychological concern always lies with the mother in the situation of unwanted pregnancy and abortion: “the prevailing social standard after *Roe* is that the mother’s interest in avoiding the burdens of motherhood outweighs the interest in life or potential life for the fetus” (Botkin, J. R., 1995, pp.33).

The Supreme Court’s stamp of constitutional approval on abortions has successfully erased the taboo nature of abortions. According to the National Right to Life organization (1994), abortion is the end-result of 28.6% of total pregnancies each year. Regardless of intention, because of the high annual abortion rate, the question must be asked: are abortions being used as a method of birth control? If this is the case, it would be common to see women going to clinics for second or third abortions. If this is not the case, and abortions are being used as an exercise of a woman’s right to decide, then lower numbers of repeated abortions would be seen in clinics. Statistics from 1995 indicate that abortions are being

regarded as a method of birth control: 43% of abortions were repeat abortions according to the National Right to Life organization (National Right to Life). While traditionally older data would be disregarded as irrelevant and overshadowed by newer data, the National Right to Life uses the older data along with newer data to create a timeline: “projection of the numbers would indicate the repeat abortions are probably closer to 50% in 1993” (National Right to Life, 1995). According to the United States Center of Disease Control, 44.9% of all abortions in 2014 were repeat abortions with at least one prior abortion (Jatlaoui, T. C., 2017, pp.1). While *Roe v Wade* did not establish abortions as a form of birth control, the Supreme Court Justices put minimal limitations on the circumstances or intentions that motivate the abortion. With the continuation of medical developments, the implications of the Fourteenth Amendment and the effects of *Roe v Wade* become fluid and interpretations are altered. The combination of *Roe v Wade*, the Fourteenth Amendment, and medical standards have paved the way for the formation of wrongful birth lawsuits as precedent.

Wrongful Birth Lawsuits. The right to privacy portion of the Fourteenth Amendment in which the *Roe v Wade* decision is structured on includes the insurance of only the most superficial knowledge concerning pregnancy. The only information required to be provided by physicians for parents to make an informed decision about the continuation of their pregnancy is the general status of the pregnancy (i.e. if the woman is in fact pregnant). At face-value, the Fourteenth Amendment does not mention the inclusion of information regarding the health of the pregnancy and the unborn child in regard to making an informed decision concerning the continuation of the pregnancy. For example, before making informed decision to terminate her pregnancy, a woman needs her doctor only to confirm that she is indeed pregnant according to the initial interpretation of the Fourteenth Amendment. Jeffery

Botkin (1995) states the predicament well: “so the ‘right to choose’ under a privacy doctrine does not require that prenatal diagnostic information be provided” (pp.33). How did the concept of wrongful birth become legal precedent in the eyes of United States courtrooms? Botkin (1995) proposes that the reasoning may be because of a more detailed understanding of “doctrine of informed consent” within the medical community that has become available through technological advances (pp.34). Because the medical technologies that allow for prenatal diagnoses are relatively new, there would have been no consideration for them during the inception of the Fourteenth Amendment. The United States court system has adjusted accordingly and has laid the framework for parents to openly and legally claim that they would have aborted their child, had they been given all the information, while the child stands next to them in the courtroom.

South Carolina’s court system ruled on December 20, 2004 to “decide the novel issue of whether South Carolina will recognize a common law cause of action for ‘wrongful life’ brought by or on behalf of a child born with severe congenital defects” (Willis v. WU, 2004). Prior to the conclusion of the case, Court Justices saw it necessary to explicitly define both “wrongful birth” and “wrongful life”. According to the South Carolina Supreme court, wrongful birth is the result of negligence of “those charged with prenatal testing or genetic counseling” resulting in the deprivation of the parents to make the decision whether to continue the pregnancy (Willis v. WU, 2004). Wrongful life is presented from the child’s point of view. The South Carolina Supreme court defines it as “The child alleges, because of the defendant’s negligence, his parents either decided to conceive him ignorant of the risk of an impairment or birth defects, or were deprived of information during gestations what would have prompted them to terminate the pregnancy” (Willis v. WU, 2004). Regardless of the

alleged offense, it is the parents that put forth the lawsuits because of the dependency of the child in reference. Even though in this case the Justices ruled against the wrongful life claim, it set concrete precedent of the definitions of wrongful life and wrongful birth.

The North Carolina Supreme court addressed the issue of wrongful birth on December 10, 1985. In this case, the complaint was that “the defendants were negligent in their prenatal care of Mrs. Azzolino in that they failed to advise the parents properly and incorrectly advised them with respect to the availability of amniocenteses and genetic counseling” (Azzolino v. Dingfelder, 1985). According to the courts, it was clear and irrefutable that the medical professionals had an obligation to the parents. The difference between this 1985 North Carolina case and the previously mentioned 2004 South Carolina case is that the North Carolina parents did not place blame for the congenital defects on the physicians. The North Carolina parents only claimed that the physician was negligent in properly informing the parents of the existing condition. The North Carolina Supreme court concluded that

As medical science advances in its capabilities to detect genetic imperfections in a fetus, physicians in jurisdictions recognizing claims for wrongful birth will be forced to carry an increasingly heavy burden in determining what information is important to parents when attempting to obtain their informed consent for their fetus to be carried to term. Inevitably this will place increased pressure upon physicians to take the ‘safe’ course by recommending abortion. (Azzolino v. Dingfelder, 1985)

Despite the increase of legal precedent demanding full access to genetic information of pregnancies, all physicians are human and are vulnerable to human error, along with bias. Darrin Dixon (2008) believes that generally medical professionals who frequently interact

with expectant mothers lack the adequate genetic counseling and training to provide informative and neutral consultations concerning prenatal testing (pp.4). The lack of training general practitioners are receiving may be a possible link between prenatal testing and wrongful birth lawsuits. Whether this possible connection is due to the inconsistency of information provided or misinterpretations of results because of a lack in training and skill is yet to be said; however, there are clear discrepancies within the medical community.

While the medical community has training discrepancies as a whole, the genetic counseling sector of the medical community is left with severe vulnerabilities. General physicians have the most direct contact with patients and expectant mothers. However, general physicians are not the most informed and are generally not extensively trained in providing genetic counseling. While genetic counselors would be the obvious choice for primary care during and after prenatal testing, they are considered secondary opinions to the primary treatment by general physicians and gynecologists. Dixon (2008) believes that “While genetic counselors around the world offer prenatal testing as an opportunity to maximize a couple’s reproductive choices, disability scholars have recently condemned prenatal testing as typically done with the goal of identifying an effected fetus so that the fetus may be aborted” (pp.14). Dixon may have a stronger opinion than what is an accurate depiction of reality. Genetic counselors have an undeniable bias in terms of prenatal testing and in the consultations of prenatal testing, but that bias is unlikely to be an intentional bias. As professionals of a medical specialty, genetic counselors should not only want the best for their patients and supply them with all the information, but they would also provide more detailed information on the topic that they understand the most, e.g. prenatal testing. Medical professionals may be incapable of complete neutrality in the case of prenatal testing and

abortion because of “ingrained deference” which may result in unconscious endorsement (Dixon, 2008, pp.4). Dixon also states that, “the medical establishment is sending a message to patients that the goal is to guard against the birth of children with disabilities” (pp.18). General physicians are not the only ones guilty of bias. According to LaPan (2015) “genetic professionals are apt, intentionally or not, to steer patient decisions toward prenatal testing and selective abortion utilization, thus potentially undermining patient self-determined decision-making” (pp.11). It is uncertain that this unconscious promotion and preference toward abortion is the result of genuine affliction toward the procedure, or it is the result of complete disclosure of information throughout the medical community. Abortion becomes an endorsement of physicians once it is deemed that the baby is “unhealthy”. It was decided during the *Planned Parenthood of Central Missouri v Danforth* Supreme Court case that it is constitutional for the definition of “unhealthy” to vary from physician to physician (Planned Parenthood, 2015). While it is the job of genetic counselors and the medical community to provide complete information to parents and to offer prenatal testing as a way to gain more information, it is wrong to allow prenatal testing results to dictate which children are born and which are terminated. The medical community needs to readdress what it means to be legitimately unhealthy and rather than immediately pushing for abortion, develop protocol and procedure for the parents moving forward.

Pathological View of Down Syndrome

On October 25, 2017 Frank Stephens gave a testimony before the Subcommittee on Labor, Health and Human Services, and Education for the United States House of Representatives’ Committee on Appropriations. Stephens is a strong advocate for the Down syndrome community and its worth. One of Stephens’ opening statements is “I AM A MAN

WITH DOWN SYNDROME AND MY LIFE IS WORTH LIVING [sic]” (Down Syndrome: Update on the State, 2017). According to Stephens, the value and human worth of people with Down syndrome have been stolen. The perception of Down syndrome and people with Down syndrome has become warped so much so that “in places as wide-spread as Iceland, Denmark, and South Korea, government officials have proclaimed that these government encouraged terminations will make them ‘Down syndrome free by 2030’” (Down Syndrome: Update on the State, 2017). The year 2030 is only twelve years away, thirteen from the time that Stephens gave his testimony. Results from the van Schendel study (2017) on the perceptions parents have on prenatal testing indicated that “Down syndrome really gets labelled as a disorder that should not exist” (pp.527). While no one is proposing termination of people with Down syndrome, the upwards trends of selective abortions and prenatal detection it is not unreasonable for Stephens projection to potential become reality in the near future.

One of the biggest threats that prenatal testing poses to the Down syndrome community is the potential for prenatal testing to be regarded as a *cure* for Down syndrome rather than a tool for anticipation and preparation for the condition. The medical community is not only disrespecting the Down syndrome community by aiming to “eradicate” the condition, the Down syndrome community is made to feel that they should have been *cured* of Down syndrome by being terminated in the womb.

During the beginning stages of noninvasive prenatal testing (NIPT) in the Netherlands, the concern of routinization of NIPT resulting in Down syndrome being less accepted as socially acceptable was raised by parents in focus groups and interviews (van Schendel et al., 2017, pp.525). NIPT is also regarded as the “Down-test” by Dutch media

according to van Schendel et al. which infers not only that NIPT only tests for Down syndrome, but also that Down syndrome is the worst-case-scenario defect for a baby (pp.525). Parents expressed the concern that society is becoming “programmed to think it is terrible to have a child with Down syndrome” (van Schendel et al., 2017, pp. 527). According to some of the parents interviewed by van Schendel et al., there is a disconnect between the medical community and Down syndrome. Additionally, there is an absence of genuine understanding of the condition which was cause for parental unease since these same members of the medical community are interacting first-hand with expectant mothers and advising them on their next steps (van Schendel et al., 2017, pp.528). Common misconceptions of Down syndrome are the result of negative, assumptive fallacy, it should be the job of medical professional to erase these beliefs rather than reinforce the beliefs that children with Down syndrome are “examples of avoidable human suffering” (Lindeman, 2015, para.4).

Anti-natalism. According to Christopher Belshaw, anti-natalism is the belief that all reproduction is bad and that it is more beneficial not to be born than to live a life of suffering (Belshaw, 2012, pp.117). Belshaw makes the claim that “either through being dead or through never being born, [it] might be better or worse for someone than existing. The anti-natalist’s claim isn’t that it would be better for other creatures, or for the environment, or for the universe, or in itself (whatever that means) if we didn’t exist. It would be better for us” (Belshaw, 2012, pp.118). Presumptively, this validation for nonexistence is the support behind wrongful life and wrongful birth lawsuits. Anti-natalists operate under the assumption that all pain is bad and that nothing good can be the product of suffering. This is an incomplete assumption. For example, it is not until alcoholics reach rock bottom that they see

the errors of their ways; it is not until a bone is rebroken and set that it can be repaired and healed. To say that the suffering and pain inevitably experienced in life outweighs any and all of the joys of life is a superficial analysis of human life. Not only do anti-natalists believe that they personally should not have been born because of the suffering they experience, but they also quantify the life worth of everyone based on the general concept of pain and suffering.

Belshaw proposes an argument that clearly presents the controversy behind wrongful life lawsuits and the grey area courts must make decisions about, “someone can reasonably wish they’d never been born, reasonably judge their life to have been best not lived, even while they have now no wish to die, and want now to live on” (Belshaw, 2012, pp.119). The grey area of these wrongful life lawsuits is that generally it is the parents bringing forth these charging on behalf of the child either because of prolonged guardianship or because the child is a minor. Self-reflection is necessary for an individual to claim that his life would be significantly better had he were never born. Parents are removing the self-reflection from the declaration of wrongful life and the courts are not validating the claims because of the paradoxical nature of the claim and the lack of concrete evidence.

Parents’ Perspective. Prenatal testing, selective abortions, wrongful birth, and wrongful life lawsuits are all continual testaments of the growing intolerance of Down syndrome births. While this intolerance is becoming a societal norm, expectant parents have the power through their reactions and decisions toward children with Down syndrome. Christine Rosen (2008) describes today’s culture as “‘democratic calculus of worth’... And that calculus has resulted in a society hostile to people who refuse to make the culturally acceptable choice of ridding themselves of a disabled child before she is born” (pp.102). It

has become the socially accepted norm for every person to be an abled-body so much so that any unborn child that may not be an abled-body is seen as less viable and parents are urged to reject it. Lindeman (2015) notes that it was not until she had a daughter with Down syndrome that she realized “[her] ideas were based on negative, outdated information that had nothing to do with the reality of life with Down syndrome today” (para. 2). Ironically, today’s society has the most advanced medical technology and scientific knowledge, yet it is not uncommon for misbeliefs about Down syndrome and other congenital conditions to be widely accepted. Society as a whole is uninformed and falsely *educated* about Down syndrome which is in turn resulting in expectant parents making termination decisions motivated by what they believe will inevitably be the child’s low-quality life. Medical advances have been able to increase the life expectancy of a person with Down syndrome to as high as forty-nine years (Rosen, 2008, pp.102). The simple joys of life and the potential of people with Down syndrome are being overshadowed by the fear of suffering and disconformity. Expectant mothers are the focal points of the examination of the decision-making process and the factors that influence the decision to terminate or continue the pregnancy of a child with Down syndrome. While there are many influencing factors to consider concerning the decision to abort, expectant mothers are the ultimate decision-makers in the situation.

Alison Piepmeier (2015) interviewed many mothers about their decision-making processes of either abortion or continuation of the pregnancy of a child with Down syndrome. Piepmeier notes that while she is aware of the ultimate decisions the mothers made, it is less important to readers because it is the process of coming to the decision that is important, not the decision itself (pp. 4). Judith McCoyd (2007) also interviewed mothers, except the mothers that McCoyd interviewed were mothers who had decided to terminate

their pregnancy. McCoyd states that “Women do not arrive at ultrasonographers’ or perinatologists’ office with a ‘blank slate’, but with adherence to a set of expectations, derived primarily from social messages” (pp.38). She goes on to list and describe seven categories of expectations: “*Our baby would be fine*”; “*I wouldn’t terminate anyway*”; “*I thought I was home free—no miscarriage in the first trimester*”; “*Testing is nothing to worry about*”; “*The right decision couldn’t possibly hurt this much*”; “*By the time of the first doctor visit, the healing would be all done by then*”; “*I was very afraid of running into someone who would pass judgment*”; and “*Down’s syndrome is the worst that it could get,*” (McCoyd, 2007, pp. 38-41). These expectations reflect the mistaken assumptions of Down syndrome and the impact of societal expectations on the external awareness of expectant mothers. Women should not have to worry about judgment from friends and family for having a child with a disability. Down syndrome should not be seen as the worst thing possible to be wrong with a child. Not only does this assumption overexaggerate the conditions that make up the syndrome, it asserts that anyone living with Down syndrome is in the worst possible situation there could ever be and says that they are living the worst life imaginable. Therefore, it can be rationalized to sparingly killing unborn children.

The possibility and the openness to disability has become so distanced in society that women appear to be going through stages similar to the stages outlined by Kubler-Ross’s (1969) theory: denial, anger, bargaining, depression, acceptance. Mothers operate under the illusion that nothing could possibly be wrong with their unborn child, once they receive a less-than perfect health report, they enter the denial stage. In the case of expectant mothers the original Kubler-Ross stage of anger is more appropriately expressed by sadness and loss. Expectant mothers are filled with raw emotions. Some of these feelings are self-directed

while others are related to their child and the decision they must now make. Bargaining occurs the same way in expectant mothers as it does in Kubler-Ross's model. Expectant mothers are resistant to make the life-defining decision to allow their child to be born with Down syndrome or to terminate the pregnancy and abort the child. Piepmeier (2015) states "these women did not want to have to choose; they wished for something to happen to make the decision for them, or for some other way to escape the responsibility of having to determine the right answer for the life of their child. But it is equally true that they did not want someone else to actually make the decision for them" (pp.15). While the mothers would never allow another person to make the decision for them, they bargain for another way or solution to the situation. Acceptance is experienced by expectant mothers before depression. Before women can become depressed and regretful of their decision, they must make a decision. Acceptance occurs when the expectant mothers makes a decision about their pregnancies. She accepts her circumstances and the situation she is in and decides what her outcome will be—a baby with Down syndrome or terminating her unborn child. Depression is the last stage which may or may not be experienced by all expectant mothers. The depression stage is likely to occur after-the-fact in women who decided to terminate their pregnancy. It may also occur in mothers who decided to continue their pregnancy while they are coming to terms with the reality that their child has Down syndrome.

The Science Behind It All

Prenatal genetic testing became a possibility in 1911 when the Human Genome project began as undergraduate research on fruit flies by Alfred Sturtevant (www.genome.gov). First published in 2001, the Human Genome project was driven by the goal of mapping and classifying every gene in the human chromosome (www.genome.gov).

The Human Genome project paved the way for medical professions to identify, even invitro, the potential results of the prescribed genes of a fetus. However, prenatal genetic testing is not a one-and-done test that provides every definite answer to the questions. There are many types of prenatal tests, many of which come with their own risks and limitations. Prenatal testing also occurs in stages generally. Amniocentesis, noninvasive prenatal testing (NIPT), chorionic villus sampling (CVS), and MaterniT21 are common types of prenatal testing used in the United States. Amy LaPan (2015), quotes Rayna Rapp describing this process of prenatal testing as a “prenatal technological conveyor belt” (quoted in LePan, 2015, pp.13). Prenatal testing is not just a one-and-done treatment. Physicians usually begin with the procedure that carries the least amount of risks which is noninvasive tests. These tests also happen to be the least accurate, therefore, any concerning results would require additional tests before an official diagnosis is given.

The first level of prenatal testing is NIPT which includes many different utilizations of ultrasounds. It is routine for all expectant mothers to receive two ultrasounds during her pregnancy: “first trimester dating scan, usually with a Nuchal Translucency measurement as part of the screening for Down's syndrome, and an anomaly scan at around 20 weeks of gestation” (Collins, S. L., & Impey, L., 2012, pp.4). Dagmar Tapon (2010) classifies NIPT as a screening technique because no confirmed diagnosis can result from NIPT alone. Even though some noninvasive methods of prenatal testing have up to a 99% sensitivity rate, an invasive method must be used to confirm the diagnosis (van Schendel, R. V., et al., 2017).

After NIPT has raised the possibility of a genetic defect in the fetus, the next step is an invasive diagnosis technique. Amniocentesis and CVS are two types of invasive prenatal testing techniques. Chorionic villus sampling, or CVS, is utilized after the pregnancy has

progressed to the tenth week (Collins, S. L., & Impey, L., 2012). The procedure involves obtaining a small sample of fetal tissue with the visual assistance of a continual ultrasound (Collins, S. L., & Impey, L., 2012). The obtained tissue sample can be used for “karyotyping when first trimester screening suggests a high risk of aneuploidy” (Collins, S. L., & Impey, L., 2012, pp.6). CVS can be performed 10 weeks earlier than the NIPT screening ultrasound which allows expectant mothers more information on a shorter time frame. Because CVS is an invasive testing technique, there is an increased risk of miscarriage as a direct result of the procedure. Amniocentesis is another invasive prenatal testing technique. Whereas CVS retrieves a sample of fetal tissue at 10 weeks, amniocentesis involves removing a sample of amniotic fluid from the amniotic sac with the visual guidance of a continual ultrasound at 15 weeks (Collins, S. L., & Impey, L., 2012). Removing amniotic fluid poses less of a risk to the fetus than removing a sample of fetal tissue, however there is still a high risk of miscarriage as the technique is invasive to the fetal environment. Amniocentesis carries with it a risk for miscarriage and is only able to be performed once the pregnancy has reached 15 weeks of gestation, but it is safer for the fetus than CVS because nothing is being removed from the fetus itself, only from the environment around the fetus.

MaterniT21 is a relatively new technique that has been developed. Researchers believe that it has the potential to override the incomplete techniques currently in use. The MaterniT21 is a noninvasive technique that tests a sample of the mother’s blood (Kaposy, C., 2013). If this testing technique proves to be as effective as it claims, the MateriT21 test would significantly decrease—almost eliminate—the risk of miscarriage resulting from prenatal testing. In clinical settings, MaterniT21 has a 99.1% sensitivity and a 99.9% specificity, meaning that 99.1% of the time it correctly detected Down syndrome and 99.9%

of the time correctly denied the presence of Down syndrome (Kaposy, C., 2013, pp.299). MaterniT21 has yet to become available for public use because of ethical and moral criticism. Critics have raised the question of what effects will MaterniT21 have on selective abortion rates, as well as what will the effect be to the Down syndrome community. According to Kaposy, “the most up-to-date systematic review of research into selective termination rates within the US population reveals that women terminate their pregnancies 60-90% of the time when prenatal testing diagnoses their fetus as having Down syndrome” (Kaposy, C., 2013, pp.300). MaterniT21 has the potential to get rid of the need for preliminary testing such as amniocentesis and CVS because not only is MaterniT21 more accurate than either of these tests, but it can also be performed by ten weeks of gestation (Kaposy, C., 2013). The argument of the critics against MaterniT21 is that the direct influence the test has on selective abortions sends the negative message that “an outcome in which [the] child has Down syndrome is undesirable” to the Down syndrome community (Kaposy, C., 2013, pp.304). This same criticism is applied to prenatal testing in general. The criticism is only more focused on MaterniT21 because of the nearly perfect prediction rate.

There is a fine line between providing adequate information to allow the patient to have informed consent and presenting excess information in persuasion of a preferred outcome. It is the responsibility of medical professionals to walk that line in an ethical manner while eliminating bias as much as possible. Dixon makes the claim that it is the increase in prenatal testing and medical advances that is responsible for a “lack of genuine informed consent” in the context of expectant mothers and the continuation of gestation (Dixon, D. P., 2008, pp.4). Dixon refers to the current status of informed consent as inauthentic informed consent this is probably because Dixon perceives the bias of the

medical community to be influential to the point that it is bordering on persuasion and manipulation rather than neutral presentation of information. Sonia Suter describes the relationship between informed consent and prenatal testing in the following way:

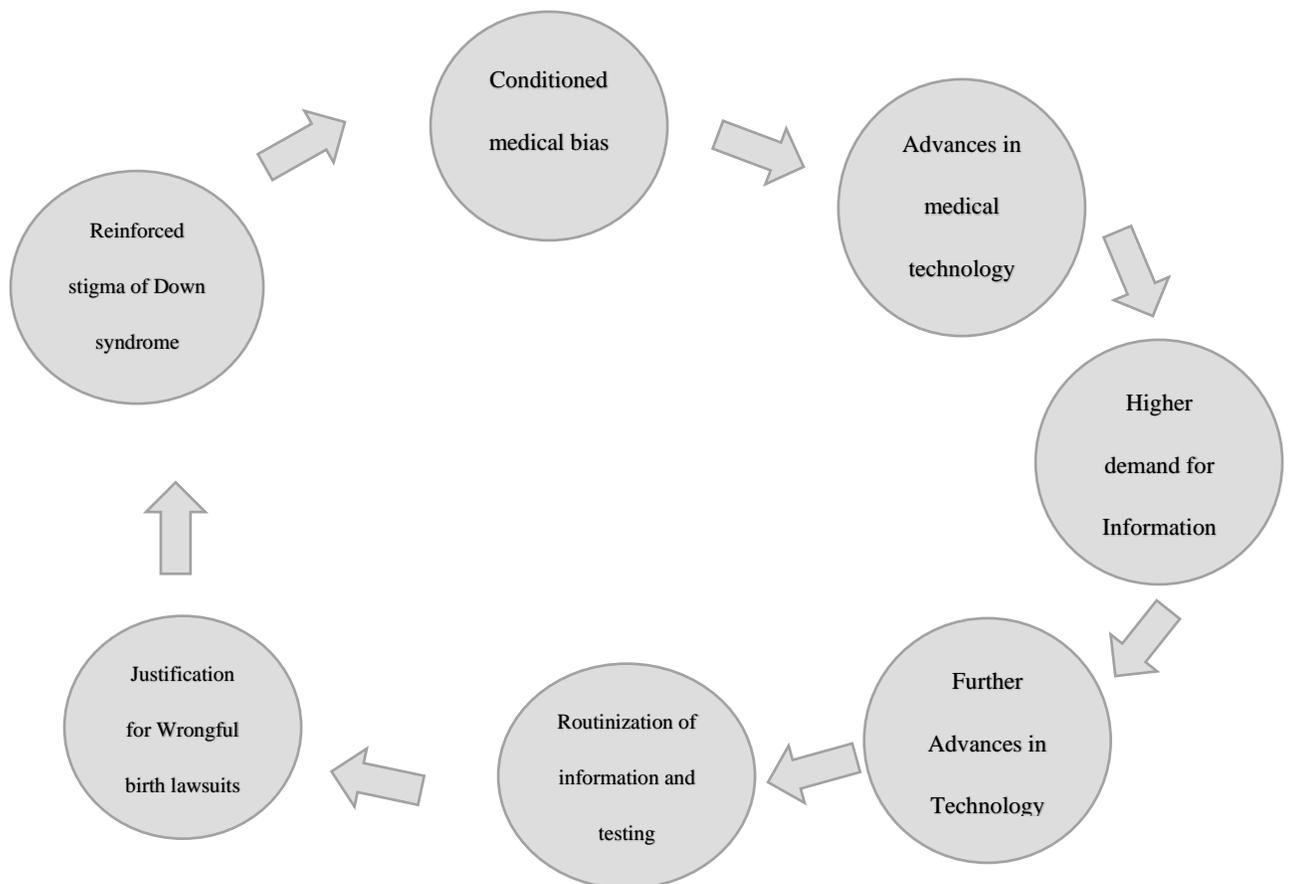
The routinization of prenatal testing has impoverished the informed consent process in many ways; little emphasis is placed on the many emotional and psychological ramifications of undergoing such testing, leaving patients unprepared for certain choices and emotional reactions. (Suter, S. M., 2002, pp.234)

Now not only is informed consent weakening, but an inadequate preparation for repercussions and consequences is being provided by physicians prior to prenatal testing.

A circular pattern has begun to develop involving the medical community, court systems, and expectant parents. Medical advances have made new techniques available to parents and physicians. With the medical advances, such as prenatal testing techniques, the information that physicians can provide to parents increases. The failure to provide this newly available information has now become vulnerable to legal action. This threat of legal accountability places increased pressure on medical professionals to provide and offer new techniques in order to gain the optimal informed consent. The bias of professionals increases the utilization of prenatal testing and other medical advances. The increased utilization of testing is shown to increase abortion rates for select pregnancies. Increased abortions for specific congenital disorders (i.e. those of fetuses with Down syndrome) reinforced the stigmatism that is associated with Down syndrome, which implies that it is not acceptable to give birth to a baby with Down syndrome because prenatal testing can now detect that prenatally. Suter (2002) argues that as utilization of testing increases, the routinization of prenatal testing also increases. Routinization of prenatal testing strips away the possibility of

genuine informed consent and replaces it with “the *illusion* of choice” (pp.255). Suter goes on to quote Ruth Hubbard and comments that “as Ruth Hubbard has observed, when ‘choices become available, they all too rapidly become compulsive to choose the socially endorsed alternative.’ Even when women understand conceptually that they have a choice, social norms and beliefs about what is best for their child may make choice illusive” (Suter, S. M., 2002, pp.255). For the fate of unborn children to rely so heavily on testing results, it is evident that prenatal testing has been too much authority by both the medical community and society. The idea that it is the job of prenatal testing to detect and alert the presence of Down syndrome allows for the concept of wrongful birth lawsuits to be socially accepted.

Figure 1:



The world has come so far since the inception of the idea of mapping the human genome, yet history is vulnerable of repeating itself soon if intervention does not occur. The completion of the Human Genome project opened many doors for science. It is important, however, that the opportunities are not taken advantage of and respect and dignity for people are preserved. The negative effects of eugenics can be seen in the aftermath of the Holocaust with the Nazis and the forced sterilizations of patients in mental asylums. Many connections can be drawn between Hitler's goal of a master race and the mentality that children with Down syndrome—or any abnormality—are less desirable. Hitler used techniques of identifying Jews with the Star of David and isolating them in ghettos. Modern society has begun to fully utilize prenatal testing as a method of identifying the health status and is using that information to decide which children are most desirable. Hitler exterminated anyone that did not fit the mold that was the master race. Abortion is the most common next step after learning that the fetus has Down syndrome— 60-90% of the time, expectant mothers abort the fetus after learning it will be born with Down syndrome (Kaposy, C., 2013, pp.300). Aside from the targeted population, what is the difference between the attitudes of Hitler and the attitudes of today's society? There is no difference. Prenatal testing is a form of modern-day eugenics. Maurice Bigelow, a leading researcher in eugenics, is quoted by Mark Meehan as referring to selective abortions and prenatal genetic testing as “family eugenics” (Meehan, M., 2009, pp. 88). Additionally, Kurt Hirschhorn called “abortion for disability, at the family level, as ‘negative eugenics’” (quoted in Meehan, M., 2009, pp. 88). Selective abortions, motivated by prenatal testing, are eugenics on the individual scale, whereas the termination of Jews by Hitler was eugenics on the large-population scale. As Meehan describes it, “while they rejected the ethnic and racial bigotry of eugenics, they accepted its bias against people

with disabilities” (pp.88). The difference in scale size and targeted population does not eliminate the similarities and existence of prenatal testing eugenics.

Despite the common misbelief, Down syndrome is not the only detectable condition that is screened for with prenatal testing; it is just one of the most common ones. Prenatal testing allows parents to know the preexisting conditions of their unborn child and give them the opportunity to decide the fate of their child based on that information before the child is ever born. That process is post-conception-controlled breeding. That is eugenics. One of the rationales behind selective abortions post Down syndrome diagnosis is that the parents are relieving the child of the inevitable pain that is to come to the child if he or she is born. However, the problem with prenatal testing is that there is no way for physicians to diagnose the severity of the syndrome. In one study, fifty-six percent of respondents said that they were in favor of prenatal testing if the tests were detecting “a serious condition” (Reynolds, T. M., 2003, pp.270). When the risk of spontaneous abortion to “unaffected fetuses” was increased to half— “one unaffected lost for every two affected diagnosed”—the approval rate of prenatal testing for serious conditions dropped to twenty-one percent (Reynolds, T. M., 2003, pp.270). Rather than a universal blanket agreement with prenatal testing—recognizing the effects it has on selective abortion rates—there is now a conditional acceptance of prenatal testing. The condition that appears to be present is that it is acceptable only when unaffected children are not at risk, and when the testing only screens for serious conditions. The issue comes in strong when terms such as *serious* and *unaffected* are used without providing concrete definitions. Concrete definitions for these words are almost impossible because they are subjective descriptions, what may be *serious* to one parent may not be *serious* to another.

Playing God: The Prescribed Humanity

While the question of ethics is applicable in many situations and circumstances, it is commonly applied to the medical community. Rightly so, doctors and physicians are constantly concerned with what is and what is not ethical. They must put their opinions and beliefs aside, remain neutral, remove all bias, and proceed ethically with the patient's best interest in mind. However, doctors and physicians are human. It is unrealistic to expect them not only to proceed with a complete lack of bias one hundred percent of the time, but also to know what is ethical in every situation. Mianna Meskus (2012) provides the label of "Personalized Ethics" to this dilemma of individualized ethical standards among the medical community in regards specifically to prenatal testing (pp.376). Currently, the medical community is severely lacking in universality of ethical standards, specifically in concern to prenatal testing and selective abortions. Professional opinions are being confused and intertwined with personal opinions. Patients are receiving large quantities of information with little guarantee of reliability and less than perfect explanation as to what the information means. Medical professionals have been put in the position to choose between the genuine interest of their patients and protecting themselves from a potential negligence suit because they did not provide enough information.

The Finnish-based research by Meskus (2012) explicitly shows that at the early stages of prenatal testing in Western countries "it was considered appropriate from clinicians to express their opinions on the prevention of disability. Clinical geneticists advised their colleagues that in cases of chromosomal anomalies leading to 'Mongoloidism' as Down's syndrome was termed then, 'abortion should be recommended'" (Meskus, M., pp.379). Modern society and the medical community have come far since 1972 when the above

quotation was held as a common belief, but progress may not completely erase the problem. Rather progression allows for new interpretations of the same problem. It is not just that the child may have Down syndrome that parents are urged to choose abortion, it is what society believes Down syndrome locks into the fate of the child, and what Down syndrome takes away from the child. There is still a bias towards abortion after the pregnancy has been screened for Down syndrome, but there are new motivations today than there were in 1972. Today, the preferences for a child that fulfills the expectations of *perfection* reinforces the negative stigma associated with individuals with Down syndrome. Dixon concludes that “this negative view of Down syndrome will not change until we begin to accept those who are differently abled” (Dixon, D. P., 2008, pp.21). Not only has society begun to idealize the unattainable goal of *perfection*, it has developed an intolerance for individuals that do not fit the mold. Until the playing field is leveled and the value of a person is within the person rather than in appearances, there is no hope of equality or the removal of negative stigmas.

Through interviews with women, Alison Piepmeier (2015) discovered that despite whether the women terminated their pregnancy or not, all the women she spoke with humanized and personally identified with their child even before any prenatal tests, “Whether or not Susan continued her pregnancy, she was pregnant with a child she had identified, imagined, and named” (pp.10). It is clear that expectant mothers do not have an issue of transitioning their beliefs from a conceived fetus to an unborn child. The difficulty is when tests diagnose a condition, specifically Down syndrome, and the value of life or personhood is partly removed from the child. The mothers were foremost concerned with the quality of life that their child would have: “Meriah lists the ways in which her daughter would be at risk, identifying not only that she could be abused, but that cultural stigmas regarding people

with intellectual disabilities might mean that her explanations would simply be rejected,” (Piepmeier, A., 2015, pp.12). Meriah has just fallen instigator of the same cultural stigma that she cites as validation for aborting her child. If no children with Down syndrome are deemed worthy of life, the negative stigma will remain concrete in the minds of society because the abortion rate is reinforcing it.

Harriet Johnson made this statement before her death: “the presence or absence of a disability doesn’t predict quality of life” (quoted in Rosen, C., 2008, pp.101). Johnson described this problem of prenatal testing-influenced abortions as “disability-based infanticide” (quoted in Rosen, C., 2008, pp.101). The idea that a single condition or a group of conditions has an impact on the quality of life that an individual has available to him or her is unsupported. Rather it is more accurate that the presence of a condition or group of conditions may imply more effort from the parents and from physicians. Despite the progress made with medical technologies, the response to prenatal genetic conditions is mainly preventative care, such as screening and testing, rather than treatment development (Bromage, D. I., 2006).

A main opponent to many aspects of prenatal testing and selective abortions is the Disability Critique. The Disability Critique of prenatal testing is that the pressure on expectant mothers to receive prenatal testing along with allow the results to influence the fate of the unborn child create and reinforce negative stigmas of Down syndrome and of individuals living with the syndrome (Kaposy, C., 2013; Meskus, M., 2012). According to Bromage (2006), the disability critique has two components: it is ethical to repair or attempt to cure an individual’s condition so long as it does not imply an attempt to increase the value to the individual’s life, “many people in the disability community support research of the

prospect of alleviation of the harm inflicted by their disability” (Bromage, D. I., 2006, pp.39). Secondly is the belief that all unborn children should be given the opportunity to live life and be given “full personhood” (Bromage, D. I., 2006, pp.39). The disability critique is an advocacy for the populations of people living with a disability of any kind. While taking a stance for the lives of unborn children with disabilities, the disability critique also attempts to preserve the dignity of individuals currently living with disabilities. By terminating their pregnancies, mothers are indirectly deciding the level of worth of their child. They are making the decision that their child’s life is not worth living even before their life has a chance to begin.

In a Texas news article, Yvette Blackman (1989) discusses an instance in which a plastic surgeon was sought to correct a physical abnormality of a child with Down syndrome. The surgeon offered to preform a craniofacial reconstruction as a solution to the problem the child was having. Individuals with Down syndrome may experience physical conditions related to the extra chromosome. In this case, the child had difficulty closing his mouth and as a result experienced an increase in saliva production. The procedure the plastic surgeon would have corrected the issue the child had, however it is the rational of the surgeon that demonstrated the issue at hand. Blackman (1989) reports “Plastic surgeons admit they can’t cure Down’s syndrome, but they say a procedure known as craniofacial reconstruction may increase their patients’ self-esteem by giving them more ‘normal’ facial features” (para. 4). By accrediting the increase of self-esteem to the increase of normality rather than the preservation of dignity is ignorant (Blackman, Y. H., 1989). Physicians and parents alike are searching for ways to make children with Down syndrome more like everyone else, more *normal* that they have begun to strip away the dignity of the individual with Down syndrome.

Human beings, people, have Down syndrome; Down syndrome does not have people. For anyone to suggest a child have a craniofacial reconstruction simply to give them “more ‘normal’ facial features” is misguidance and uninformed egocentrism. It is true that a craniofacial reconstruction can be used to allow for better control over the mouth and decrease saliva production as is in the case of Blackman (Blackman, Y. H., 1989). However, such procedures should be approached with the intention of preserving the dignity of the individual rather than to increase the mainstream appearance of the individual.

Blackman’s article demonstrates a second issue present within society which is the reliance on appearance as a measure of intelligence and worth. Blackman believes that if plastic surgery becomes accepted, that “society will expect too much from mentally retarded children made to look ‘normal’” (Blackman, 1989, para. 6). Shortly after, Blackman continues “They also say it helps raise society’s low expectations of Down children and helps ease them into the social and educational mainstream” (Blackman, 1989, para. 7). It should not be the responsibility of the individual with Down syndrome to change themselves to better fit the mold of society before being accepted into society. One would think that in an age where acceptance and originality has become widespread, that it would be the responsibility of society to erase the prejudices it has on individuals with Down syndrome. Rather it has become the responsibility of the individuals with Down syndrome to erase any evidence of their condition before being accepted into society. The educational expectations that society has for individuals with Down syndrome should be no different than those of individuals without Down syndrome.

The Philosophy Behind It All

The many philosophies and beliefs surrounding the debate on abortion and specifically the topic of selective abortion have one problem: they do not agree on when life starts. If there is no agreement of when a fetus obtains the status of living, there will never be any final agreements. The debates will continue and the argument of whether abortion qualifies as murder will never be settled. For the purpose of this research, it will be said that life begins at conception. This belief is not universally held. Some believe that life begins after birth while others believe that life begins before conception. The following topics and philosophical arguments will be approached from the perspective that life begins at conception.

Prior to the rise of postmodernity, scholars operated under the thinking processes of modernity. The beliefs of modernity relied heavily on scientific findings and supported the idea of universal truth. During the period of postmodernity, scholars completely rejected everything that was previously accepted by modern philosophers. Science and scientific findings were removed from their pedestals. No longer was it acceptable to offer support for the universal truth or universal knowledge. James Sire (1997) offers the opinion that postmodernism develops in the way that “it is not just that there have long been many stories, each of which gives its binding power to the social group that takes it as its own. The naturalists have their story, the pantheists theirs, the Christians theirs, ad infinitum. With postmodernism no story can have any more credibility than any other. All stories are equally valid” (pp.174). Postmodernity rejects the idea of universal truth which allows for the acceptance of many stories. Conflict arises when one accepted story contradicts another accepted story. How can two stories both be accepted when they counteract one another? It is impossible for both truths to be true if the validity of one true proves the invalidity of the

other. It could be said that each story is true in the context of the social group that claims it any only in that context. However, to make that statement, it would have to be agreed that it is a universal truth that stories are only true and applicable within the context of their respective social group. For there to be a complete absence of universality, there must be the absolute truth of that absence.

Joseph Torchia (2008) assumes the perspective of postmodernity and says, “moral values are viewed as by-products of nonrational decisions, based on the instincts of the heart rather than the dictates of discursive reasoning and the shared values of culture or society” (pp.218). In a truly postmodern society, moral values would be rejected in favor of socially agreed upon truths. There would be no morally right and wrong, only socially understood right and wrongs. If this is the case, the right and wrong becomes subjective to the society in which one lives. While the individual is a part of the society, the ideals held by the whole society are superior than those of the individual. In the context of modern society and selective abortion, a postmodernist would completely reject any argument that selective abortions are wrong that originate in morality of any kind. Postmodernist may see the societal acceptance of women’s rights as the agreed upon value. In a postmodern world, the individuals of the society are controlled by the beliefs of the majority, regardless of personal beliefs.

Ironically, the art industry of the postmodern era focuses on establishing iconic images portraying perfection. Bromage (2005) demonstrates this through a comparison of ideal sand artists, “Postmodern society, like the work of Andy Warhol and Richard Hamilton, is dominated by mass marketed images. Representations of the “perfect body”, glossy commercial photographs and television pictures of models and film stars saturate our

society” (pp.41). Postmodernist thinkers have rejected any evidence of universal knowledge, yet the artists during this era are creating an unattainable, ideal image. Therefore, although modernity supported universal truths and relied heavily on scientific findings, the idea of perfection and the desire for it may have begun during the era of postmodernity.

The foundation of feminist ideals originated with equality. Women wanted to erase the variation between men and women’s wages. Women wanted to level the playing field. Everyone should have equal opportunity. However, along the way the feminist movement grew to include reproductive rights. Through the inclusion of reproductive rights, the same people who had been fighting for equality began to fight for the right to take the opportunity of equality from unborn children. The disability critique, previously mentioned, is a counter argument, not against the totality of feminism, rather it is against the idea that only post-birth individuals should be given to equality. Kaposy provides this description of the disability critique, “The disability critique of selective abortion has often been equated with the ‘expressivist objection.’ According to the expressivist objection, the prenatal testing and termination of fetuses with disabilities express negative or offensive messages about people living with disabilities.” (Kaposy, C., 2013, pp.303). Feminism has progressed in such a way that it no longer focuses on the equality of men and women. The focus is now on the empowerment of women. Women should feel empowered; that is not a negative thing. However, it becomes a negative characteristic when the empowerment of one person disempowers another. In its truest form, feminism would take up arms for people with disabilities. They would help to ensure that men, women, and children with disabilities have equal rights. Feminism would include the disability critique in its fight for equality. Feminists work to erase the stigma that women are less than men, why do they not also work to erase

the negative stigmas associated with disabilities? In studies researched by Kaposy, “researchers found that beliefs about negative parental quality of life when one has a child with Down syndrome and negative attitudes toward people with Down syndrome were significantly associated with the intention to terminate an affected pregnancy” (pp.305). If the negative stigmas and false assumptions of Down syndrome and disabilities would be addressed, then the work to reverse their effects can begin.

Anti-natalism is a newly developed philosophical outlook. While some supporters of anti-natalism also rationalize suicide using anti-natalist arguments, these individuals are also pro-mortalists. Pro-mortalism and anti-natalism are not synonymous terms. Pro-mortalism is supported by anti-natalist arguments, but anti-natalism is not supported by pro-mortalism. Belshaw argues that pro-mortalism occurs when anti-natalism is taken to the extreme. The idea that nonexistence is better than existence does not readily imply that when an individual does exist, he should feel obligated to take steps toward nonexistence. While the idea that nonexistence is better than existence fuels the motivation for an existing individual to desire nonexistence, that is where the one-way comparison ends. The connection between anti-natalism and pro-mortalism is not a two-way comparison.

Many people may not be familiar with the ideology of anti-natalism because it only developed within the past two decades. Thaddeus Metz suggests that anti-natalism may have developed out of utilitarian ideals. It may be that anti-natalism is actually an off-branch of negative utilitarianism. Metz (2012) argues that “Negative utilitarianism is the view that one’s sole duty is to minimize pain, where positive goods such as pleasure have no moral weight” (pp.1). Belshaw (2012) defends anti-natalism by saying that, “the smallest amount of pain is sufficient to make our lives not worth living, and cannot be countered by any degree

of pleasure” (pp.118). The above descriptions provided by Belshaw and Metz sound as if they are describing the say ideals. At minimum, this attests to a similarity or relationship between the two set of ideals.

How to Proceed Forward

Anti-natalism, pro-mortalism, negative utilitarianism all center around the negative parts of human life. There is no consideration of all the positive aspects and potential that all human live innately are given. Despite popular belief, all lives are worth living. Who has the right and authority to declare a life unfit for living even before that life has a chance to begin? Psalms 139:14-16 proclaims

I will praise thee; for I am fearfully and wonderfully made: marvelous are thy works; and that my soul knoweth right well. My substance was not hid from thee, when I was made in secret, and curiously wrought in the lowest parts of the earth. Thine eyes did see my substance, yet being imperfect; and in thy book all my members are written, which in continuance were fashioned, when as yet there were none of them.

(KJV)

God, the creator of all life, knew each and every life before it even existed on earth. God endowed each life to be lived and saw perfection where there were flaws. Life is given by God, yet today life is being destroyed before even becoming simply over the fact that the life id undesirable. Again in Psalms 8:5, the worth and endowment of human life if demonstrated, “For thou has made him a little lower than the angels, and hast crowned him with glory and honour” (KJV). Every individual life had been chosen by God to be in existence. God has placed glory and honor in every life that is to be. That God-given glory and honor is being

stripped away by other flawed people because they are failing to recognize the God-given attributes of that life.

In the American society that has become motivated to be all-inclusive, exclusion and discrimination still occurs. The transition from appeared inclusion to genuine inclusion needs to take place. Galatians 3:28 attests that “There is neither Jew nor Greek, there is neither bond nor free, there is neither male nor female; for ye are all one in Christ Jesus” (KJV). There should be no discrimination between individuals with special needs and individuals without special needs. Just as there was revolts and outburst over segregation in schools and racial violence, there should be not be tolerance for discrimination and borderline segregation of individuals with disabilities. There must be a desire for unity and acceptance in society. Today needs to be the start of acceptance for everyone. If efforts are delayed, there will never be change. Let it start today, and let it continue until discrimination ends and unique life is cherished.

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