

Prenatal Testing, Reproductive Autonomy, and Disability Interests

ROSAMUND SCOTT

Introduction

The issue of prenatal testing and selective abortion has never received open public appraisal. This is somewhat regrettable. The interest in this area, however, is rapidly growing. In part this is a result of concerns about the rate of development in genetic knowledge and questions as to its application. For instance, there will be a huge increase in the scope of conditions or features for which we will be able to screen, some of which could hardly be described as significant. Further, for some time now, people with disabilities have had concerns about the practice of prenatal testing and selective abortion. This article looks at the relationship between reproductive autonomy, prenatal testing and associated practices, and the interests of people with disabilities. It asks whether such practices negatively affect the interests of such individuals, and if so, how. This is an important question for the formulation of public policy in this area. Although some groups have studied this issue in detail, policy bodies do not necessarily fully engage with their analyses.¹ This may be a reflection of public confusion about this issue. To some degree, fear of causing offense may also inhibit both expression of public opinion and, in turn, policy analysis. This is unfortunate and needs to be acknowledged.

The article considers the relationship between reproductive autonomy and disability interests with reference to three main points: the view that testing and selection practices are misleadingly dominated by a medical model of disability and that this has discriminatory implications; the view that such practices will result in a loss of support to people with disabilities; and the view that such practices, particularly through their increasingly routine nature,² express the view that such people should not be (or have been) born. The article concisely reflects on significant aspects of recent U.S. and English work in this area.

The Significance of Reproductive Autonomy

Many writers have eloquently elaborated on the moral significance of a pregnant woman's autonomy regarding abortion in general—among legal writers notably Ronald Dworkin and John Robertson. Philosophically, the idea of

I am grateful to participants of the Mt. Sinai School of Medicine—King's College London—Oxford Consortium on Bioethics, 2003, for comments on an earlier draft of this paper and particularly to Professor Jonathan Glover and Dr. Bobbie Farsides for conversations relating to it.

reproductive autonomy has been the subject both of recent defenses, for instance, by Alan Buchanan, and criticism, for example, by Onora O'Neill.³ As part of her critique, O'Neill observes that while *abortion* concerns the avoidance of the birth of another, by contrast, in *reproduction* the creation of another is what is at stake. Hence, although regarding abortion autonomy may have important connections with self-expression, because reproduction entails the creation of another person, it is not appropriate "primarily"⁴ to construe it in this way. These thoughts may particularly have application in relation to selection practices in preimplantation genetic diagnosis (PGD).

Although there is not scope to argue for it here, broadly speaking I accept the value of reproductive autonomy. In any event, the difficult questions always concern its limits. In this context what is really at stake is how extensive we think such autonomy should be and in what ways, if any, it might be both protected and limited. Given that parents are entitled to choose whether to reproduce, it might be argued that they should also be able to choose to avoid reproduction under certain conditions, for instance because of what caring for a severely disabled child may entail for them. There are a number of writers supporting this position⁵ including, to some extent, from the perspective of disability interests.⁶ Such a position need not deny the positive aspects of raising a disabled child or express a view as to the net balance of positive and negative experiences that might result. It simply holds that parents are entitled to form a view, which should be appropriately informed—a thorny issue in itself—as to what broad kind of reproductive experience they wish to embark on.

The Interests of People with Disabilities

It would likely be hard to argue that the interests of people with disabilities should curtail abortion options or the legality of prenatal diagnosis (PND) or PGD as these practices currently exist. Nevertheless, it is arguable that the interests of people with disabilities need to be addressed in the formulation of the policies underlying these practices. Women or couples engaging in these practices may also want to think about this issue to some degree.

Models of Disability and Discrimination Issues

Models of disability may affect our perception of disability and the desirability of avoiding it. Typically, views of disability have been dominated by a medical conception of what it is to be disabled. A proponent of the medical model is the English philosopher John Harris, although he prefers to call this a "harmed condition" model. Harris defines disability as a "physical or mental condition which we have a strong [rational] preference not to be in," a "harmed condition".⁷ By contrast the "social model," as defended by Tom Shakespeare, distinguishes between impairment, as a medical condition of the body, and disability, as social prejudice and discrimination.⁸ By this latter understanding, whether an impairment will lead to a disability will depend on the nature of the social environment the individual inhabits. The suggestion is that whereas disability is social in nature, impairments are not. By contrast, on the medical model disability is situated within the individual.

Both models have been strongly defended and I cannot enter this debate here. It should be noted, however, that John Harris accepts that there may be “social dimensions” to physical and mental conditions that disadvantage the individual, whereas Tom Shakespeare accepts that some impairments can result in significant problems in themselves and suggests that disabled people should debate “the differential impact of impairment.”⁹ The implication is that the problems of disability are not all due to inadequacies of social response.¹⁰ Indeed, there are some conditions that will be disabling despite all possible support: “Most physical and some mental disabilities can be overcome with social support and changes in the physical environment. Some mental and neurologic disabilities, however, require lifetime care and overwhelm parents’ lives. Such disabilities may never be overcome even with massive economic and social support.”¹¹ This suggests that an important aspect of the social model has been in drawing attention to the important issue of discrimination against people with disabilities and their need for social support.¹² In itself, however, the social model appears limited to some degree. For instance, John Harris has suggested that if we were to reject the medical or “harmed condition” model, we would have no way of explaining what is wrong in disabling or failing to cure, where possible, a disability.¹³ Further, Sally Sheldon and Stephen Wilkinson (among others) have drawn attention to the inaccuracies of failing to distinguish between disability and disadvantage, which may occur with the social model.¹⁴ Because some combination of the two models is preferable to reliance on either one, hereafter I continue to refer both to “impairments” and “disabilities.”

Despite their criticisms of the social model, the issue of discrimination is of lingering concern to Sheldon and Wilkinson in their reflections on the disability ground of the English Abortion Act. In English law, the fourth ground of the Act provides a defense, up until birth, to two doctors who certify of any given pregnancy that there is a “substantial risk” of the child being born “seriously handicapped.”¹⁵ Sheldon and Wilkinson have recently argued that, in the vast majority of cases in which being born is compatible with a good or reasonable quality of life, it is *parental* interests that to a large degree underlie this section of the Act. Further, they argue that where these parental interests relate to impairment harms, then the section is nondiscriminatory, but that it is otherwise where, as might be possible, the underlying parental interests relate to the harms of social discrimination.¹⁶ (The extent to which this distinction can really be made is unclear.¹⁷) In essence, the thought is that by screening and terminating for *disabilities* one may in fact be selecting against *impairments* that could be successfully alleviated with greater public support and that this can appropriately be seen as discriminatory. A question that then arises is how much we should do to address the latter harms. Sheldon and Wilkinson note that an aspect of such discrimination may be a lack of social support. Yet they also note the necessity of resource allocation decisions.¹⁸ Although their argument is directed to the English legal position, in principle the point applies to selective abortion more generally, and thus also to the position under U.S. law.

The connection between lack of assistance and discrimination is not a necessary one. Even if we could eradicate discrimination, we may not have ideal levels of assistance for those with impairments. Alan Buchanan and others have argued that, in the light of legitimate conflicting interests, society is not required to *prioritize* the interests of the disabled in reviewing social

structures and arrangements.¹⁹ They develop this point in relation to the requirements of the Americans with Disabilities Act, emphasizing that what the Act requires in the interests of equal opportunity is “‘reasonable’ accommodations” and that this implies that some weight should be given to the interests of others. “The addition of this qualifier signals a recognition that the interests of employers, of workers who do not have disabilities, and of consumers of the goods and services that public and private organizations produce are also legitimate and should be accorded some weight.”²⁰ Acknowledging this point does not establish that more should not currently be done to support those with impairments and (where relevant) their carers. If justified, however, it would mean that eliminating discrimination does not *necessarily* entail the provision of optimal levels of assistance. If this is so, then the decision to terminate a pregnancy that is in part based on lack of support will not necessarily be discriminatory, either in the United States or England.

Information and discrimination. This does not mean that parents might not be made more aware of the issue of discrimination and the role of social support in alleviating the effects of impairment as part of the officially nondirective counseling process that attends prenatal testing practices. Indeed, to the extent that the decision to terminate or continue a pregnancy should be as informed as possible,²¹ such information could be seen as necessary. The resulting discussion would mean that the woman or couple would reflect on their reasons for seeking a termination in relation to issues of social support and discrimination. Yet, because the issue of discrimination is a moral one, to incorporate some information about or discussion of this issue into the ethos of nondirective counseling would entail careful thought about and perhaps some reevaluation of that process. In the United States in particular, the scope under the U.S. Supreme Court abortion decision of *Planned Parenthood of Southeastern Pennsylvania v. Casey* to consider the interests of the fetus (through the State’s interest in potential life) is finely balanced, because too much concern (e.g., by promoting childbirth) will be considered a burden on the abortion right.²²

Indeed, this aspect would also have to be addressed generally in relation to attempts better to inform parents about what it is like to raise an impaired child. Arguably, prospective parents may wish to know that studies now show that “there is a level of agreement approaching consensus that the overall adaptational profile of families who have children with disabilities basically resembles the overall profile for families in general (including children with and without disabilities)” and also that “family responses to disability are immensely variable.”²³ Yet, although it is undesirable if a decision *not to terminate* an affected pregnancy is viewed negatively, the position in which parents fear that the decision *to terminate* will be viewed negatively must likewise be avoided. Indeed, as Erik Parens and Adrienne Asch have noted, the fact that many families cope well with stress does not mean that it is “unreasonable or morally problematic” for parents to decide to avoid it where possible.²⁴ Furthermore, they note that “[s]keptics about the [above] research findings and interpretations ... suspect that the research reviewed does not tell the whole story and that a child with a disability poses substantial heartache, difficulty, and burden to families that far exceed in kind and degree the stresses modern parents typically face.”²⁵

Information and assumptions about suffering. Attitudes toward impairment can also helpfully be challenged and informational issues explored through discussions with people with impairments. For instance, Prescilla Alderson undertook a series of interviews with adults who have one of a number of different conditions: cystic fibrosis, sickle cell anemia, thalassaemia, Down's syndrome, and spina bifida. She sought their views about their lives and about screening practices. Her findings make revealing reading. Alderson sets out to "challenge general assumptions, by showing how these interviewees did not fit the negative images propounded in the prenatal medical literature".²⁶ This clearly relates to the distinction between medical and social models of disability discussed earlier. Importantly, she found that those interviewed felt they suffered more from social stigma than from their actual physical conditions. A recurring theme was of "adaptation, ingenuity and a resilience that grows through accepting and surmounting difficulties." (Alderson acknowledges that qualitative research of the kind undertaken here cannot claim necessarily to be representative.)

She compares this with the concern, which she thinks is inherent in prenatal screening practices, to *avoid* difficulties, noting that in any event these are an inherent aspect of the human experience and that some degree of disability is inevitable at both ends of life. She is troubled by our "fearful avoidance of disability," which she considers is "liable to diminish people rather than freeing them into new achievement and confidence," as would occur if we were instead to promote ways to support the lives of those with disabilities. A central implication seems to be the need to redress the informational imbalance that has come to be of such concern in this area. Accordingly, she asks why there is not further discussion of the potential range of the severity of a condition, of the possibility of new treatments for some conditions, and of the possibility that abortions may be preventing lives that are worth living. There may also be a "mismatch" between the severity of a physical disability and the way a given life is enjoyed and valued. In this way, she challenges the assumption that it is "kinder" to terminate because of the potential severity of the condition in any given case, calling into question once more the accuracy of current information practices. In effect, Alderson draws attention to the need for better information in the course of screening practices. Implicitly, her work also highlights that we think more carefully about whose interests we think and tell ourselves are really at stake in screening practices.

Indeed, an unstated implication of these interviews is the need to consider how much *parental* versus *children's* interests are of central concern in prenatal screening and abortion. I address this question, which goes to the heart of the moral justification for screening and termination practices, below. Interestingly, those interviewed held a range of views about screening and termination practices, with those with sickle cell anemia, thalassaemia, and cystic fibrosis tending to be in favor, provided the information was accurate (currently unlikely, they thought). They also respected the parents' possible decision to terminate, while hoping that a given pregnancy would continue. (Indeed, it would likely be very difficult actively to support termination when this implies that one would not have been born.) By contrast, those with Down's syndrome and spina bifida, which are the subject of the most routine (therefore potentially the most unreflective, undebated) screening, were the least happy with the relevant practices.

Of course, although it is critical that parents better understand the interests of the prospective child as well as their own, it should be remembered that parents can and do choose whether to have children and that this constitutes a significant change from the time when it was simply expected that parents would reproduce. In turn, this is bound to impact on the manner in which parents view this enterprise. Indeed, arguing that better information should be provided does not commit one to a view as to what is the better parental course of action thereafter and the issue of information provision and discussion is clearly very sensitive. Interestingly, James Nelson has questioned whether “interfering” with reproductive autonomy is the right approach, or whether it would not be better to focus on educating people more widely about disability.²⁷ On this view, prenatal diagnosis is “at worst the symptom, not the disease.” Although “interference” with reproductive autonomy would be needed less if people were more informed about disability issues in the first place, the success of public education programs will always be uncertain. Thus, perhaps both approaches are required.

The Loss of Support Argument

A second argument put forward in the disability critique of prenatal screening is not so much about whether selection practices are discriminatory, but rather about whether selection against fetuses or embryos with impairments may result in a loss of support to existing people with disabilities, because fewer people with such conditions will be born. The loss of support might be medical—as there may be less research into conditions that fewer people have—or it may concern the arrangements of social support. A lower incidence of a certain condition could indeed mean that there is less medical interest in researching it.²⁸ Yet it has also been noted that the birth of fewer people with a certain condition could increase the funds available to support others with that condition, because funds earmarked for existing treatments will go further.²⁹ At some level, however, the concern about loss of support is one connected with the *political visibility* of people with impairments and political strength in numbers.

An empirical appraisal of the loss of support argument is not one on which philosophers or lawyers can readily embark. Those with empirically oriented public policy interests in this area are better placed to engage in such assessments. It is possible that this kind of appraisal may indeed suggest that the birth of fewer people with a certain condition does or would result in less medical or social support (especially perhaps the development of new forms of support) to existing people with that condition, though the evidence for this is currently lacking.³⁰ Even if this were so, however, this could not be a reason to support a *duty* to avoid the termination of impaired fetuses or, in the case of PGD, either to select embryos with such impairments or to avoid selecting against them. Indeed, one important flaw in the “loss of support” argument is that it concentrates on the interests of those with disabilities, despite the decrease in genetically caused disabilities in people.³¹ I now turn to the “expressivist objection.”

The “Expressivist Objection”

This line of thought predominantly concerns the idea that prenatal testing and abortion send the message to people with impairments that they should not

have been born and that their lives are in some sense worth less than other lives. This view is strongly expressed, for instance, in the cases opposed to wrongful birth liability.³² Adrienne Asch has expressed the objection clearly, stating that “prenatal diagnosis and selective abortion communicate that disability is so terrible it warrants not being alive.”³³

It has been argued that to be successful the expressivist objection requires one of two positions: either that the fetus is a person or that “it is motivationally impossible or irrational” both to seek to avoid disabilities because one devalues them and equally to value the disabled.³⁴

The fetus and personhood. Regarding the first of these points, it is often argued that if the fetus (or embryo) is *not* in fact a person, then no rights are violated when its life is terminated (or the embryo is not implanted) and nothing is thereby said about the *rights* of born people, including those with disabilities.³⁵ We know that in law—in the United States, England, and more broadly in the Commonwealth—the fetus is not a person and arguably it is not one morally.³⁶ Nevertheless, although crucial in its ability to protect the interests of a pregnant woman, the rule that the fetus is not a legal person (and the view that it is not one morally) can seem like a rather *technical* point that may not always be fully convincing in itself when it comes to justifying fetal death. This is so even if the rule answers the issue of rights violation. For instance, to say that a pregnant woman has the right to refuse medical treatment because the fetus lacks legal status does not tell us anything about *why* she should have that right; it simply ensures that she has it.³⁷ A similar point could be made about the statement that abortion is legal because the fetus is not a legal person: An account of the justifiability of abortion that looks to the importance of a woman’s interests in this context is much better placed to justify the abortion right.³⁸ What are we to make, then, of the suggestion that because the fetus is not a person and abortion does not violate its rights, at most offense to people with disabilities can be caused when a fetus is selectively aborted? The accompanying thought, of course, is that offense cannot be the cause for the curtailment of freedoms in a liberal society.

This may well be so, but offense can be a pretty significant issue.³⁹ In the context of PND, selective abortion, and PGD, one implication is that we need to address how offense can be minimized.⁴⁰ For instance, the widespread screening for Down’s syndrome can mean that children born with Down’s are regarded as “mistakes.”⁴¹ Indeed, the routine nature of screening, coupled with the lack of at least overt moral reflection on this process, can be interpreted as an overzealous attempt to eliminate disability. Further, in many people’s minds responsibility and the avoidance of disabled births are linked.⁴² In this sense, unfortunately prenatal testing may sometimes be seen not so much as being about trying to give greater control to couples as to the circumstances in which they become parents, but rather as a key feature of good parenting.⁴³ The need for debate acknowledging the highly moral nature of screening and associated abortion practices⁴⁴ and an approach to screening that sensitively provides a “more balanced” picture of what it is like to live with a disability, both from the child’s and the parents’ perspectives,⁴⁵ has already been noted and I now turn to the second aspect of the expressivist objection.

Devaluing impairments but equally valuing those with impairments. The issue of offense is also present at some level in the idea that one cannot rationally seek

both to avoid impairments and equally value the life of someone with an impairment. Allan Buchanan and others have suggested that there “are many instances in which we devalue (and seek to avoid) certain characteristics that some individuals have without devaluing individuals who have them.”⁴⁶

This is surely true. At some level, however, it is preferable if it convinces the person with those characteristics. For this to occur effectively requires that that person can “separate” themselves from their negative characteristic or impairment. This may be particularly difficult in the case of prenatal screening because *the avoidance of the impairment—through abortion—is equivalent to the avoidance of that particular person*. A person with Down’s, then, who might well have been aborted, may find it hard to accept both that Down’s, particularly in its more severe manifestations, might be viewed negatively and yet that her life is said to be of equal value to her non-Down’s sibling: Although she might see this distinction, it would be understandable if she did not.⁴⁷ The difficulty, in effect, is that although there is a *conceptual* distinction between the disvalue of the impairment on the one hand and the value of a life of someone with that impairment on the other, in the practice of prenatal testing and abortion the impairment and the actual life are both avoided *one and the same*, so that that particular individual will never come to exist. This requires some acknowledgment. With abortion in general, of course, it is also true that the person whom the fetus would have become is not and will never be known. The difference is that in the latter case there was never any concern about a feature of the *particular* fetus.

Does it help to stress that the practice of prenatal testing and abortion is aiming at the *impairment*, such that one does not yet know—and will never know—the person whom the fetus would otherwise have come to be? In fact, this itself can be interpreted negatively: It is sometimes said that in the practice of selective abortion the potential person has been *reduced* to his or her impairment.⁴⁸ In reality, of course, all that is known about the potential person at this time is that he or she will have an impairment. As Asch interprets this point, however, “this one characteristic” is the basis for a decision to terminate.⁴⁹ Note that Asch’s use of the word “characteristic” obscures the point that, as she admits, “the trait of disability may not be neutral.” (On the other hand, she also criticizes “the majority” for “see[ing] disability as a form of human difference that is worse than other types of difference”.)

Asch’s point is part of her argument that although abortion in general may be defensible as being in a woman’s interests, abortion of the disabled fetus in particular says something about the *fetus* rather than the interests of the pregnant woman, as is normally the case.⁵⁰ Her point is that, in the case of an abortion that is not concerned with fetal disability a woman may have very strong reasons for wanting to avoid reproduction due, say, to her current life situation, but that in the case of an abortion of a *disabled* fetus, she wishes to have a child and her reasons for aborting simply relate to the *particular* fetus. The implication seems to be either that aborting the particular fetus does not have a strong relation to her reproductive autonomy interests, which Asch appears to want to limit to an interest in avoiding reproduction, or that to claim a connection between the reproductive interests of the parents and the characteristics of the fetus is problematic or offensive in some way.

With regard to the first point—that aborting the particular fetus does not have a strong relation to a woman’s reproductive autonomy interests—the

reproductive interests of the pregnant woman (and her partner) might not in fact be so easily separated from the characteristics of the particular fetus, as Asch would seem to require. Turning first to the most straightforward of examples, the birth of a child with Tay-Sachs will impact hugely on parents, causing them great emotional distress as the child's condition deteriorates and he dies, having lived at most four to five years. Indeed, it might be said that by seeking to avoid the birth of such a child the parents are thereby expressing an aspect of their own interests in reproduction, which are thus more extensive than simply choosing whether or not to procreate.⁵¹ In such a case, of course, parents can also be legitimately concerned to prevent a certain degree of suffering in the prospective child. The suffering has to be extreme, of course, for it not to be in the fetus's interests to be born.

In less extreme and much more common cases, however, it has already been noted that we should be wary both of making assumptions about a child's suffering and of the relevance of the language of suffering.⁵² The "personal tragedy" model of disability is another formulation of such assumptions.⁵³ Arguably we should not presume a connection between disability and suffering.⁵⁴ Further, if being born in any given case is compatible with having a good or reasonable quality of life, then one cannot say that it is not in the fetus's interests (or embryo's—loosely understood because arguably it has none until it acquires them as a fetus at sentience) to be born. This will be the case for a huge array of conditions for which we currently routinely screen. In such cases, if parents have an interest in avoiding certain experiences that the birth of a given child might entail, parental and fetal interests may well become opposed to one another. In this light, we must be honest about whose interests we might really have in mind.

To the extent that the prevention of a child's suffering cannot be seen as the real issue in a given termination, which will very often be the case, we need to reflect further on the nature and strength of the parents' interests. I have already suggested, in agreement with various others, that if one can decide whether to reproduce, *some* degree of control over roughly what that might involve is arguably entailed, both morally and legally.⁵⁵ I cannot defend this fully here, but it may be that the desire to abort for reasons related to serious fetal impairments is justified because such reasons may seriously invoke the parents' reproductive autonomy interests and thereby determine whether or not they reproduce.⁵⁶ Importantly however, for this line of thought to have much application requires that, as we move away from the extremes of conditions such as Tay-Sachs, other conditions are deemed "sufficiently serious" *meaningfully* to invoke reproductive autonomy and to justify fetal death.

Yet the degree of disagreement, including among genetics professionals, about what counts as "serious" is one of the most difficult issues in this context.⁵⁷ Although we likely have some sense of these issues at the extremes—for instance Tay-Sachs versus the webbing of two toes⁵⁸ or, say, a susceptibility to moderate obesity—difficulties attach to the large array of "midspectrum" conditions. A complicating factor is the question of the *legitimacy of differing perspectives* on these issues—medical, parental, and those of people with disabilities (who may in part "speak" for or about the fetus). In this way, the question of the meaning of seriousness is in part a question of "serious for whom?"⁵⁹ An argument of the disability critique has been that health professionals working in prenatal testing (rather than, say, pediatric care) have partial

understanding of what living with certain conditions is like.⁶⁰ This is related to the distinction between medical and social models of disability. Because of this, arguably the views of people with disabilities should be given some thought when we reflect on the interests of the *fetus* in being or not being born. Indeed, “serious” for the child the embryo or fetus will become may have its own set of meanings and uncertainties, which may turn in part on its own mental attitude, the reactions of others, and the social conditions it encounters. The perspective of people with disabilities may also be helpful to *parents* in their perceptions of what the future will be like if they continue with the pregnancy of an “affected” fetus. Where birth is compatible with a good or reasonable quality of life for the child but the parents wish to avoid a potentially more difficult or distressing rearing experience, we are faced with a conflict of interests between the fetus and its parents. In such a case, it is the *parents’* (perception of their) *interests* that may be particularly invoked when we reflect on the question of seriousness.

The discussion so far shows that analyzing the relationship between the reproductive interests of the pregnant woman (and her partner) and the characteristics of the particular fetus is clearly complex, as there are considerable difficulties in judging when a possible child’s condition will be “serious” and hence when parental interests will be seriously invoked. In this regard, we may have to defer here, to some extent, to liberalism’s recognition of the scope for reasonable disagreement. This may go hand in hand with a realization that arguably parental interests are the most important, especially before fetal viability.

Where does this leave us with regard to what might be a second interpretation of Asch’s point—that to claim a connection between the reproductive interests of the parents and the characteristics of the fetus is in some way offensive? Indeed, what are the implications of the discussion so far for the expressivist objection that one cannot both devalue an impairment and equally value the life of a person with that impairment? If parents decide to abort a fetus affected by cystic fibrosis, does this say something about an already born child with cystic fibrosis, the parents, or both? Cases have been made out for each of the first two possibilities and the likely complexities of meaning in this context have also been explored.⁶¹ For instance, James Nelson argues that there may not be the direct relationship between meaning and intention that Buchanan’s analysis of the expressivist objection may entail. Nelson’s view “is that even considered as a social practice, the meaning of testing and abortion remain both vague and ambiguous, and insofar as this practice does enfold objectionable meanings, the way to unseat them is not by restricting access to information and medical services.” Overall, he observes that “[t]he meanings of decisions, practices and policies that involve screening and abortion cannot be determined outside the context of a broader set of decisions, practices, and policies as they affect people with disabilities, as well as women and family life more generally.” To return then to my question, on the one hand I think it is right that the action of aborting a child with cystic fibrosis is not *intended* to express anything about an already born child with this condition. The action does mean, however, that the parents do not *themselves* want a child with cystic fibrosis.⁶² On the other hand, then, that they prefer to abort such a child may in turn be offensive or hurtful to children or adults with cystic fibrosis. Where do we go from here?

Arguably, consistent with the above thoughts, the case for justifying such offense can be made out in the case of serious impairments in a prospective child because these will significantly impact on its parents. In other words, in such cases the parents' reproductive interests will be seriously invoked. In this way, any offense to people with impairments caused by selecting against such impairments might be seen as unfortunate but justifiable. By contrast, because relatively trivial impairments or features do not begin seriously to implicate parental interests, it would be hard to argue that screening and abortion in relation to these could justify offense to those with impairments. In fact, such practices could be especially offensive to them, perhaps increasing the stigma felt by them.⁶³ This does not mean, however, that the possibility of this latter "unjustifiable offense" will necessarily be a reason to stem the growing information flow provided by ever more sophisticated and powerful genetic tests, particularly when relatively trivial information is detected as part of a package of more serious information. Having said this, the law of tort may have some ability to control what becomes part of the standard of care in screening practices.⁶⁴ In the absence of public consultation and agreement about whether and how to limit these practices, it seems likely that ameliorating offense to people with impairments will best be achieved by the way in which screening and testing information is presented and discussed.

Ultimately, in reflecting on the possible offense that PND, selective abortion, and PGD may cause to those of us with impairments, we are left to ponder the significance of parental interests in this process and the legitimacy of parental reasons for wanting to avoid the birth of an impaired child. People (typically) choose to become parents and exist thanks to the various efforts of their parents. Although there are many senses in which children are a gift, there is also a sense in which life itself is a gift to the child. This is so even when, as is likely the case, reproduction is chosen as one way of enriching parental lives. Biologically, the giving of life happens through conception and gestation. In other senses, it happens through the way children are brought up and nurtured. If parents embark on this process at least partly to enrich their own lives, then at some level this enterprise will, understandably, be related to their conception of their lives. Metaphorically, as it were, we might say that there has to be some "give and take," some degree of compromise on both parts, although the embryo or fetus is not in a position to agree to this. Assuming the parents have been fully counseled about the medical and social aspects of the birth of a child with a certain condition (which, as we know, may not currently be the case) they may still decide that, with the necessarily limited knowledge they now have, they wish to avoid a certain kind of *potentially* more difficult or distressing reproductive experience.

It is helpful here to flesh out some of the sympathetic thoughts of those writing from a disability perspective. For instance, Asch acknowledges that "[m]ost project members believe that people with significant disabilities can have lives they experience as rewarding but worry that life with a disabled child would be more difficult than life with a child without disabilities. On this view, parents could or should not be expected to envision the family life that included a child with a disability as equivalent to family life where no children had disabilities."⁶⁵ In a similarly sympathetic vein, Tom Shakespeare observes:⁶⁶

The role of prospective parents has largely been ignored by disabled radicals. Because these are predominantly non-disabled people, it is likely that they will hold some of the prejudicial attitudes to disability which are common in society. Yet the decision to terminate pregnancy is not one that the majority of people take lightly. Moreover, there are reasons to want to prevent the birth of a child affected by impairment which do not reflect discrimination against disabled people: for example, the desire to avoid the early death or suffering of a loved child, or a feeling that a family will be unable to cope with the strain of looking after a very impaired member. (p. 821)

(He also emphasizes the need “for better provision of welfare services and financial benefits to parents of disabled children, in order to make it easier for parents to choose to ... continue such a pregnancy”.⁶⁷) These observations point once again to parents’ legitimate perception of their interests and limits.

A further strand of thought examining the legitimacy of parental reasons that I have not been able to explore here could focus on the degree of opportunity open to a child with cystic fibrosis, spina bifida, or Down’s syndrome, particularly because there is at least some agreement that a negative feature of impairment may be that it restricts opportunities, *despite* all social support.⁶⁸ Barring those cases where, for instance, deaf parents seek a deaf child, it would, after all, be strange for a parent to *hope* for a child with health problems or limited opportunities,⁶⁹ however much the child may in fact successfully cope with these difficulties. Asch herself, in recognizing that impairments are not neutral, suggests that “[w]e can agree that our disabilities impose limitations we might sometimes wish were not there.” She notes: “Fortunately, everyone in our project affirms that much of disability is socially constructed; what has remained a contentious and painful divide has concerned just how much is ‘social’, how much is irremediable, and how negative for child, family, or society those irremediable facets of disability turn out to be.”⁷⁰ Further, the disvalue in constraint of opportunity was a point of extensive agreement among the Hastings Center working party that looked at these issues.⁷¹ It is in this sense that the language of “wrongful disability” with which midspectrum cases are often discussed—and which can be hard to reconcile with the views of disabled people themselves—may best be understood. Thus, one may respectfully argue that, overall, it is not undesirable if people with greater opportunities—including because of the inevitable and reasonable limits to social support where impairments exist—are born.⁷²

Finally, in connection with the expressivist objection, it is sometimes suggested that people with disabilities may really be *harmed*, rather than offended, by the practices of PND and selective abortion, and PGD.⁷³ To the extent that these practices may be fueled by or, in turn, fuel a predominantly medical model of disability, which may, in turn, be linked with issues of discrimination and possible loss of support, then it is fair to say that these practices have the potential to result in actual harm to people with disabilities. In terms of the current discussion, however, I have related these potentially real harms to my points about conflicting models of disability, issues of discrimination, information, and loss of support. That is, assuming these former concerns are acknowledged and addressed, we are left with the question of the potential *messages* that PND and associated practices may send. It is these that I have sought to address in relation to the expressivist objection. Although the sending of these

messages, however they are interpreted, is unavoidable as long as these practices continue, *how* they are sent can be the focus of positive concern, for instance, by reflecting on the blandly underinformed and underinforming routinization of mainstream aspects of PND, such as those relating to Down's syndrome or spina bifida. This takes us back to the issue of the provision of information about disabilities discussed earlier.

A related point here, however, concerns who might *receive* these messages. It is sometimes suggested that people with disabilities can claim to be harmed by the dissemination of misleading assumptions about disability and suffering.⁷⁴ To the extent that this assumption may lead parents to abort certain fetuses, it is unclear how this actually *harms* already existing disabled people. Conversely, to the extent that such assumptions negatively affect how existing people with impairments are treated by third parties or the options open to them, then it would be meaningful to talk of them being harmed. In this way, messages relating to PND may be picked up by third parties whose attitudes and actions then impact on those now living with disabilities. Public education about disability beyond that which occurs in the context of PND is part of the solution here.

Conclusions

This article has briefly reviewed three main lines of thought concerning the relationship between reproductive autonomy and selection practices on the one hand and the interests of people with disabilities on the other.

The debate on the medical as opposed to the social models of disability has become increasingly sophisticated, with a certain degree of common ground being found, even though important differences remain. Arguably, some combination of the medical and social models is best placed to capture the reality of impairment and disability. Further, for parents to wish to avoid the harms of impairment that are accentuated by lack of social support is not necessarily to collude in discriminatory practices, where society cannot be expected absolutely, rather than reasonably, to provide social support, given the diverse and conflicting interests that it is required to accommodate. Similarly, although representing concerns of some legitimacy, the "loss of support argument" cannot be expected fairly to prompt a radical change in the shape of current arrangements, at least where these make reasonable provision for those of us with impairments.

The expressivist objection is in many ways the most intangible of concerns and, at the same time, given the progress that is clearly being made in refining our perceptions (and models) of disability, the most lingering. Two possible meanings of the objection were explored, one entailing the view that the fetus is a person and the other the view that one cannot select against an impairment and yet equally value a person with that impairment. As for the first point, although technically correct to say that the fetus or embryo is not a person and that therefore no violation of rights occurs through PND, selective abortion, and PGD, this does not go the heart of the expressivist objection. Rather, the real nub of the objection surely lies in the second sense.

As regards the idea that one cannot select against an impairment and yet equally value a person with that impairment, the point is often made that people are not their impairments and that the disvalue lies in the impairment,

not the person. I emphasized, however, that although there clearly is a *conceptual* distinction between the disvalue of an impairment on the one hand and the value of a life of someone with that impairment on the other, in the practice of prenatal testing and abortion the impairment and the actual life are both avoided *one and the same*, so that that particular individual will never come to exist. Thus, however correct the conceptual point may be as a matter of logic and however much it may be repeated, we need to acknowledge that in practice it loses its force. I discussed the possible offense that prenatal testing practices may cause and argued that that offense was unfortunate but justifiable where parental interests in the broad shape of their reproductive future are at stake. I argued that parental interests are seriously invoked where a child would have a serious impairment. This might consist of significant mental impairment or serious health problems requiring, for instance, repeated hospitalization with an uncertain future. Honesty about whose interests might really be at stake is crucial, notably regarding the huge array of midspectrum conditions where birth is nevertheless in the interests of a fetus. In this connection, the language of “suffering” may be of particular concern to people with disabilities, at least in that it may make presumptions about, rather than listen to, their views. This again highlights the importance of careful reflection about whose interests may be truly or most at stake in prenatal screening, PGD, and associated selection decisions. The pressing issue in relation both to parents’ interests in making reproductive decisions as well as to the interests of those with impairments is how best to enhance the deliberative processes attending these reproductive decisions.

Notes

1. In England, for instance, a recent consultation on the legitimate scope of preimplantation genetic diagnosis (PGD) resulted in a statement of public policy by the Human Fertilisation and Embryology Authority and the Human Genetics Commission: HFEA and HGC. *Outcome of the Public Consultation on Preimplantation Genetic Diagnosis*, Jun. 18, 2001. This concern can be found in the Outcome Document: para 22: “... PGD guidance should support difficult parental choices rather than appearing to discriminate against individuals with certain conditions.” But the document does not in itself explain how PGD might in fact be discriminatory. (The kernel for the ideas in this article originates in brief thoughts in my article: Scott R. Prenatal Screening, Autonomy and Reasons: The relationship between the law of abortion and wrongful birth. *Medical Law Review* 2003;11:265-70.)
2. See, for example, Suter S. The routinization of prenatal screening. *American Journal of Law and Medicine* 2002;28:233-70, at 268.
3. See, respectively, Buchanan A, Brock D, Daniels N, Wikler D. *From Chance to Choice: Genetics and Justice*. Cambridge: Cambridge University Press; 2000 and O’Neill O. *Autonomy and Trust in Bioethics*. Cambridge: Cambridge University Press; 2002.
4. See note 3, O’Neill 2002:61.
5. For example, see note 3, Buchanan et al. 2000; Robertson J. Genetic selection of offspring characteristics. *Boston University Law Review* 1996;76:421-82, at 421; Steinbock B. Disability, prenatal testing and selective abortion. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000;108-23, at 108; Botkin J. Line drawing: Developing professional standards for prenatal diagnostic services. In: Parens E, Asch A. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000;288-307, at 288.
6. See, for example, Shakespeare T. Choices and rights: Eugenics, genetics and disability equality. *Disability and Society* 1998;13(5):665-81, at 672.

Prenatal Testing and Disability Interests

7. Harris J. Is there a coherent social conception of disability? *Journal of Medical Ethics* 2000;26:95–100, at 99. See also at p. 97, citing S. Reindal's interpretation of Harris in Reindal S. Disability, gene therapy and eugenics—A challenge to John Harris. *Journal of Medical Ethics* 2000;26:89–94.
8. See note 6, Shakespeare 1998 at p. 665 (citing Oliver M. *The Politics of Disablement*. Basingstoke: Macmillan; 1990).
9. See note 7, Harris 2000:95; also see note 6, Shakespeare 1998:670.
10. "Not all problems of disability are socially created and, thus, theoretically remediable. ... The inability to move without mechanical aid, to see, to hear, or to learn is not inherently neutral. Disability itself limits some options." See note 5, Steinbock 2000:69–124, at 115, citing Asch A. Reproductive technology and disability. In: Cohen S, Taub N. eds. *Reproductive Laws for the 1990's*. Clifton, N.J.: Humana Press; 1989:69 at p. 73.
11. Wertz D, Fletcher J. A critique of some feminist challenges to prenatal diagnosis. *Journal of Women's Health* 1993;2:173–8, at 175, as cited in note 5, Steinbock 2000:115.
12. See note 5, Steinbock 2000:115. Indeed, it is understandable that if medicine has done all it can for one's impairments, then one can only look to social conditions further to redress these. John Harris suggests that there is a preference for the "social model" in "[p]eople with irremediable disabilities ... because the medical model is of no further use to them." See note 7, Harris 2000:99.
13. See note 7, Harris 2000:99.
14. Sheldon S, Wilkinson S. Termination of pregnancy for reason of foetal disability: are there grounds for a special exception in law? *Medical Law Review* 2001;9:85–109, at 103.
15. The relevant part of s.1(1) of the Abortion Act 1967 as amended by the Human Fertilisation and Embryology Act 1990 reads: "Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith ... (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."
16. See note 15, Sheldon, Wilkinson 2001 at p. 107.
17. Wertz D. Drawing lines: Notes for policymakers. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000 at pp. 261, 268.
18. See note 14, Sheldon, Wilkinson 2001:108.
19. See note 3, Buchanan A et al., 2000, esp. 291–3.
20. See note 3, Buchanan A et al., 2000:292.
21. See Williams C, Alderson P, Farsides B. "Drawing the line" in prenatal screening and testing: Health practitioners' discussions. *Health, Risk and Society* 2002;4(1):61–75, at 73, for discussion of the value of this. For specific consideration of the information provided in relation to Down's syndrome, see Williams C, Alderson P, Farsides B. What constitutes "balanced information" in the practitioners' portrayals of Down's syndrome? *Midwifery* 2002;18:230–7, at 230. T. Shakespeare has addressed the inadequacies of current counseling services, observing that "[d]ecisions about screening should be based on good information: rather than evaluating screening programmes in terms of those who undergo tests and terminations, programmes should be evaluated in terms of the proportion of people who were empowered to make an informed choice." "Losing the plot?" Medical and activist discourses of contemporary genetics and disability. *Sociology of Health and Illness* 1999;21(5):669–88, at 685. For a detailed discussion of the ways in which information giving in this context should be developed, see Bowles Biesecker B, Hamby L. What difference the disability community arguments should make for the delivery of prenatal genetic information. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:340–57, at 340.
22. 120 L.Ed.2d 674 (1992). In reviewing the idea of a framework in which third parties, such as the State, or family members in the case of minors, may themselves "express profound respect for the life of the unborn," (120 L.Ed.2d at 715) both Blackmun and J.J. Stevens were keenly aware of the need to distinguish *neutral medical information* legitimately related to *health* on the one hand and information concerned with *moral consequences*, coupled with the question of *persuasion* in relation thereto, on the other.
23. Ferguson P, Gartner A, Lipsky D. The experience of disability in families: A synthesis of research and parent narratives. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:72–94, at 81 and 85, respectively.
24. Parens E, Asch A, The disability rights critique of prenatal genetic testing: Reflections and recommendations. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington,

- DC: Georgetown University Press; 2000:3–43, at 22. M. Baily in Baily M. Why I had amniocentesis. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:64–71, at 70, notes the unknown variation in severity of a condition may well affect decisionmaking in people who are risk averse: “A woman’s decision may reasonably be influenced more by the ‘worst-case’ Down syndrome scenario than by the average.”
25. Asch A. Why I haven’t changed my mind about prenatal diagnosis: Reflections and refinements. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:234–58, at 248, footnote omitted. See also note 24, Parens, Asch 2000:22.
 26. Alderson P. Prenatal Counselling and Images of Disability. In: Dickenson D, ed. *Ethical Issues in Maternal-Fetal Medicine*. Cambridge: Cambridge University Press; 2002:195–212, at 203. The quotes immediately following are from pp. 208 (twice) and 207.
 27. Nelson J. The meaning of the act: Reflections on the expressive force of reproductive decision making and policies. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:196–213, at 207.
 28. The possibility is acknowledged in Jackson E. *Regulating Reproduction*, Oxford: Hart Publishing; 2001 at p. 99, but is not thought a good reason to limit testing.
 29. See note 3, Buchanan et al. 2000:267, where they observe that this has occurred in relation to Thalassaemia.
 30. See note 3, Buchanan et al. 2000:266.
 31. See note 3, Buchanan et al. 2000:267.
 32. See, for example, *Dansby v. Jefferson*, 623 A.2d 816 (Pa. Super. 1993) 820, in which J. Wieand noted that, in part, the wrongful birth statute banning wrongful birth actions “reflect[s] the state’s view that a handicapped person should not be deemed better off dead and of less value than a ‘normal child.’” It could be argued that the state should pay the health-care costs of impaired children if it wishes to promote their births, as of course it would in any event do in England. For the views of scholars opposed to wrongful birth actions see, for example, Bopp J, Bostrom B, McKinney D. The “rights” and “wrongs” of wrongful birth and wrongful life: A jurisprudential analysis of birth related torts. *Duquesne Law Review* 1989;Spring:461–515, at 466.
 33. Asch A. Can aborting “imperfect” children be immoral? from Asch A. Real Moral Dilemmas, *Christianity and Crisis*, 46(10):237. Reprinted in Arras J, Steinbock B. *Ethical Issues in Modern Medicine*, 5th ed. Mountain View, CA: Mayfield, 1999: at 387.
 34. See note 3, Buchanan et al. 2000:280.
 35. See note 3, Buchanan et al. 2000:297. See also Gillam L. Prenatal diagnosis and discrimination against the disabled. *Journal of Medical Ethics* 1999;25:163–71, at p. 169; see also note 28, Jackson 2001:98.
 36. For discussion, see, for example, Scott R. *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict*. Oxford: Hart Publishing; 2002:chs. 3 and 2, respectively.
 37. The question of why she should have that right might be answered by reflecting on the significance of her moral and legal interests and rights in self-determination and bodily integrity. See note 36, Scott 2002.
 38. For this kind of legal explanation, see, for example, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 120 L.Ed.2d 674 (1992).
 39. Buchanan et al. acknowledge that offence can be taken, particularly given “the shameful history of discrimination against and insensitivity toward persons with disabilities.” See note 3, Buchanan et al. 2000:280–1.
 40. A distinction should be drawn, perhaps, between the message received and the message sent. See note 5, Botkin 2000 at p. 305. For thoughts on changing the way prenatal diagnosis is offered, see note 25, Asch 2000:52.
 41. R. Hubbard observes: “[T]he child’s disability is no longer an act of fate. [The woman] is now responsible, it has become her fault.” Hubbard R. Eugenics: New tools, old ideas. *Women and Health* 1987;13, at 232.
 42. Williams C, Alderson P, Farsides B. Too many choices? Hospital and community staff reflect on the future of prenatal screening. *Social Science & Medicine* 2002;55:743–53, at 751. See further Saxton M. Why members of the disability community oppose prenatal diagnosis and selective abortion. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:147–64, at 157 and Press N. Assessing the expressive character of prenatal testing: The choice made or the choices made available? In: Parens E, Asch

Prenatal Testing and Disability Interests

- A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:214–33, at 219, on the potential for misunderstandings among pregnant women about the role and purpose of prenatal testing.
43. See note 27, Nelson 2000:211.
 44. For reflections on this point see especially note 21, T. Shakespeare 1999 and note 2, Suter 2002. For practitioners' recognition that they are working in a system that has not been the subject of overt critical reflection, see note 42, Williams et al. 2002.
 45. See note 24, Parens, Asch 2000.
 46. See note 3, Buchanan et al. 2000:280. They suggest that I can believe I should not marry without believing marriages should not occur (at p. 277). While true, I do not see how this analogy helps here.
 47. It may be particularly hard to make this kind of separation in the case of mental impairment, as noted by L. Carlson in *Prenatal Testing and Selective Abortion*. *Philosophy and Medicine* 2002;75:191–213, at 207. Carlson discusses the work of disability theorists, such as S. Edwards, who emphasize that "disabilities are not detachable from selves" (p. 206). It is not clear, however, how this reluctance or inability not to separate the two can be helpfully incorporated into the moral argument at this point other than to acknowledge, as I have done, that it may always be hard for those of us with impairments to make this conceptual separation.
 48. See, for example, Jennings B. Technology and the genetic imaginary: Prenatal testing and the construction of disability. In: Parens E, Asch A, eds. *Prenatal Testing and Disability Rights*. Washington, DC: Georgetown University Press; 2000:138.
 49. See note 25, Asch 2000:236. The immediately following quotes are from pp. 247 and 252, respectively.
 50. See note 25, Asch 2000:236–9.
 51. For critiques of the "any/particular distinction," see, for example, note 48, Jennings 2000:200–5; note 27, Nelson 2000:196.
 52. See note 26, Alderson 2002:201–10.
 53. On the relationship between the expressivist objection and assumptions of "personal tragedy," see note 47, Carlson 2002:203.
 54. The point has been well made by S. Edwards, in *Prevention of Disability on Grounds of Suffering*. *Journal of Medical Ethics* 2001;27:380–82.
 55. The classic statement of this view is likely found in J. Robertson, see note 5, Robertson 1996:445.
 56. For support, see, for example, note 5, Robertson 1996:445.
 57. See note 24, Parens, Asch 2000:33: "[O]ur project group could not reach a consensus about drawing lines between reasonable and unreasonable tests..."
 58. Note, however, that a minor anomaly may be an indication of a more serious one as, for instance, Down's syndrome may be a relatively common cause. A possible concern that "that's not all that's wrong with [the] baby..." was noted by a midwife quoted in note 21, Williams et al. 2002:68.
 59. J. Botkin likewise notes this. See note 5, Botkin 2000:300.
 60. See note 21, Shakespeare 1999:678.
 61. See, respectively, note 27, Nelson 2000 and note 25, Asch 2000. For a sophisticated discussion of the possible meanings, see note 27, Nelson 2000, esp. pp. 206–11. The quotes that follow are from pp. 209 and 211.
 62. See note 42, Press 2000:226–7, where Press refers to surveys in which, on the one hand, people speak about equally valuing people with disabilities and, on the other, very strongly hope they will not have a child with disabilities.
 63. See note 42, Williams et al. 2002:748; note the comments of a psychologist to this effect.
 64. See note 1, Scott 2003.
 65. See note 25, Asch 2000:248.
 66. See note 21, Shakespeare 1999:681.
 67. See note 6, Shakespeare 1998:672.
 68. See note 24, Parens, Asch 2000:28.
 69. See note 25, Asch 2000. Asch agrees that it is appropriate for parents to "have hopes and dreams for themselves, as well as for their children" (pp. 247–8). The difference, however, is likely to inhere in perceptions about whether a disability will mean that either a child or its parents will not have a rewarding life (p. 248). Asch notes that she would not be a "critic" if she thought that the child's or parents' hopes would be "thwarted" by a child's disability. On the adjustment processes at stake in coming to terms with the prospective birth of an impaired child, see note 21, Bowles Biesecker, Hamby 2000:345–6.

70. See note 25, Asch 2000:247, 243–4.
71. See note 24, Parens, Asch 2000:28.
72. Brock D. The non-identity problem and genetic harms—The case of wrongful handicaps. In: Arras J, Steinbock B, eds. *Ethical Issues in Modern Medicine* 5th ed. Mountain View, Calif.: Mayfield; 1999:397–401. Reprinted from *Bioethics* 1995;9(3/4):289. Brock employs a same number, rather than a same person, analysis to show that in “wrongful handicap” (cases in which a child will have a life worth living) “if any one is wronged it is the class—[a parent’s children] whom [they] permit ... without adequate reason or justification to be worse off than [their] children could have been. But if this class—[their] children—has been wronged, it is in a sense from which it does not follow that any member of that class—that is, any one child—has been wronged” (p. 400). For further discussion, see, for example, note 3, Buchanan et al. 2000:242–55. The view is put in opposition to that of D. Parfit, in Parfit D. *Reasons and Persons*. Oxford: Oxford University Press; 1984:ch. 16. Parfit explores conceptual difficulties surrounding what he dubs the “non-identity problem.” Thus, any given embryo or fetus can only exist as one possible child (or twins in the case of the embryo) and it is argued that it is only if this child’s existence will be overwhelmingly awful that a welfare-of-the-child judgment could be made to terminate the fetus or against implanting an embryo.
73. Jonathan Glover has drawn this point to my attention.
74. See note 47, Carlson 2002:205.