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Achieving the desirable nation : abortion and antenatal testing in Colombia : the case of amniocentesis

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Chapter 3

From law to practice. Defining foetuses with 'conditions incompatible with life'

The knowledge about which thing will be useful at any given moment is embodied in a flow of mundane tasks and practices and many varied social roles... [S]tandards and classifications, however imbricated in our lives, are ordinarily invisible.

Bowker & Star (2000: 2)

In the previous chapter I showed that the category of 'conditions that make life unviable' – or in the general public's jargon, 'conditions incompatible with life' – is by no means a clearly demarcated category. On the contrary, despite the effort made by the Constitutional Court, it proved virtually impossible to pinpoint exactly what is a condition with such a definitive characteristic. Therefore, the Court left the decision, or rather, the responsibility for deciding which foetal conditions meet the criterion of 'making life unviable' in the hands of obstetricians. This decision was based on the notion that these specialists have the (technological and technical) means and the knowledge for diagnosing foetal conditions, and thus can classify them in terms of their severity.

In this chapter I show that 'conditions that make life unviable' or 'incompatibilities with life' is a category not limited to conditions that threaten, prevent, or end life in biological terms. Rather, it is a multiple (Mol 2002) and plastic category that has come to encompass conditions perceived as incompatible with a life plan and, to some extent, a lifestyle, and into which conditions diagnosed via amniocentesis fall easily. Following this line of argument, I suggest that when discussing or aborting foetuses with 'conditions that make life unviable', salient social imaginaries and cultural norms regarding desirable offspring, families, and citizens are revealed, particularly regarding definitions and understandings of health and illness, and of normal and abnormal people.

In order to develop my argument I present scenarios and actors that I consider shape the understanding, and also the practice, of selective abortion today. A permanent seminar on abortion de-penalisation, and a National Forum on the after effects of abortion de-penalisation, prove exemplary. Both activities were organised by the Bioethics Network of the National University in Bogotá and the Ministry of Social Protection. They were set up with the intention of promoting 'the application and recognition of human rights; the consolidation of social values that recognise in men and in women inalienable principles of dignity, honour, and unity' (Universidad Nacional de Colombia 2007a: 1, my translation). The purpose of such activities was to enable an open and fruitful discussion of Sentence C-355/06 from an 'ethical-juridical perspective' (Universidad Nacional de Colombia 2007a). For both activities, an interdisciplinary group of renowned medical, law, and bio-ethics professionals was invited, representatives of the feminist movement were summoned, and civil society was welcomed, in the attempt at having an open and public discussion of the Sentence. However, given the composition of the audience, the permanent seminar and the National Forum in practice served largely to legitimise abortion de-penalisation at the level of civil society.

For showing how actors shaped de-penalised selective abortion practice in Colombia, I have mobilised the viewpoints of people who are in close contact with the possibility of a positive antenatal diagnosis. These include geneticists from different genetic research institutions, and specialists in maternal-foetal medicine who perform amniocentesis and other antenatal tests³⁰. However, given their professional occupation, life histories, or life situations, these individuals have different understandings of the de-penalisation and practice of selective abortion in cases of foetal 'conditions that make life unviable'.

Scenarios

This section addresses particular scenarios that can be considered part of nation-building processes. Through their analysis I respond to the question of how a group of Colombians, who are both part of civil society and are also public figures, understand,

³⁰ Most of the included obstetricians work at the department of maternal-foetal medicine in which the core ethnography took place, but others work elsewhere

shape, and codify abortion de-penalisation. Further, at the same time such scenarios permit me to elucidate why abortion de-penalisation, in cases of foetal conditions 'that make life unviable', occurred. The discussions held in these scenarios show a perspective of sanitary justice, a Cartesian definition of human persons that praises the mind over the body (c.f. Lock 2002), and the resort again to the discourse of human rights. Looking closely into these scenarios, the discourses mobilised, the debates they enabled, and the dynamics they produced, allow a deeper and more articulated understanding of what these particular foetal conditions are in the Colombian context.

Permanent Seminar

Monday 23 April, 2007.

It is 07:15 in the morning. A typical cold morning in Bogotá: foggy and rainy but with the air so fresh one can actually feel it coming into the lungs.

The auditorium of the genetics institute at the National University is filling up with the already-regular audience. As usual, the audience is diverse, not only in disciplinary backgrounds, but also in age groups, gender, and positions towards abortion de-penalisation. I cannot help but feel glad for witnessing this gathering of geneticists, obstetricians, jurists, feminists, bio-ethicists, philosophers, anthropologists, medical doctors, and nurses discussing the medical, juridical, and ethical dimensions of Sentence C-355/06. This is, indeed, an experience of gigantic richness. This is one way of doing bio-ethics, law, and medical and social practices live.

Today we have a lecture by a bio-ethicist on 'the maternal-foetal conflict' as it takes place in the three de-penalised cases. When discussing the case of foetal conditions the lecturer includes the concept of quality of life and sanitary justice. For the bio-ethicist, these are paramount concepts to bear in mind when granting an abortion in the case of certain foetal conditions... The lecturer defined sanitary justice as the need for a thorough evaluation of risks, benefits, costs, resources, and therapeutic efforts when dealing with a foetus with a diagnosed condition. Basically, for the lecturer, resources should be allocated in a 'responsible' way, which means that if efforts are thought to be 'useless' then they should not be made at all... Further, sanitary justice refers to reducing the burden of disease and conditions considered to make life unviable.

By discussing the Sentence by which abortion was de-penalised, and not limiting the discussion to abortion de-penalisation as a fact, this group of people enabled a particular reading of Sentence C-355/06. It made visible the different shapes that the text in itself may acquire, depending on who is reading it. The debate also showed how the different approaches inform abortion practice today. The lectures addressed different aspects of the Sentence. Topics included, amongst others: abortion as a public health problem; fundamental rights and the Constitutional Block; foetal conditions 'that make life unviable'; risk to the life or health of the pregnant woman; voluntary interruption of the pregnancy as an ethical conflict or as a juridical determination; and the objection of conscience³¹. Given the focus of this study, in what follows I focus especially on the lecture on the 'maternal-foetal conflict', as quoted in the above excerpt. The reason for this is that this lecture brings to the surface shared conceptualisations of the foetus which resonate with an understanding of human persons and of desirable members of society. The relevance of paying special attention to this matter lies in the fact that through such a lecture, the worthiness of able, productive individuals, who comply with medical and social standards, provides the framework for defining 'conditions that make life unviable', and thus define which lives are worthy of Constitutional protection.

As presented in the above excerpt, the lecture on the 'maternal-foetal conflict' in cases of abortion was given by a bio-ethicist working at the Bio-ethics Network of the National University. For him, the starting point for understanding Sentence C-355/06 was to address the three principal concepts and rights used by the court for de-penalising abortion, namely: human life, human dignity, and human health. From the lecturer's point of view, these three concepts worked as facilitators for understanding and enabling the practice of abortion in the three de-penalised circumstances. However, given the focus of this research, I only concentrate on the arguments supporting selective abortion due to 'conditions incompatible with life'.

³¹ For a complete list of themes, see: Universidad Nacional de Colombia. Red de Bioética 2007. Texto académico. Derechos humanos, derechos de la mujer: Ante todo, el principio de la protección.

The lecturer on the maternal-foetal conflict, by articulating an argument which attempted to show that abortion in all the de-penalised circumstances is an ethical practice, not only exposed and relied on the legal arguments, but also employed bio-ethical discussions about the meaning of, and the differentiation between, a *human being* and a *human person*:

The concept of the human person is central to all debates and statements regarding the voluntary interruption of pregnancy ... [T]his constitutes a central dilemma, for we need to ask if the concept of human life can be attached not only to the woman but also to the foetus. We [as bio-ethicists] understand the human being, whose biological foundation is the human genome, who is an individual of the human species characterised by a genotype and by a phenotype. That is a human being ... but departing from there the ontological understanding develops in terms of all the characteristics and capabilities of a human being. Then, we arrive to the concept of the human person. We understand the human person as a superior category inasmuch as the full development of all the capabilities that all human beings have. ... All human beings have in their genetic code all the potentiality to become a human person and such a status is achieved through a personalisation process. But we need to consider that the potentialities and probabilities to become a human person ... will not occur, for instance, with an anencephalic foetus, for it does not have either the potentiality or the probability for becoming a human person in the terms we have formulated (bio-ethicist, permanent seminar, 2007. My translation).

The relevance of such a discussion pivoted around the understanding that, when defining both categories – human beings and human persons – and attaching both to the woman and one to the foetus (i.e. human being), the ‘maternal-foetal conflict’ could easily be solved:

Such a definition of a human person can help to make ethical-clinical decisions in the face of concrete and difficult human situations, such as the voluntary interruption of pregnancy. It helps us to solve the question of whether we are in front of an individual human being or in front of a human person as such. ... In this case, we need to consider autonomy as one of the principal capabilities of human persons, patients, who are persons

and are subjects of rights and duties ... However, we also need to take into account the vital autonomy, which in this case could be attached to a viable foetus, which imposes on the health professionals' respect for the protected juridical good of such a life (bio-ethicist, permanent seminar, 2007. My translation).

Based on this argument, the lecturer concluded that the voluntary interruption of pregnancy, in the three de-penalised cases, is an ethically acceptable practice. In the specific case of foetal 'conditions that make life unviable', abortion is an ethically acceptable practice because such a being will not be able to achieve the ontological definition of *human person*, as it will not be able to develop *all human capabilities*, and thus fulfil the personalisation process.

Another argument used in favour of selective abortion in cases of fetuses diagnosed with conditions 'incompatible with life' was that women should not be forced to carry and deliver fetuses with genetic or morphological variations, for it constitutes torture to women, and they could be traumatised by delivering such babies.

To close the lecture, which passed in almost complete silence, the lecturer presented the argument for abortion for reasons of *sanitary justice*. That is, when thinking of this type of abortion, one should also keep in mind the risks, benefits, costs, and therapeutic efforts involved in delivering and treating newborns different from the average. Following the lecturer's elaboration on what it entails to be a human person, a foetus that has limited or no potential for living a fulfilling life – according medical and social standards – should not benefit from medical and technological facilities, as such an investment supposes an act against sanitary justice. All the necessary efforts and costs that a baby with a genetic or morphological variation would suppose should instead be directed towards other individuals who have more potential to develop all human capabilities, and thus be entitled to recognition as a person:

[In cases of congenital malformations] we have to think not only in terms of viability (as referred by the Court), but also we need to include the concept of quality of life. ... The values in conflict in this case, are: [firstly] the mother's dignity, for being subjected to torture and cruel and inhuman

treatments, as it *is against the woman's dignity to have to suffer a pregnancy of a malformed foetus*, in opposition to the life of the foetus ... Secondly, the foetal life in itself, when comparing it with the quality of life of such a foetus after birth ... And thirdly, it is needed to take into account the concept of sanitary justice ... which, for me is a most valid concept, because it includes risks and benefits that the malformed foetus will face, the costs that such care will imply, the therapeutic effort that the foetus will require after birth, and the equipment of a needed therapeutic body. This malformed foetus, with a very poor quality of life, implies after birth the need for a whole use of medicine and technology. Well, we might as well think of the costs that, in terms of sanitary justices, it implies. Here then, the concept of human person gains validity. We must ask if this [diagnosed foetus] is a purely human biologic being, or if it has any possibility of a whole development of its potentialities (bio-ethicist permanent seminar 2007. My translation, emphasis added).

Interestingly, the issue of equating the birth of a child with genetic or morphological variations with an act of torture to the woman was neither addressed nor discussed, presumably since such an equation was assumed to be right. Similarly, it became clear from the bio-ethicist's exposition that, when faced with a foetus with a diagnosed condition, not only should the woman's wishes be taken into account, but also the wider concern of society given the costs and burdens that an individual with such conditions may suppose. As shown by the lecturer, in order to be able to decide whether or not the deployment and use of high-tech medicine should occur, one might think of the foetus in terms of a human being (purely biological) or a human person (as having the possibility of developing his or her potentials). But the lecturer made clear that the issue of deciding upon which conditions are more burdensome than others should come from a social dialogue. That is, there needs to be a social dialogue and a subsequent consensus in which it is decided what kind of conditions, given the particular social context of Colombia, should be regarded as 'incompatibilities with life'. In the lecturer's words:

The case of a malformed foetus is not the problem of a pregnant woman but the problem of a society, and from there [society] it should be faced as such. The society and the state have to respond to the policies they have towards congenital malformations, they have to be backed up by legislation and by

resources. ... The society is to decide how it is going to manage congenital malformations, as, for instance, to define what is the limit week for establishing viability ... what conditions are considered severe ... the concept of quality of life. ... In other words, to discuss the social implications of congenital malformations. I mean ... the issue here is that the woman with a malformed child, *for a few or for a lot of years*, is not a matter only for the woman and her family. No, this is a problem that has to be assumed as a State policy, with all the implications it carries, in terms of economic and human resources. I mean, there should be a social consensus about the management of congenital malformations and quality of life ... and then decide, for this society, which conditions meet such standards and which fall into the category of making life unviable (bio-ethicist permanent seminar 2007. My translation, emphasis added).

For this lecturer, 'unviability' or 'incompatibility with life' are conditions that relate to a human being unable to achieve a personalisation process, for such conditions limit the full development of *all human capabilities*. However, the classification of such conditions must derive from a social dialogue that regards and discusses issues of costs, socio-economic and emotional burdens, and quality of life, depending on each society's standards. But given that the concept of quality of life was neither defined nor taken into account by the Court in Sentence C-355/06, a debate around this issue arose; not because others argued that quality of life should not be taken into account, but because of the dangers implied when thinking in those terms. This debate prompted an obstetrician, who was representing the Ministry of Social Protection, to point out that when taking quality of life as a marker, many conditions could easily be considered as leading to a poor quality of life. This would suppose a move towards eugenics, and a move away from the specificities of the Sentence:

It is interesting to use the concept of quality of life, but since the Court only used incompatibility with life, it could be risky, because in that concept can fall Down syndrome and other conditions, which would point more towards eugenics. And no one wants that type of end (male obstetrician, participant, permanent seminar, 2007. My translation).

In response to this viewpoint, that seemed more of a clarification of the Ministry of Social Protection's position, the bio-ethicist replied:

Yes, it is not juridical, but it is ethical to think about the quality of life ... [W]e need the social dialogue and consensus to decide whether or not Down syndrome falls in that category [poor quality of life], that is to be decided by society (bio-ethicist permanent seminar 2007. My translation).

Following this exchange, that concluded with the Ministry's representative saying '*Yes, but quality of life was not addressed by the court*', the discussion followed an interesting path that made evident more tensions regarding this issue. A law professor expressed the view that even if society decided that Down syndrome did lead to a poor life, the Court only mentioned incompatibilities with life and therefore only such conditions could be aborted, making clear his take on, and understanding of, law and legislation:

The Court only permits unviability. The other [wider understanding of quality of life] can only be permitted by legislative acts. ... I reiterate, the information provided by the doctor cannot guide the woman to one or the other decision. The doctor can only inform the patient. ... Furthermore, regarding the mental state of the patient, we cannot talk about traumatic situations for the woman; it has to be a grave condition (male lawyer, participant, permanent seminar. My translation).

This position was not welcomed by the audience, and a female lawyer who works for the feminist group that sought abortion de-penalisation pointed out the need to construct and enable a social dialogue that permits women to make a reproductive decisions in all situations of all foetal conditions, and not only limited to those that threaten the life of the (born) baby. To support this opinion and to stress his points, the lecturer emphasised that such a dialogue and consensus has to be thought of as an ongoing process that adjusts to the advancements, as well as to the needs, of society. As a tension tamer came the opinion of a renowned feminist, recognised by many as a central figure of the feminist movement in the

country. Her words were: 'gladly the doctors are not lawyers', meaning that she was happy that obstetricians had a wider understanding than lawyers of 'conditions incompatible with life'. After a massive and long laugh, that I understood as a general agreement with the comment and position, the lecturer added: 'and unfortunately, lawyers talk about grave malformations but do not say which they are', making reference to the point that given the fuzziness of the concept 'conditions that make life unviable', it is not crystal clear who has the right to have or not to have an abortion in absolute terms. Although the points raised by the feminist and the lawyer speak eloquently about the difficulties of defining 'incompatibilities with life', which they felt should not be limited to life threatening conditions, the fact that the tension was tamed by a joke also speaks about the position that disagreement - usually downplayed- has when discussing abortion de-penalisation.

What is highly relevant in the abovementioned account is the lecturer's call, and the subsequent agreement of most of the participants, for the need to contextualise and define what 'grave malformations' are in Colombian society. From the presentation and the discussion that followed, one can assume that the vast majority of conditions diagnosed by amniocentesis are highly susceptible to count as 'making life unviable'. This is so given that most chromosomal variations suppose cognitive differences, which translate into the lecturer's point on the need to achieve 'full development of all human capabilities and potentiality' in the terms expected by society and marked by medical standards, in order to count as a human person. This latter point relates, as expressed by the bio-ethicist, to sanitary (in)justice in terms of the implications of spending human, economical, and therapeutic resources on individuals who will not be able to 'perform' fully as human persons.

The previous debate also brought to the surface the fact that there are many understandings of the same legal possibility in terms of foetal conditions, as this chapter will continue to evidence. This shows that social imaginaries, social codifications, and individual cognitions and experiences of what is understood as desirable behaviour coincide when deciding on what is a 'condition incompatible with life'. In turn, this relates to the various understandings of (human) rights that respond to diverse understandings of who counts as a human person, and so whether or not his or her life is Constitutionally protected.

These issues are raised specifically by antenatal testing technologies, which provide the relevant information for diagnosing the foetus according to specific standards which, when they are not fully met, can lead to the termination of a pregnancy. However, although such technologies have been present in Colombia for quite some time, selective abortion de-penalisation, as evidenced in the previous debate, brought an undeniable link between the technologies and the practice to the surface.

National Forum

The National Forum in Bogotá was the first of such forums to take place in the capital cities of the different departments of the country. The meeting lasted two full days: the 31st May and 1st June 2007 from 8:00 a.m. until 5:00 p.m. The venue was the Auditorium of the Military University.

The National Forum was also set up by the Ministry of Social Protection and by the National University for discussing the different aspects of the abortion de-penalisation Sentence. This time again, Court Judges, representatives of the Ministry for Social Protection and the District's Secretary of Health, Ob-Gyn's, lawyers, jurists, nurses, professors, bio-ethicists, feminists, pro-lifers, and pro-choicers gathered for a rich and varied discussion on the aftermath of abortion de-penalisation, one year after.

In what follows I address three major points discussed in the National Forum, and that relate to abortion in cases of foetal 'conditions that make life unviable': the argument that abortion de-penalisation is a matter of human rights; the consequences that the definition 'unviable life' have for obstetricians; and lastly, the issue of social justice regarding abortion de-penalisation (as not all women have access to antenatal testing technologies). I have chosen these three issues because they provide a good vehicle for problematising the case of abortion when the foetus has a condition that 'makes life unviable'. The aim here is to show that despite the halo of goodness that discussing abortion in terms of human rights brings to the debate, the Colombian reality forces us to ask who is being taken into account when defining humans as subjects of human rights.

The matter of human rights

During these two days, the theme of abortion de-penalisation in cases of 'foetal conditions that make life unviable' was addressed, yet again, as a matter of human rights. This discussion allowed for upholding the idea that such de-penalisation contributes to building and achieving a more democratic society, respectful of women's human rights.

The ethnical component of Colombia evidences the differentiation and discrimination against women, especially those living in the most deprived areas. Abortion de-penalisation ... helps to bridge that gap (female bio-ethicist, lecturer, National Forum, 2007).

Abortion de-penalisation helps to build a more just society, inclusive and knowledgeable of women's rights (female lawyer, lecturer, National Forum, 2007).

Abortion de-penalisation represents, indeed, a leap and a progress to the respect of persons and especially of women (male bio-ethicist, lecturer, National Forum, 2007).

In addition to such a generalised understanding, a Judge of the Constitutional Court expressed the view that abortion de-penalisation represents a natural step for Colombian legislation, for de-penalisation helps to:

Construct a moral and ethical capital that is missing in Colombia. The Sentence searches for the defence of life ... [given] the decrease of religious ethics in terms of practice, which has not been replaced yet by a consistent civil ethics. ... De-penalisation attempts to make visible and transparent denied practices that take place on a permanent basis (male judge, National Forum, 2007).

With regard to the argument that to not allow a woman to abort a foetus with 'conditions that make life unviable' entails torture and cruel treatment to the woman, and amounts to a violation of women's human and Constitutional rights, various viewpoints were presented at the Forum. The first to address this issue was a young female lawyer who forms part of the women's group to which Roa belongs. The lawyer expressed the idea that:

A life that is not viable cannot be superior to the life of the woman. To oblige a woman to continue with the social, cultural, physical, economical, and emotional burdens of such a pregnancy constitutes inhuman and cruel treatment. It is a torture (female lawyer, lecturer, National Forum, 2007).

Later in the Forum, a professor of law explained that abortion de-penalisation in cases of foetal malformation represented a torture to the women, given that:

To keep abortion penalised in the case of grave foetal malformation was to force women to be walking coffins (male lawyer, university professor lecturer, National Forum, 2007).

Again, from these lawyers' speeches, the category of what constitutes a 'condition that makes life unviable' is treated as autonomous and self-evident. However, the female lawyer spoke of conditions that are not exclusively those which end the newborn's life in a matter of hours or days; rather, she included those conditions that speak to social norms and values portrayed as intrinsically burdensome, and that are costly in social, economic, and emotional terms. Once more, the plasticity of such a category is made evident yet not properly addressed. Such plasticity brings me to the second point I want to discuss related to the National Forum.

Challenges for obstetricians: the plasticity and multiplicity of 'incompatibilities with life'

In the morning of the first day, the medical aspects of Sentence C-355/06 were discussed. This was a good opportunity for obstetricians to express their concerns and doubts about the definitions used by the Constitutional Court when referring to women's health and to foetal 'conditions that make life unviable'. An obstetrician, who works both at a Governmental health institution and who has his own private practice, presented a lecture in which he pointed out the difficulties that obstetricians now face when trying to adjust to the Sentence's concept of 'incompatibilities with life'. What makes his presentation ethnographically rich is that he speaks from his own daily experience:

There is an enormous lack of knowledge, on the part of physicians, regarding the Sentence. The implementation of it has not been easy at all, given the ambiguity with which the Court de-penalised the cases. The Secretary of Health has so far registered 40 abortions in cases of foetal malformations, and from those cases one can tell that there is no unanimity whatsoever about what conditions count as making life unviable. ... It is also not clear in which week life is viable. We know about the threshold of weeks 22 to 28, but as you know, those dates are relative to the location of the woman and the facilities that she has access to depending on where she is (male obstetrician, lecturer, National Forum, 2007).

In order to illustrate the complexity and difficulties faced by obstetricians, the lecturer addressed those conditions that he found to be the most difficult cases to deal with:

There are severe foetal malformations in which life prognosis is almost zero, for example anencephaly, bilateral renal agenesis, or thanatophoric dysplasia. ... [I]n these cases an abortion decision is understandable. But there are other malformations, which are viable but rather problematic because parents still want to have an abortion, for example chromosopathies (trisomy 21, 13, or 18), heart pathologies, malformations of the central nervous system, metabolic alterations, cleft lip and palate ... (male obstetrician, lecturer, National Forum, 2007).

For many obstetricians in the audience, they felt their work to be more complex due to the ambiguous definition of health implied in the Sentence. Obstetricians and other medical doctors recognise that sometimes there is a condition that, although from a biological perspective it does not necessarily make the future baby's life unviable, makes life *difficult* for both the future child and the parents. From the debate that followed the lecturer's presentation, most of the obstetricians that were present agreed that in such a case, women and couples are the ones who should decide which course the pregnancy should take. Obstetricians could neither decide for prospective parents, nor impose the pregnancy. This possibility was voiced in terms of women's right to choose:

The problem here has to do with the definition of health used by the Court. If we think of health in those terms we have to think about the baby who will be born and will fit that definition. If we look at malformed foetuses we must also ask what kind of life the baby will have, and probably will not fit the definition of health (male obstetrician, participant, National Forum, 2007).

Yes, but not only that, you also have to think of the burden it is to have a disabled child. Who are we [medical doctors] to impose that onto a family? Women have the right to choose if they want to have a child like that, because it is them who have to take care of the child and not us (female paediatrician, National Forum, 2007)

At this point a connection was made clear: foetal 'conditions incompatible with life' are not limited to conditions that suppose the imminent end of the biological life of the newborn. Such a category can be stretched to include conditions that alter health as defined by the Court and by WHO on the one hand, and also the burden for women and families to give birth to and bring up children different from the average on the other. That is, 'conditions incompatible with life' also refer to incompatibilities with prospective parents' lives.

Social justice – for whom?

The issue of social justice was also raised at the Forum. Lawyers and obstetricians mostly recognised a gap between regulation and practice, because although women in the whole of Colombian territory are supposed to have equal possibilities for accessing an abortion under the de-penalised circumstances, there do not exist all over the country facilities for antenatal testing; and in those urban centres in which such facilities are found, not all women have access to the same technologies and procedures, given the expenses involved in such exams. That is, the majority of the pregnant population cannot count on the real possibility of accessing high-tech antenatal testing, monitoring, and care:

Although abortion de-penalisation represents a big step for reducing discrimination against women in general, the practice [abortion] is still very discriminatory against poor women. They have no real access to proper antenatal care and diagnostics. They are way too expensive for many women, not only the very poor (male obstetrician, lecturer, National Forum, 2007).

Antenatal testing, of the kind that can tell if the foetus is malformed, is too expensive for poor women, only the rich can access it (male obstetrician, participant, National Forum, 2007).

The issue of differential economic and geographic access to antenatal diagnostic technology that allows families to *partake* in their reproductive experiences makes evident that only a very small portion of the pregnant population has access to such technology. What is problematic in this situation is that it is through the use of and access to this kind of technology that women can exercise what are considered to be their human rights: not to be subjugated to torture on the one hand, and enabling women and couples to match up (at

least ideally) antenatal life with desired offspring and thus their life plans on the other, as expressed by the presenting Judge³².

This point complicates further the matter of selective abortion, because we are not only facing the need to define who is human enough have their life Constitutionally protected – as in the case of a foetus with genetic or morphological variations. We are also talking about exercising human rights in relation to a technology that the pregnant population has limited access to. This inevitably forces one to wonder about who is human enough to exercise their human rights in terms of economic conditions.

The three points addressed above make evident that concepts such as human rights, medical conditions, and social justice cannot be taken for granted without recognising that to determine such categories is an exercise of deliberate inclusion and exclusion.

The permanent seminar and the National Forum display different views, positions, and voices that, one way or another, are shaping and constructing the practice and understanding of de-penalised selective abortion in Colombia. Today, abortion has been equated to women's Constitutional and human rights, and is seen as a major leap towards *development* and to becoming a more *modern* nation. That is, to reach international (and by international I mean US and Western European) standards of civil rights, guarantees, and obligations.

From the discussion presented so far it is evident that the category 'conditions incompatible with life' is one that is flexible in nature; not limited to life in biological terms, but informed by a wider social understanding of health, illness, normal, and abnormal.

³² See Chapter 2 for the arguments used by Presenting Judge Araújo when defending selective abortion due to foetal conditions. Briefly, the Judge argued that not de-penalising abortion in cases of foetal conditions meant going against the woman's Constitutional right of '*choosing her life plan*', in order to privilege a life that *scientifically would not be viable*, or that is considered to be incompatible with life' (Sentencia C-355/06: 333, my translation, emphasis added).

Actors: Everyday understandings of 'incompatibilities with life'

Ethnographic data show how law and practice co-exist and shape one another. In this section I address what the generalised use of 'incompatibilities with life' means for actors that are in constant contact with foetal 'conditions incompatible with life'. Such actors are geneticists and specialists in maternal-foetal medicine. The following accounts echo the complexities and difficulties that selective abortion entails, as raised by lecturers and participants of the permanent seminar and of the National Forum; in this way making evident that the issues they raise reflect the opinions of a much wider public and, to some extent, an important portion of civil society.

I show that despite the attempt to pigeonhole foetal conditions into apparently absolute medical terms, seemingly devoid of any socio-cultural context, diseases and conditions are culturally constructed, so displaying the plasticity of the category 'incompatibilities with life'. Conditions belonging to such a category respond to a myriad of referents, cognitions, and social imaginaries that inform and are informed by the apparently objective scientific medical standards. Such an understanding of 'conditions incompatible with life' and disabilities are the ones shaping the practice of selective abortion today.

Geneticists

Four geneticists were interviewed in order to account for the viewpoint that such professionals have of abortion de-penalisation when the foetus has a 'condition incompatible with life'. Each belongs to a different genetics research institute. One is part of the genetics institute at the National University; another is the director of a private genetics institute and is also on staff at the institute at the National University; the third geneticist is a person considered by many to be the founding father of genetics in Colombia; and finally, another geneticist, the youngest of them all, is a staff member at the genetics institute of a private Catholic university, the representative for Colombia to the ECLAM (Latin American

Collaborative Study of Congenital Malformations), and, at the moment of this research, served as consultant to the Department in which the main fieldwork took place.

Amongst this group of geneticists exists different opinions and assessments of abortion de-penalisation in cases of 'incompatibilities with life', as expected. For three of these geneticists abortion comes in a natural equation with positive amniocentesis results. Moreover, since the possibility of testing the foetus in the uterus has been available in the country, many women have chosen to end their pregnancies once they learned that the foetus they were expecting had a chromosomal or genetic variation:

Abortion and amniocentesis go hand in hand. I mean, women who undergo an amniocentesis should, at least in principle, agree to have an abortion, even though they may change their mind later. If they cannot agree to that [abortion] then they shouldn't have an amniocentesis. It is a waste of resources to do this just to be prepared ... they can get prepared during the life they have ahead (Dr Ceballos, interview 2007).

Not all women who had an amniocentesis and had a problem sought an abortion. Also not all geneticists working with karyotypes or obstetricians doing amniocentesis regarded amniocentesis as mainly leading to abortions. Many did and do see it as a way to have information to be prepared for the child that will be born. But yes, many people used and use amniocentesis for terminating pregnancies if something is found. I mean, regardless of penalisation or de-penalisation, women have always aborted malformed foetuses if they wanted to. That is why in the Javeriana [Jesuit University] at the genetics institute they don't perform amniocentesis, because they see it as mainly leading to abortion (Dr Santos, interview, 2007).

I'm happy that abortion was de-penalised. I don't think that a woman has to have a child if she knows it has a genetic or congenital malformation and doesn't want to have it. If you have an exam like amniocentesis and it has a positive result, and you don't want to have it, you have to be able to choose not to have it (Dr Clavijo, interview, 2007).

However, the above views on the link between amniocentesis and abortion are not shared by all of the interviewed geneticists. One geneticist, Dr Tovar, rejects both abortion and amniocentesis, and sees abortion de-penalisation as a response to pressures from the WHO on Colombia to reduce rates of infant mortality due to congenital malformations, and thus meet standards of *development*. For him, abortion (in all cases) is an ethically regrettable practice. With regard to abortion in cases of foetal diagnosed conditions, he also finds it a move against biology:

If Colombia wants to meet indicators of development, the country needs to reduce the rate of congenital disease. There is a recent effort to study congenital malformations in order to prevent them, but also abortion de-penalisation responds to the urge of reducing them ... I personally do not agree with abortion. But regardless of that, what abortion de-penalisation did goes against biology. You must know that species strength lays on its genetic variability. We do not know if what we today consider as a disability could in the future be more adaptable than us to environmental changes ... that was, of course, not considered by the Judges. Colombia needs to meet the goals the country committed to with the WHO and the fast solution for reducing congenital malformations is abortion (Dr Tovar, interview 2007).

Dr Tovar's position, however, does not necessarily reflect a more inclusive understanding of people with disabilities, and thus of foetuses diagnosed with a 'condition incompatible with life'. On the contrary, Dr Tovar's quest and commitment is to reducing the rate of congenital and genetic conditions *before* conception takes place, so that the regrettable practice of abortion – with which he does not agree – would not have to take place at all.

However, despite their different positions towards selective abortion de-penalisation and practice, the interviewed geneticists all found the concept of 'incompatibilities with life' narrow to the extreme. Narrow because –as I show in what follows– only very few conditions can be considered 'incompatible with life', therefore, from these specialists' viewpoint, abortion de-penalisation will not have any effect on the epidemiology of public health indicators, so discussed in the abortion debate and de-penalisation.

The new abortion law is rather innocuous. Real severe malformations do not even come to term. The body itself rejects those cases of severe malformation. It is natural selection. So the idea of incompatibilities with life is irrelevant. We are then left with what is called minor malformation such as cleft lip and palate, Down syndrome – mongolism you know – and other malformations. In the case of cleft lip and palate I do not agree with abortion. Then you are left with abortion of, say, trisomy 21, Down syndrome. Those, in my view should be aborted. And you see how the rate of mongoloids is increasing and no one is doing anything about it. But Down syndrome does not count as an incompatibility with life, from a strictly medical point of view (Dr Ceballos, interview 2007).

That thing of the exceptions for interrupting a pregnancy because it is incompatible with life makes no sense. What does that mean? That means nothing. What is really incompatible with life does not make it to term. That [de-penalisation] was made for giving women a palliative solution, to make the process shorter. But in reality that means nothing, as very few cases are really incompatible with life and those cases are self interrupted by the body (Dr Santos, interview 2007).

Abortion de-penalisation, if we think only of foetuses with conditions that make life unviable, will not have any repercussions to public health indicators ... the incidence of severely malformed foetuses is so low that the rate of maternal death due to mal-practiced abortions will not be affected. But de-penalisation will have an impact on the composition of the population. That is because of the cases the Judge used as examples of conditions that make life unviable³³. I, mean, from his exposition many conditions fall then into that category. Because of the cases he used, medically those cases do not fall into the category of making life unviable, but he used them as if they do. ... You must know that he [the Judge] had no idea of what he was talking about, and Court Judges had also no idea of what they were listening to; in that sense everything, from limb malformation to anencephaly, count as conditions that make life unviable (Dr Tovar, interview 2007).

³³ As shown in Chapter 2, the conditions that the presenting Judge used for characterising 'conditions that make life unviable' were the use of Thalidomide during pregnancy, Tay-Sachs, sirenómelia, and cyclopia.

For geneticists, the understanding of ‘incompatibilities with life’ is very much limited to those medical conditions – the product of genetic or chromosomal composition – that result (in most cases) in the auto-elimination of the foetus. There is, apparently, no broader understanding of what ‘conditions incompatible with life’ suppose on the wider social level. This understanding, however, does not necessarily mean that geneticists do not agree with abortion of less severe conditions. The limitations they find in the narrow definition of ‘incompatibilities with life’ translate into a wish for a more flexible abortion possibility in cases of foetal diagnosed conditions that are less severe from a biological perspective, but that have implications at the social level and at the individual level of families with children with such conditions. That is the case, for instance, with Down syndrome, as expressed by Dr Ceballos in the above excerpt. This position is shared by Dr Santos and Dr Clavijo:

Yes, women should have the possibility to abort a foetus with Down syndrome. I mean, they have always done that, the majority of women, but that is not part of the de-penalisation, and it should be (Dr Santos, interview 2007).

I think that for society and for the being that is being gestated it is much better to interrupt that pregnancy, than to let a defective being be born. I support abortion because I believe that for both the individual and society it is better that cases of mental retardation do not make it to be alive. They would be a burden for the rest of their lives, to their families and to society (Dr Clavijo, interview 2007)

The strict view that geneticists have of the category ‘incompatibilities with life’ may be the result of a combination of factors, such as their professional background, and also because geneticists rarely meet women and couples after amniocentesis results have been provided, and therefore these professionals are not part of women’s and couples’ decision making processes in which the ample sensitivity of the term ‘incompatibilities with life’ materialises.

Specialists in maternal-foetal medicine

In this case, for most of the interviewed obstetricians and specialists in maternal-foetal medicine, abortion de-penalisation is a sensible and needed answer for women and couples who undergo antenatal testing. Furthermore, for most of the specialists and fellows on maternal-foetal medicine, abortion de-penalisation due to foetal 'conditions that make life unviable' provided this specialty with more possibilities for action. Nevertheless, all the interviewed obstetricians and specialists agreed on the point that abortion due to a diagnosed foetal condition is a decision only women can make. As these specialists perceive it, obstetricians or specialists can provide women and couples with valuable *objective and neutral* knowledge about their foetuses, but only the women should decide on what path to take once the foetal information is delivered³⁴. This is so because only women and couples can decide what kind of children they want, or feel like being able to bring up:

Amniocenteses are done for ruling out grave foetal conditions such as Down syndrome and other trisomies or chromosopathies ... I mean, what is grave is defined by each person. We as doctors must inform women about all the complications that a condition implies, but only they can decide if a [foetal] condition is too severe for them as future mothers and thus they decide if they want to abort (Dr Arroyo, interview 2007).

Having stated their position towards selective abortion decision making, obstetricians and specialists in maternal-foetal medicine expressed their understanding of 'conditions incompatible with life', which relate directly to how they perceive and practice selective abortion de-penalisation. Conditions that are considered severe enough to grant women and couples the possibility of an abortion range from extreme complications in medical terms, as previously presented by the geneticists, to conditions such as Down syndrome and the other trisomies, to all foetal conditions that women and couples may

³⁴ In Chapter 5 I delve further into the topic of selective abortion decision making in relation to how information is retrieved and handed in.

decide not to accept, as, for instance, cleft lip and palate. The understanding of 'incompatibilities with life' depends very much on each practitioner and his or her take on selective abortion. The wide range of variability in the understanding of 'incompatibilities with life' dovetails with the practice of selective abortion:

Incompatibilities with life are not well defined at all. For me, only conditions that are absolutely incompatible with life, such as heart conditions without surgical solutions, anencephaly, the absence of kidneys, or trisomy 13³⁵ or 18³⁶, can be aborted, but never Down syndrome ... but the thing is that the majority of amniocenteses that we perform are meant for ruling out Down syndrome ... most of the times one encounters couples that are not willing to accept a diagnosis of Down syndrome. For them the condition seems incompatible with life in economic and individual terms. Fortunately here we do not perform abortions, so I am not left with such a responsibility. I think I would not accept that case of abortion (Dr Cifuentes, interview 2007).

Abortion de-penalisation is seen and understood as solving a problem for the Colombian population, but what problem is it going to solve? There is no problem. What abortion de-penalisation did was to legalise a possible treatment ... now women do count with all the possibilities to chose. And they choose based on what they consider best for them, and we, as doctors can defend from a legal and scientific point of view almost all abortions. For instance Down syndrome, it not only refers to a chromosomal pathology but it refers as well to the concept of family, of life that couples may have and that may make that condition an incompatibility with life for them ... so basically women have to be well informed about everything and the decision is only theirs (Dr Sossa, interview 2007).

When the Court talks about incompatibilities I see it as incompatibilities with normal life, not only extreme situations as anencephaly, but also about Down syndrome or other conditions, you know ... but not to the extreme to

³⁵ Trisomy 13: 'a congenital condition that is characterized especially by usually severe mental retardation and by craniofacial, cardiac, ocular, and cerebral abnormalities, is caused by trisomy of the human chromosome numbered 13, and is typically fatal especially within the first six months of life — called also *Patau syndrome*'. Merriam Webster Dictionary. Online source: <http://www.merriam-webster.com/medical/trisomy%2013>. Accessed on 9th March 2009

³⁶ Trisomy 18: 'a congenital condition that is characterized especially by mental retardation and by craniofacial, cardiac, gastrointestinal, and genitourinary abnormalities, is caused by trisomy of the human chromosome numbered 18, and is typically fatal especially within the first year of life — called also *Edwards syndrome*'. Merriam Webster Dictionary. Online source: <http://www.merriam-webster.com/medical/trisomy%2018>. Accessed on 9th March 2009

abort a child who is missing an arm, that is where the whole thing gets complicated you know? Who gets to choose what is incompatible with life and what is not ... It really depends on how you feel about facing a situation, but I think minor physical defects cannot be aborted (Dr Arroyo, interview 2007).

I think that all malformed fetuses should be aborted. I am not saying I tell women to abort, but I think they should. You have to think that such individuals will be very expensive to both families and the health care system (Dr Torres, interview 2007)

In this sense, for these specialists abortion de-penalisation represents indeed the possibility for prospective parents to decide on the offspring they are willing to rear. From the above excerpts it is evident that, for this group of obstetricians, 'incompatibilities with life' refer directly to prospective parents' perceptions of a condition, which in turn responds to prospective parents' life plans. Such a wide understanding of this category speaks eloquently about the impossibility of defining it in absolute terms, on the one hand, and about the volatility of its understanding which informs the practice of selective abortion, on the other. From the viewpoint of some of these doctors (the vast minority), such a volatile definition opened a door that could easily lead to a slippery slope:

I can understand abortion in cases that are really extreme, that are even out of discussion, as for instance anencephaly. But you know that many cases can be put in terms of incompatible with life, obviously not from a medical or scientific point of view. I've seen many abortions that I do not consider incompatible with life; I don't know where this [selective abortion] is leading us. Now that it is de-penalised, everyone wants to abort what is not perfect, and doctors are allowing people to do that. Who are we to choose who is able to live? That, for me, is pure eugenics (Dr Isaza, interview 2007).

However, most obstetricians who support abortion in all cases of foetal diagnosed conditions find the flexible definition of 'incompatibilities with life' and the broad definition

of 'maternal health' the way out for helping women and couples to abort fetuses different from the average.

Most of those cases of minor physical defects, like missing an arm, are not accepted for abortion in the case of incompatibilities. Then, in those cases, if the woman does not want that defective child she alleges that that pregnancy puts a risk on her health. I mean, the woman, after being denied an abortion for a minor malformation uses the 'mothers' health argument'. There, in the definition of the mother's health, the Court did leave a very big opening, in which everything can count as endangering the emotional and mental health of the mother. So the lady says she is not able to continue with the pregnancy that falls into mother's health [category] and the foetus missing an arm is legally aborted (Dr Arroyo, interview 2007).

Nowadays it is possible to abort all malformed fetuses, because of the door opened by the law when the Court said 'mental and emotional health' of the woman. So every woman can opt for that option and say "Oh I am not prepared for this child, I am very upset, I may commit suicide", or whatever they want to say, and so the psychiatrist grants them the abortion. That happens all the time (Dr Torres, interview 2007).

Since de-penalisation, all cases of foetal conditions are aborted. Women either say it is an incompatibility with their life, or say they are in terrible distress. It is one way or another that women get legal abortions nowadays and doctors do not care about that. They [doctors] are no longer in danger of being prosecuted, so they do not care who aborts what (Dr Villa, interview 2007).

Another understanding, although marginal and expressed only by the limited number of fellows who have experience working in regions ridden by poverty, is that abortion de-penalisation due to foetal 'conditions incompatible with life' enables poor women to have access to services that only rich women had before (i.e. safe abortion):

I see it [abortion de-penalisation] as justice, you know? Women have been aborting malformed fetuses for many years now. Rich women who are less

willing to have disabled children had all the opportunities to abort in clean and safe ways, even in private clinics; doctors performed the abortions but named them differently, as miscarriages. But poor women had to either have their malformed children or undertake serious risks for accessing an abortion in an awful place, or they had to do it by themselves. Abortion of malformed foetuses will always take place, they have always been there; the difference now is that it is more just for poor women, who can abort safely (Dr Arroyo, interview 2007).

However, the fact that access to antenatal diagnostic technologies is only possible to those women living in urban centres and who have the economic means to afford them is not addressed or acknowledged by this specialist.

For other specialists, especially those starting their training in maternal-foetal medicine, selective abortion de-penalisation is seen as providing maternal-foetal medicine with a better reason to exist and to keep on existing. That is, selective abortion de-penalisation and practice comprises a fundamental component of the profession they belong to:

Abortion de-penalisation gave more opportunities and possibilities to this profession. I mean, really, this profession, maternal-foetal medicine, is basically the quality control check point. Without abortion de-penalisation this was not possible, now we [maternal-foetal doctors] are able to do what we are supposed to do: not to let pass what is not alright, see? (Dr Torres, interview 2007).

Now that abortion is de-penalised I see more possibilities for antenatal diagnosis. When I started studying perinatal medicine I liked it but was not sure about the real possibilities; now I see more clearly the use of it. Just to diagnose was a very narrow possibility of this speciality. Now we [doctors] can be part of the decision making process; before we [doctors] were completely left outside (Dr Leal, interview 2007).

These accounts show the imaginary that there is about the social mission of obstetrics and of maternal-foetal medicine. This understanding goes back to the roots of modern obstetrics, an issue that is addressed in Chapter 4.

Nevertheless, and despite the effervescence of having a wider scope of action, of perceiving more opportunities for women to choose on the quality of their offspring, of making legal a practice that has been going on illegally for as long as antenatal testing has been available, there is also – however marginal – the perception of an important downside to selective abortion de-penalisation. For only two maternal-foetal physicians, some obstetricians, and the lecturer at the National Forum, de-penalisation was seen as complicating further obstetricians' tasks. Given that abortion is now an option that obstetricians may eventually face (and to which they have to respond according to regulations), they are no longer in the comfortable position of leaving entirely to women the decision making process and further course of action. Today, obstetricians need to become involved in women's reproductive decisions in a visible way.

I defend life very much, that is why I decided to specialise in this [maternal-foetal medicine]. I want to protect life, to help women and babies who are in danger. Before [de-penalisation] I needed not to worry when women asked me for an abortion: it was illegal and penalised. The only thing I could do was to tell them to be careful and to recommend a clinic that performs abortions in a safe and hygienic way. Now, I know I will need to face eventually that [a woman wanting to abort a malformed foetus], and I know I need to be responsible and faithful to science's ethics (that is to fully inform the patient about the situation), but also to my morals, so I think that, if the day comes, I will refer the woman to a colleague. I think I won't be able to perform an abortion, especially in the case of a condition I don't consider incompatible with life, such as Down syndrome for instance (Dr Isaza, interview 2007).

With de-penalisation we have to be more involved in the whole process of decision making. It is not that we were not there before, but now it is more visible. It is no longer a matter entirely of the woman and her husband; we have to become also part of the process, you follow? We can no longer tell a woman a diagnosis, inform her that we do not perform abortions and leave

her to her fate. Today we not only diagnose but also perform abortions, and that is a big change (Dr Rincón, interview 2007).

So abortion de-penalisation contributes to a change in the responsibilities and scope of actions for obstetricians, from diagnosis to intervening in reproduction. Obstetricians' various points of view make it visible that there is not a unified understanding of what can be categorised as an 'incompatibility with life'. Also, there is not a common understanding of the effects of abortion de-penalisation. The result of such diverse opinions takes shape when physicians interact with women and couples and inform them about the diagnosis. Nuances, points of view, and life trajectories mould the information women and couples receive, which in turn is interpreted through women's and couples' life experiences and life and family plans.

In this section it was possible to elucidate that in practice the applicability of abortion de-penalisation in cases of foetal 'conditions incompatible with life' is far more nuanced and complex than anticipated by the Constitutional Court. There is not a unified and shared understanding of what 'incompatibilities with life' mean, for health conditions constellate within a given cultural context, and meanings attached to conditions shape and are shaped by such a context (c.f. Van der Geest 2000).

As exposed in this section, there exists a generalised perception of people with disabilities as burdensome to families and to society. Furthermore, when looking at the actors' accounts exposed in this section, in combination with the shared understanding that people with disabilities make life rather difficult for parents and the society in which they live, one can argue that the practice of abortion of foetuses that do not comply with prospective parents' expectations do fall into the de-penalised category of *incompatibilities with life*. As such foetuses are portrayed as preventing women's and couples' fulfilment of a life plan, not to grant an abortion violates a woman's Constitutional right to 'free development of the personality' (Sentencia C-355/06: 333).

Final comments

The public scenarios in which abortion de-penalisation was discussed, but mostly in which it was legitimised, and the accounts of actors who are in close contact with antenatal testing that can lead to abortion, show that abortion de-penalisation and practice in cases of foetal 'conditions incompatible with life' is a multilayered issue full of nuances and understandings. All such understanding and attitudes interrelate, inform, and shape abortion practice due to foetal conditions that 'make life unviable' today.

In this chapter I showed that the plasticity of the category (made evident in the variety of meanings attached to it) speaks volumes about issues regarding the role of the socio-cultural context in constructing the perceived severity of a condition, and of the attached usages, meanings, and functions of antenatal diagnostic technologies in relation to the categories such technologies enable (Latour 2002; M'charek & Keller 2008). In addition, I showed that it is not only the generalised rejection of foetuses that are different from the average, but also that given the existing imaginary about people with disabilities as inherently burdensome in emotional, social, and economical terms, there exists too a generalised desire to prevent them from coming to be. Such is the case of chromosomal conditions of the kind of trisomy 21 – associated with Down syndrome – which although they do not represent an imminent threat for life in biological terms, are perceived by most of the presented actors as an 'incompatibility with prospective parents' lives', which then makes foetuses with those conditions susceptible to being aborted. Furthermore, given the generalised perception of people with disabilities as inherently burdensome at all experiential levels, if women are not granted the legal possibility of abortion in cases of 'incompatibilities with life' (because the treating obstetrician does not recognise the diagnosed foetal condition as falling into that category), women may resort to the argument that their emotional and mental well-being is at risk and will thus be granted the abortion possibility anyway. Abortion de-penalisation enables, in many ways, prospective parents to choose their offspring in terms of quality and suitability to their life plans.

Finally, through Chapters 2 and 3, we can see that an ideal of a child, family member, and fellow citizen is emerging. Hence, it is paramount to dig into the history of such an

anthropological ideal, while digging as well into the history of the role of obstetrics, and especially of amniocentesis. This will reveal their role as key elements for helping to achieve the birth of such ideal individuals, and their role in setting the standards of *normality* and thus of desirability of prospective children and fellow citizens. This is the focus of the following chapter.