4 needed rules for fetal-tissue use

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Brian Lies illustration

The use of aborted fetuses as a source of tissue transplants has reignited antagonisms among anti-abortion advocates, women's rights proponents, and the biomedical community.

Anti-abortion groups oppose the use of fetal tissue in medical treatments not explicitly designed to save fetal life for two principal reasons. First, they argue that such use will increase the rate of abortion. Second, they claim that since abortion is immoral, it is also immoral to use the tissue from aborted fetuses, even if that use successfully treats otherwise untreatable diseases.

The Supreme Court in Roe v. Wade declared that abortion is legal and that the fetus is not a person within the meaning of the 14th Amendment to the Constitution. While the debate over the morality of abortion persists, public policies must be developed to address new biomedical research programs and therapies that require living, non-viable fetuses or newly obtained fetal tissue.

In May 1988, the Department of Health and Human Services instituted a moratorium on research utilizing human fetal tissue obtained from induced abortions for therapeutic transplantations. The restrictions did not apply to therapeutic research using human fetal tissue from spontaneous abortions or stillbirths, nor did they apply to non-therapeutic research uses of any legally acquired human fetal tissue.

The National Institutes of Health, a part of DHHS, convened an ad hoc advisory committee to address the ethical and medical implications of human fetal tissue transplants, and to consider the circumstances of their therapeutic use.

In September 1988, the NIH panel reached a tentative conclusion that it was acceptable public policy to use human fetal tissue obtained from legal abortions for research and therapy. In that month, President Reagan directed the secretary of health and human services to prepare policy that would "protect unborn or newborn children from experimentation, research, and organ transplantation, except in cases where the unborn or newborn would itself directly benefit."

A draft executive order was then circulated that would ban the use of fetal tissue from induced abortions in federally financed research. Thus, federal policy on the use of fetal tissue for research and therapy is still unresolved.

The recent fetal tissue transplant experiments performed at Yale were allegedly supported by private funds and thus did not fall within the purview of the current federal moratorium on such experiments. Clearly, the Reagan administration is not of one mind on this issue.

With the Reagan presidency coming to a close, it is unlikely that an executive order will preempt the direction NIH seems to be taking, which also reflects widely held views in the biomedical community.

Given the legality of abortion, the main policy issues regarding the use of tissue from non-viable aborted fetuses must focus on the protection of the rights of women from whom the fetal tissue is obtained and the rights of people who are the recipients of these transplants.

There must be a reasonable medical consensus that this type of therapy promises sufficient benefits to be worth pursuing. Guidelines need to be established about which patients should be eligible to receive transplants and how to evaluate the results.

A woman who chooses an abortion deserves to have her emotional and physical safety be given the highest priorities. To this end, she must be protected from undue pressure to donate fetal tissue as a way of allaying possible guilt about the abortion. The method and timing of abortion must not be tailored to obtain fetal tissue at a particular stage of gestation.

Women must not be placed under pressure to produce embryonic tissue for a relative or a friend. (In one reported case, the daughter of a man who had Alzheimer's disease asked to be inseminated with her father's sperm to provide him with fetal tissue for a neural tissue transplant.) This is similar to the pressures people have been put under to donate a kidney or other organ for a close relative, but, unlike the donation of fetal tissue, at least that pressure has been gender-neutral.

The demand for fetal tissue could reinforce existing social pressures on women to sacrifice their well-being for others.

We propose the following minimum conditions on the use of fetal tissue in research or therapy:

1. Consent for such use must be derived from the pregnant woman whether the fetus is aborted spontaneously or by choice.

2. There should be no commercialization of fetal tissue at any level. Women should not obtain money for donating fetal tissue. Physicians, brokers and other intermediaries should not profit from providing the tissue for research or therapy. There should be no patenting of fetal material.

3. Women should be adequately protected from being pressured in any way to undertake pregnancies for the purpose of providing fetal tissue for transplants. These pressures are particularly heightened when a transplant is needed for a member of the immediate family.

4. The standards on the use of fetal tissue should be uniform and not depend upon the source of the tissue or on whether the experiments are done with public or private funds.

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